Unannounced Inspection Report: Independent Healthcare

Service: Nova Recovery
Service Provider: Nova Recovery Ltd

5–6 December 2022
Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Advisor on 0141 225 6999 or email his.contactpublicinvolvement@nhs.scot
1 Progress since our last inspection

What the provider had done to meet the requirements we made at our last inspection on 5–6 April 2022

Requirement
The provider must ensure that the flooring in the dining room is replaced to allow for its effective decontamination.

Action taken
New flooring had been fitted which could be easily cleaned. This requirement is met.

Requirement
The provider must ensure that all relevant staff members have carried out training to make sure clinical observations are fully and accurately recorded in patient care records.

Action taken
Staff had completed training in the national early warning score (NEWS) tool used to score physiological measurements, such as blood pressure. This requirement is met.

What the service had done to meet the recommendations we made at our last inspection on 5–6 April 2022

Recommendation
The service should comply with national guidance to make sure that the appropriate cleaning products are used for the cleaning of all sanitary fittings, including clinical hand wash sinks.

Action taken
Cleaning products used in the service had been changed and now included using an appropriate chlorine solution in line with national guidance.

Recommendation
The service should add a ‘date opened’ label to all food stored in patient fridges.

Action taken
The fridge was clean and tidy. A notice had been attached to the fridge door to advise all patients to use the labels supplied to write their name and date of the item being placed in the fridge. The kitchen porter checked the fridge daily, and signed and dated a recording sheet to confirm this had taken place.
Recommendation
The service should destroy Disclosure Scotland Protecting Vulnerable Groups (PVG) records in line with current legislation and implement a system to record PVG scheme identification numbers for all staff.

Action taken
All PVG Disclosure documents had been destroyed and only the PVG number for staff members was kept electronically.

What the provider had done to meet the requirements we made after a complaint investigation on 6 May 2022

Requirement
The provider must ensure that all consultations including those by medical practitioners are fully documented in the patient care record, this must include the date and time of every consultation with, or examination of, the service user by a health care professional and the name of that health care professional.

Action taken
Electronic patient care records were reviewed and all consultations were documented, including the date and time of the contact with the patient. This requirement is met.

Requirement
A provider must, having regard to the size and nature of the service, and the number and needs of service users—

(a) Ensure that at all times suitably qualified and competent persons are working in the independent health care service in such numbers as are appropriate for the health, welfare and safety of service users.
(b) The provider must ensure that patients have full access to a registered medical practitioner who attends the service and is accessible over a 24 hour period.

Action taken
The service employed suitably qualified practitioners, with appropriate staffing levels to maintain patients’ safety and welfare. A system was in place to give patients access to a registered medical practitioner over a 24-hour period. This requirement is met.
What the service had done to meet the recommendations we made at a complaint investigation on 6 May 2022

Recommendation
The service should ensure that information provided to patients prior to admission clearly sets out what the service provides and that avenues of referral are provided with this information to disseminate to potential patients.

Action taken
Detailed information and patient welcome packs were available to patients through the admissions team. Both had a comprehensive overview of how to refer patients to the hospital, what to expect during a stay and an in-depth description of therapies available.
2 A summary of our inspection

The focus of our inspections is to ensure each service is person-centred, safe and well led. Therefore, we only evaluate the service against key quality indicators which apply across all services. However, depending on the scope and nature of the service, we may look at additional quality indicators.

About our inspection

We carried out an unannounced inspection to Nova Recovery on Monday 5 December 2022. We spoke with staff and patients during the inspection.

The inspection team was made up of three inspectors and an external advisor. A key part of the role of the external advisors is to talk to key members of staff about their area of expertise.

As part of the inspection process, we asked the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Framework and ask the service to tell us what it does well, what improvements could be made and how it intends to make those improvements. We did not request an updated self-evaluation from the service before the inspection.

What we found and inspection grades awarded

For Nova Recovery, the following grades have been applied to the key quality indicators inspected.

