

Unannounced Inspection Report: Independent Healthcare

**The Priory Hospital – Glasgow
Priory Healthcare Limited, Glasgow**

9–10 January 2018

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1 A summary of our inspection

About the service we inspected

The Priory Hospital – Glasgow is a private psychiatric hospital registered to provide nursing care for up to 42 inpatients and up to 40 day patients. The hospital has two units: a facility for women with an eating disorder and a second unit for adults with a range of general mental health disorders including substance misuse. The hospital offers a range of therapeutic programmes for