<table>
<thead>
<tr>
<th>Key quality indicators inspected</th>
<th>Grade awarded</th>
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<tbody>
<tr>
<td>Domain 2 – Impact on people experiencing care, carers and families</td>
<td></td>
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<tr>
<td>Quality indicator</td>
<td>Summary findings</td>
</tr>
<tr>
<td>2.1 - People’s experience of care and the involvement of carers and families</td>
<td>Patients we spoke with were pleased with their care and treatment and felt well informed. Group and one-to-one therapy sessions were readily available. Patients were comfortable and could make certain personal choices, such as food. Complaints information for patients must include Healthcare Improvement Scotland contact details.</td>
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### Key quality indicators inspected (continued)

#### Domain 5 – Delivery of safe, effective, compassionate and person-centred care

<table>
<thead>
<tr>
<th>Quality indicator</th>
<th>Summary findings</th>
<th>Grade awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 - Safe delivery of care</td>
<td>The environment was clean. An audit programme was in place. All patients had individual risk assessments in place. The provider must notify Healthcare Improvement Scotland of certain matters noted in the notification guidance. The policy for managing healthcare emergencies must be reviewed. Although a risk register was in place, it must be further reviewed. Medication reconciliation processes should be introduced. Clinical practice policies should reflect practice in the service.</td>
<td>Satisfactory</td>
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#### Domain 9 – Quality improvement-focused leadership

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<tr>
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<tbody>
<tr>
<td>9.4 - Leadership of improvement and change</td>
<td>The service’s leadership team was visible and responsive. Staff and patient suggestions were considered and an improvement plan helped identify improvement actions. Oversight of the quality assurance systems and processes must be improved. A whistleblowing policy should be developed.</td>
<td>Satisfactory</td>
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The following additional quality indicators were inspected against during this inspection.

### Additional quality indicators inspected (ungraded)

#### Domain 3 – Impact on staff

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<tr>
<td>3.1 - The involvement of staff in the work of the organisation</td>
<td>Staff felt supported in their role and received regular supervision and yearly appraisals. Regular staff meetings were held. Staff told us management was approachable and open to ideas. Communication between teams and senior management should be improved.</td>
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### Additional quality indicators inspected (ungraded) (continued)

#### Domain 5 – Delivery of safe, effective, compassionate and person-centred care

<table>
<thead>
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<tr>
<td>5.2 - Assessment and management of people experiencing care</td>
<td>A detailed assessment process is in place. Treatments and therapies are available to support patient recovery, including aftercare. Patients must be regularly monitored and documentation of the monitoring must be audited. Medicines and prescribing policies should be updated in line with General Medical Council guidance. The Patient’s GPs should be given a discharge summary of any inpatient episode. A programme of patient care record audits should be introduced.</td>
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#### Domain 7 – Workforce management and support

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<tbody>
<tr>
<td>7.1 - Staff recruitment, training and development</td>
<td>A recruitment process was in place for new staff, as well as an induction programme. Staff had a training and development plan. All staff and volunteers should have suitable background checks carried out. Staff files should be complete and a system should be in place to check this. A sessional doctor policy should be developed.</td>
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Grades may change after this inspection due to other regulatory activity. For example, if we have to take enforcement action to improve the service or if we investigate and agree with a complaint someone makes about the service.

More information about grading can be found on our website at:  
http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/ihc_inspection_guidance/inspection_methodology.aspx

Further information about the Quality Framework can also be found on our website at:  
What action we expect Nova Recovery Ltd to take after our inspection

This inspection resulted in eight requirements and 14 recommendations. Requirements are linked to compliance with the National Health Services (Scotland) Act 1978 and regulations or orders made under the Act, or a condition of registration. See Appendix 1 for a full list of the requirements and recommendations.

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/find_a_provider_or_service.aspx

Nova Recovery Ltd, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at Nova Recovery for their assistance during the inspection.
3 What we found during our inspection

Outcomes and impact

This section is where we report on how well the service meets people’s needs.

Domain 2 – Impact on people experiencing care, carers and families

High performing healthcare organisations deliver services that meet the needs and expectations of the people who use them.

Our findings

Quality indicator 2.1 - People’s experience of care and the involvement of carers and families

Patients we spoke with were pleased with their care and treatment and felt well informed. Group and one-to-one therapy sessions were readily available. Patients were comfortable and could make certain personal choices, such as food. Complaints information for patients must include Healthcare Improvement Scotland contact details.

The service’s website was informative and patients could ask for information about the service and its available treatments before agreeing to admission. The information given to patients included a detailed and easily understood brochure. All patients we spoke with were complimentary and positive about the information they received.

Patients were told what to expect on arrival and in the days following admission. All patients we spoke with told us they appreciated this as it made the transition to being an inpatient much easier. Each bedroom had a detailed patient welcome pack which included the risks and benefits of medically-assisted detoxification and how staff would support them through the process. It also gave details of daily routines and the rules of the service.

Patients we spoke with commented:

- ‘Brilliant on admission, I was so nervous and scared.’
- ‘Gobsmacked with the staff, it was care and then some.’

Patients were involved in their own care with the service’s recovery team and had control over decisions for their recovery. Patients could attend one-to-one therapy, group sessions and could also book additional therapy sessions with a cognitive behavioural therapist (CBT).
It was agreed with patients that, throughout their stay, their significant family member was called to discuss progress and discharge arrangements, including ways to support the patient after discharge.

The service had a participation policy in place, which detailed a variety of ways patients were involved in the service’s development and running. This included a patient discharge survey as well as weekly, patient-led meetings, called community meetings. These community meetings were open to everyone in the service and we saw patients were able to give their opinions on anything about their care or environment. From minutes of community meetings, we saw the service had quickly taken actions to address issues patients had raised. Community meeting minutes were shared with the senior management team and the directors of the service. Patients could also raise concerns directly with their support worker. All patients we spoke with were very satisfied with how they could affect change.

Examples of environmental changes made from community meetings included:

- radiators fixed
- rubber mats on the decking to reduce slips, and
- shower pressure adjusted.

We also saw the service had made changes to improve patient wellbeing following suggestions from community meetings, including:

- a community café on a Friday evening, with transport provided for patients
- a group email to keep people in contact and share information
- a request for patients not to smoke under bedroom windows, and
- more CBT therapy appointments available for patients to book themselves.

We reviewed some completed patient-discharge surveys and saw the average patient satisfaction rate was 98%.

We saw patients were involved in decisions around social activities and outings, such as where to go for the weekly outing to a variety of different venues.

We spoke with two patients scheduled to be discharged shortly after our inspection. They told us they felt confident about leaving after receiving the support in the service and knowing the support was available post-discharge. Comments included:
• ‘Once I was in here I did not want to be discharged, now I am looking forward to going home.’
• ‘I feel well equipped for discharge, I now know what my triggers are and how to avoid.’

The service had a complaints policy in place and staff had been trained in managing complaints. Complaints we reviewed during our inspection were managed in line with the service’s policy timeline and had reached a satisfactory conclusion for the complainant.

Duty of candour is where healthcare organisations have a professional responsibility to be honest with patients when things go wrong. The service had a duty of candour policy in place. It had not had any instances where it had been required to be implemented.

**What needs to improve**

Complaints information in patients’ welcome pack referred to the Scottish Public Services Ombudsman. This is inaccurate as the service is not a public service. It also did not make it clear that Healthcare Improvement Scotland can be contacted at any time during the complaints process (requirement 1).

The service had not published a yearly duty of candour report (recommendation a).

We discussed with the service that it may be of benefit to have an external body to review complaints that the service could not resolve internally. We will follow this up at future inspections.

The service had a list of ‘useful numbers’ in its patient information pack. We discussed with the service that Healthcare Improvement Scotland’s contact details could be added to this list.

**Requirement 1 – Timescale: immediate**

- The provider must update its patient information to make clear that complainants can contact Healthcare Improvement at any stage of the complaints process.

**Recommendation a**

- The service should publish a yearly duty of candour report.
Domain 3 – Impact on staff

High performing healthcare organisations value their people and create a culture and an environment that supports them to deliver high quality care.

Our findings

Quality indicator 3.1 - The involvement of staff in the work of the organisation

Staff felt supported in their role and received regular supervision and yearly appraisals. Regular staff meetings were held. Staff told us management was approachable and open to ideas. Communication between teams and senior management should be improved.

Members from all staff groups we spoke with told us that management supported them well and listened to service improvement ideas they had, such as:

- staff asking to complete training to allow them to provide additional patient therapies, and
- increasing staff numbers to improve the service for patients.

Staff had regular supervision and support from the learning and development lead. Line managers met with their staff twice a year to review their personal development plan and set personal objectives for the year ahead. Staff we spoke with felt valued and supported to do their job well.

‘All staff’ meetings were held every 6 weeks to share information and covered areas, such as:

- clinical staff
- housekeeping and maintenance staff, and
- kitchen staff.

We received 14 responses to a staff survey we sent out during inspection. The majority of staff who responded were very positive about the service’s leadership and culture. Respondents told us that concerns they had were heard. The majority told us it was a good place to work and staff we spoke with during our inspection told us the same.
Comments from our survey included:

- ‘The service manager is very supportive and encouraging. Concerns are taken seriously and dealt with.’
- ‘Nova Recovery is a fantastic place to work.’

What needs to improve

Some staff we spoke with told us that the communication between teams and senior management could be improved. A ‘communication book’ on the unit was used to share useful information or messages with colleagues. However, we saw this was not always effectively used and staff told us that some useful information was not shared, such as maintenance issues. We saw no evidence of the sharing of staff updates, such as in a regular newsletter, email to staff or on the staff noticeboard (recommendation b).

Of the 14 respondents to our staff survey, six told us they were unable to influence how things were done in the service. We discussed with the service manager the value of capturing staff feedback about the service’s work, so that staff could be involved in identifying areas of improvement service development (recommendation c).

- No requirements.

Recommendation b

- The service should develop different communication strategies to ensure staff are kept up to date with information about the service.

Recommendation c

- The service should develop systems to ensure it engages and captures feedback from staff.
## Service delivery

This section is where we report on how safe the service is.

### Domain 5 – Delivery of safe, effective, compassionate and person-centred care

High performing healthcare organisations are focused on safety and learning to take forward improvements, and put in place appropriate controls to manage risks. They provide care that is respectful and responsive to people’s individual needs, preferences and values delivered through appropriate clinical and operational planning, processes and procedures.

### Our findings

#### Quality indicator 5.1 - Safe delivery of care

The environment was clean. An audit programme was in place. All patients had individual risk assessments in place. The provider must notify Healthcare Improvement Scotland of certain matters noted in the notification guidance. The policy for managing healthcare emergencies must be reviewed. Although a risk register was in place, it must be further reviewed. Medication reconciliation processes should be introduced. Clinical practice policies should reflect practice in the service.

The environment was clean and homely with suitable spaces for group work and individual therapeutic meetings. We saw evidence of routine reporting of maintenance issues, including environmental and health and safety checks in a maintenance file. A risk register with appropriate actions documented was in place.

The service had several bedrooms downstairs which were appropriately prioritised for new admissions, where patients may present with higher risks. All patients had individual risk assessments in place and these were accessible to the team on the electronic patient care record system.

We saw safe medication storage and destruction systems in place and were told that nurses checked medication that patients bring with them.

We were told the service could respond appropriately in the event of a medical emergency. Necessary medical emergency equipment was available and staff had received appropriate training, including essential life support. A GP who visited the service weekly for routine monitoring of patients could be contacted out-of-hours for advice. From incidents we reviewed, we saw evidence that
emergency services were contacted when patients’ needs were not able to be managed in the service.

Staff we spoke with who had completed training for the protection of vulnerable adults and children knew how to raise a concern.

An audit programme was in place and covered a wide range of areas, including:

- accidents and incidents
- agency use
- catering, and
- workforce.

**What needs to improve**

The service had a number of emergency situations whereby patients experienced seizures while in its care. These had been managed through contact with emergency services rather than following the service’s policy for seizure management. The emergency medication available in the service also did not match what was stated in its policy (requirement 2).

Staff were aware of what and how to report an incident on the service’s manual accident and incident reporting system. From incidents we reviewed, we saw that the service manager had made changes to systems and processes after investigating them. However, we found some incidents which met the criteria had not been notified to Healthcare Improvement Scotland. This is not in line with our notifications guidance (requirement 3).

While a risk register was in place, we found some issues which had not been captured on the register or been effectively managed, such as management of patient seizures as a patient safety risk (requirement 4).

Learning from incidents was inconsistently recorded and we saw no evidence that learning was shared with staff. We were also told that on-site debriefs were carried out when staff had faced a challenging situation or were involved in an incident in the service. However, we saw no written evidence of these debriefs or learning from incidents (recommendation d).

Patients’ prescribed medication was discussed during the initial assessments and patients were asked to bring a 28-day supply of any regular medication. The service had an electronic patient care record system which allowed patients’ prescriptions to be directly inputted. However, an internet issue prevented the system being used in the administration area and so nurses transcribed
prescriptions to paper medication charts. The service was aware of the potential risks of transcription errors and had a process in place for a second nurse to counter-sign all charts. We also found that the service did not have a formal documented medication reconciliation process nor was there a record of medicines reconciliation recorded in the patient care record. This is where services make sure that a patient’s medication list is as up to date as possible in patient care records (recommendation e).

The service had a range of detailed clinical practice policies in place. However, we found duplication between some clinical practice policies. Some were out of date, some did not have named individuals as authors and not all reflected the care provided at Nova Recovery (recommendation f).

We found inconsistencies between audit results the service had carried out and what we found during our inspection. For example, while the service’s infection prevention and control audit had found 100% compliance, we found:

- incorrect sharps bins being used
- sharps bins with no details, and
- staff carrying dirty linen through the dining room (recommendation g).

**Requirement 2 – Timescale: immediate**
- The provider must review its policy for managing patient healthcare emergencies, including seizures, in the service and make sure staff are trained in the policy to allow them to manage these situations safely, including the administration of emergency medication.

**Requirement 3 – Timescale: immediate**
- The provider must notify Healthcare Improvement Scotland of certain matters as noted in the notifications guidance.

**Requirement 4 – Timescale: immediate**
- The provider must review the risk register to ensure that all risks in the service have been identified and assessed. This will ensure effective oversight of how the service is being delivered.

**Recommendation d**
- The service should ensure that learning from incidents and incident debrief meetings are documented and shared with staff.
Recommendation e
- The service should make sure there is a formal documented medicines reconciliation process put in place and that medicines reconciliation is recorded in the patient care record.

Recommendation f
- The service should ensure relevant clinical practice policies are reviewed to ensure they reflect how the service is delivered.

Recommendation g
- The service should ensure that staff follow its infection prevention and control policy.

Our findings

Quality indicator 5.2 - Assessment and management of people experiencing care

A detailed assessment process is in place. Treatments and therapies are available to support patient recovery, including aftercare. Patients must be regularly monitored and documentation of the monitoring must be audited. Medicines and prescribing policies should be updated in line with General Medical Council guidance. The Patient’s GPs should be given a discharge summary of any inpatient episode. A programme of patient care record audits should be introduced.

Non-clinical staff in the admissions team carried out a remote pre-admission assessment for every patient to determine suitability for the service. A doctor carried out another assessment on admission virtually or face-to-face to further explore patient needs and inform treatment plans.

The service had a range of interventions available as part of the recovery programme, including:

- ‘12 steps’ sessions
- cognitive behavioural therapy, and
- psychoeducational group work.

The service had recently introduced an electronic patient care record system which allowed the majority of patient care records to be stored on one platform. In the five patient care records we reviewed, we saw personalised
care plans in place and routine entries documenting engagement with the recovery programme.

Nursing staff and recovery workers carried out handovers between each shift. From handover records we reviewed, we saw evidence of progress notes and risks for each patient. They also contained important information, such as incidents and outstanding duties.

A ‘recovery worker’ had recently been introduced to make all patients aware of and encourage engagement with the aftercare services available. Patients could attend remote, weekly group sessions for a year after their discharge from the service. The recovery worker was also available to give advice, guidance and support to patients if they wished. The service also tried to link patients with mutual aid groups in their local community to help support recovery beyond discharge.

Recovery workers supported patients and families during the patient’s stay and arranged weekly calls post-discharge. This could be more frequent if it was felt necessary. The calls were supportive and also gave patients and families the opportunity to talk through challenges and re-enforce coping techniques.

The service was also linked with community drug and alcohol support groups. Transport was available and patients were encouraged to attend. This also prepared them for the groups they would be linked into post-discharge in their local area.

**What needs to improve**

Patients had regular physical health monitoring for alcohol withdrawals and blood pressure care planned at regular intervals. However, patient care records we reviewed showed this was not carried out consistently. For example, patients who may have required monitoring every 3 hours had patient care records showing checks were completed only twice in 2 days. Some patients had previously experienced seizures while under the service’s care and so monitoring was important to identify potential deteriorating health (requirement 5).

The service told us that while it routinely asked for patients’ consent to access or share their medical records, to allow for safe care and detoxification planning, it rarely received consent. GP summaries of patient medical records were not available for any of the 12 patients in the service at the time of our inspection. This made it difficult for the service to make sure it had adequate knowledge of the patient’s health, allowing it to safely prescribe medicines in line with GMC guidance. We saw no recorded discussions with patients about:
• the importance of providing the consent to share this information
• the risk associated if it was not shared, or
• any reason or justification for the decision to prescribe (recommendation h).

While the service had developed its aftercare provision to patients, it had no standardised discharge summary provided to patients’ GPs (recommendation i).

The service had recently introduced an audit to monitor the number of patients with GP details recorded. From patient care records we reviewed, we found inconsistencies between the service’s audit results and what we found. While the service carried out a generic patient care record audit, this was limited in the information it checked (recommendation j).

We also spoke with the service manager and discussed auditing the number of GP summaries provided. This would help to reduce the risk of patients receiving treatment without GP information. We will follow this up at future inspections.

**Requirement 5 – Timescale: immediate**

- The provider must ensure that patients’ physical health is regularly monitored and documentation audited to make sure these checks are carried out.

**Recommendation h**

- The service should record patient consent for sharing information with their GP and other medical staff in patient care records, the risk associated if it was not shared and any reason or justification for the decision to prescribe.

**Recommendation i**

- The service should provide GPs with a discharge summary of any inpatient episode.

**Recommendation j**

- The service should develop a programme of patient care record audits. Audits should be documented and improvement action plans implemented.
Domain 7 – Workforce management and support
High performing healthcare organisations have a proactive approach to workforce planning and management, and value their people supporting them to deliver safe and high quality care.

Our findings

Quality indicator 7.1 - Staff recruitment, training and development

A recruitment process was in place for new staff, as well as an induction programme. Staff had a training and development plan. All staff and volunteers should have suitable background checks carried out. Staff files should be complete and a system should be in place to check this. A sessional doctor policy should be developed.

Appropriate recruitment policy and procedures were in place. We reviewed 10 staff records, including four for the sessional doctors during our inspection. Sessional doctors is a term used in the community and GP practice for doctors working one or more sessions (usually a morning session or afternoon session). We saw that new staff completed an induction period, role-specific training and had an induction pack. The service had developed a training dashboard, along with a service-wide training and development plan. This allowed managers to easily see when staff were due refresher training.

Staff received regular support and supervision from managers and were encouraged to perform well and develop their skills. A process was in place to make sure managers carried out yearly appraisals for staff. We saw examples where staff had been promoted to roles with more responsibility.

Staff we spoke with understood their individual roles and had been suitably trained for them. They knew other team members’ responsibilities and who to contact for information or to resolve an issue. Staff kept up to date with changes in legislation and best practice through online training courses and continuous professional development.

Members of the management team told us about challenges the service had with local recruitment. While this did mean the service sometimes used agency staff, two agency staff were used regularly and had become familiar with the service and its routines. Since staff were willing to be flexible with shift patterns to meet its needs, the service’s use of agency staff was minimal.
What needs to improve
The service used volunteers to assist with group sessions. However, it did not have a policy in place to manage this practice (requirement 6).

When checking that all staff or volunteers had Protecting Vulnerable Groups (PVG) checks in place, we noted that one sessional doctor and none of the volunteers had a PVG check documented (requirement 7).

Some staff files we reviewed had gaps in documentation, including missing:

- induction packs
- references, and
- training records.

The staff files for the sessional doctors we reviewed also had no evidence of:

- contract or engagement agreement
- indemnity insurance certificates
- evidence of a completed induction or orientation (recommendation k).

While the service carried out professional registration checks for all staff at recruitment, we saw no evidence that this was checked yearly (recommendation l).

No policy was in place for the sessional doctors (recommendation m).

Requirement 6 – Timescale: immediate
■ The provider must develop a policy to support the recruitment and management of volunteers working in the service.

Requirement 7 – Timescale: immediate
■ The provider must ensure that it follows guidelines on safer recruitment. This must include carrying out PVG checks.

Recommendation k
■ The service should ensure staff files are complete and information recorded in line with safe staffing best practice.

Recommendation l
■ The service should ensure that an annual professional registration check is completed and recorded for all relevant staff working in the service.
Recommendation m

- The service should develop a sessional doctor’s policy.
Vision and leadership

This section is where we report on how well the service is led.

Domain 9 – Quality improvement-focused leadership

High performing healthcare organisations are focused on quality improvement. The leaders and managers in the organisation drive the delivery of high quality, safe, person-centred care by supporting and promoting an open and fair culture of continuous learning and improvement.

Our findings

Quality indicator 9.4 - Leadership of improvement and change

The service’s leadership team was visible and responsive. Staff and patient suggestions were considered and an improvement plan helped identify improvement actions. Oversight of the quality assurance systems and processes must be improved. A whistleblowing policy should be developed.

The senior management team was visible, approachable and we found a positive atmosphere in the service. The management team was keen to improve and develop the service. We saw that it actively listened to patients, for example feedback from the patients’ community meetings. The service had an improvement plan in place which identified areas of improvement. The improvements in the plan had been granted funding approval from the board and work had started on an IT upgrade to assist digital patient care records. The improvement plan also documented requests from the community meetings. The provider’s senior management team members supported clinical governance and management activities in the service.

Staff we spoke with enjoyed working in the service and told us they had a good team with colleagues always willing to support each other. Senior management staff told us that a confidential helpline was available for staff. Feedback we received from staff included:

- ‘This is the best job I have had.’
- ‘Happy to change shifts to ensure patients are safe.’

The provider’s operations manager attended on the second day of our inspection and regularly visited the service to support the team and share information from the wider organisation. The operations manager was aware the service would need to assess the local community and stakeholders’ reaction to future plans before any further development action takes place.
Regular staff meetings covered a wide range of topics, including feedback from community meetings. The senior management team shared complaints, compliments and feedback received with staff to help identify areas of improvement. Staff told us they felt comfortable raising queries and concerns with management in staff meetings. Staff meeting minutes were made available for the staff who could not attend.

A monthly board meeting of the directors and regional managers discussed the minutes from all the provider’s different services. This provided an opportunity to share best practice and learning from any recent issues and incidents. The minutes were shared with each service manager.

As part of a corporate strategy to give back to the community, one free patient admission per year was offered for patients referred from a NHS health board.

**What needs to improve**

While the required structures were in place, we did not find a strong quality and risk culture in the service. We found discrepancies in audit results, post-incident reviews and gaps in the risk register. This meant the service was not able to accurately assess the quality of care it delivered or develop a learning culture (requirement 8).

The service did not have a whistleblowing policy or whistleblowing champion in place (recommendation n).

While the senior management team told us of plans to develop the service, we did not see a formal plan in place for these ideas. We discussed the benefit of developing a formal long term strategic plan, as well as becoming a member of the Independent Healthcare Providers Network for peer support. We will follow this up at future inspections.

**Requirement 8 – Timescale: by 30 April 2023**

- The provider must ensure a suitable quality assurance system is put in place and maintained. This will demonstrate effective oversight of the safe quality of the service is being delivered.

**Recommendation n**

- The service should develop a whistleblowing policy and support staff to create a whistleblowing champion role. This would ensure that staff have the opportunity and confidence to raise concerns and promote a culture of speaking up.
Appendix 1 – Requirements and recommendations

The actions that Healthcare Improvement Scotland expects the independent healthcare service to take are called requirements and recommendations.

- **Requirement**: A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the National Health Services (Scotland) Act 1978, regulations or a condition of registration. Where there are breaches of the Act, regulations, or conditions, a requirement must be made. Requirements are enforceable at the discretion of Healthcare Improvement Scotland.

- **Recommendation**: A recommendation is a statement that sets out actions the service should take to improve or develop the quality of the service but where failure to do so will not directly result in enforcement.

## Domain 2 – Impact on people experiencing care, carers and families

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<tr>
<th>Requirement</th>
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Timescale – immediate

*Regulation 15(6)(a)*
*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

<table>
<thead>
<tr>
<th>Recommendation</th>
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Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
## Domain 3 – Impact on staff

### Requirements

| None |

### Recommendations

**b** The service should develop different communication strategies to ensure staff are kept up to date with information about the service (see page 15).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.27

**c** The service should develop systems to ensure it engages and captures feedback from staff (see page 15).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

## Domain 5 – Delivery of safe, effective, compassionate and person-centred care

### Requirements

| 2 | The provider must review its policy for managing patient healthcare emergencies, including seizures, in the service and make sure staff are trained in the policy to allow them to manage these situations safely, including the administration of emergency medication (see page 18).

Timescale – immediate

*Regulation 3(a)*

*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

| 3 | The provider must notify Healthcare Improvement Scotland of certain matters as noted in the notifications guidance (see page 18).

Timescale – immediate

*Regulation 5(1)(b)*

*The Healthcare Improvement Scotland (Applications and Registration) Regulations 2011*
Domain 5 – Delivery of safe, effective, compassionate and person-centred care (continued)

4. The provider must review the risk register to ensure that all risks in the service have been identified and assessed, this will ensure effective oversight of how the service is being delivered (see page 18).

Timescale – by 28 February 2023

Regulation 13(2)(a)
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

5. The service must ensure that patients’ physical health is regularly monitored and documentation audited to make sure these checks are carried out (see page 21).

Timescale – immediate

Regulation 3(a)
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

Recommendations

d. The service should ensure that learning from incidents and incident debrief meetings are documented and shared with staff (see page 18).

Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14

e. The service should make sure there is a formal documented medicines reconciliation process put in place and that medicines reconciliation is recorded in the patient care record (see page 18).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11

f. The service should ensure relevant clinical practice policies are reviewed to ensure they reflect how the service is delivered (see page 19).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
### Domain 5 – Delivery of safe, effective, compassionate and person-centred care (continued)

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<tr>
<td><strong>g</strong></td>
<td>The service should ensure that staff follow its infection prevention and control policy (see page 19).</td>
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<td>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11</td>
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<tr>
<td><strong>h</strong></td>
<td>The service should record patient consent for sharing information with their GP and other medical staff in patient care records, the risk associated if it was not shared and any reason or justification for the decision to prescribe (see page 21).</td>
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<tr>
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<td>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 2.14</td>
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<tr>
<td><strong>i</strong></td>
<td>The service should provide GPs with a discharge summary of any inpatient episode (see page 21).</td>
</tr>
<tr>
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<td>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11</td>
</tr>
<tr>
<td><strong>j</strong></td>
<td>The service should develop a programme of patient care record audits. Audits should be documented and improvement action plans implemented (see page 21).</td>
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<td>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19</td>
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### Domain 7 – Workforce management and support

**Requirements**

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<td><strong>6</strong></td>
<td>The provider must develop a policy to support the recruitment and management of volunteers working in the service (see page 23).</td>
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*Regulation 8(1)*

*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Domain 7 – Workforce management and support (continued)

7 The provider must ensure that it follows guidelines on safer recruitment. This must include carrying out PVG checks (see page 23).

Timescale – immediate

Regulation 9(1)(2)
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

Recommendations

k The service should ensure staff files are complete and information recorded in line with safe staffing best practice (see page 23).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.24

l The service should ensure that an annual professional registration check is completed and recorded for all relevant staff working in the service (see page 24).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.24

m The service should develop a sessional doctor’s policy (see page 24).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.24

Domain 9 – Quality improvement-focused leadership

Requirement

8 The provider must ensure a suitable quality assurance system is put in place and maintained, this will demonstrate effective oversight of the safe quality of the service is being delivered (see page 26).

Timescale – by 30 April 2023

Regulation 13(1)
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011
<table>
<thead>
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<th>Recommendation</th>
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<tr>
<td>The service should develop a whistleblowing policy and support staff to create a whistleblowing champion role. This would ensure that staff have the opportunity and confidence to raise concerns and promote a culture of speaking up (see page 26).</td>
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Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
Appendix 2 – About our inspections

Our quality of care approach and the quality framework allows us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this approach to check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. Inspections may be announced or unannounced.

We follow a number of stages to inspect independent healthcare services.

**Before inspections**

Independent healthcare services submit an annual return and self-evaluation to us.

We review this information and produce a service risk assessment to determine the risk level of the service. This helps us to decide the focus and frequency of inspection.

**During inspections**

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.

**After inspections**

We publish reports for services and people experiencing care, carers and families based on what we find during inspections. Independent healthcare services use our reports to make improvements and find out what other services are doing well. Our reports are available on our website at: [www.healthcareimprovementscotland.org](http://www.healthcareimprovementscotland.org)

We require independent healthcare services to develop and then update an improvement action plan to address the requirements and recommendations we make.

We check progress against the improvement action plan.

More information about our approach can be found on our website: [www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.aspx)
**Complaints**

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

**Healthcare Improvement Scotland**
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

**Telephone:** 0131 623 4300

**Email:** [his.ihcregulation@nhs.scot](mailto:his.ihcregulation@nhs.scot)
You can read and download this document from our website. We are happy to consider requests for other languages or formats. Please contact our Equality and Diversity Advisor on 0141 225 6999 or email his.contactpublicinvolvement@nhs.scot.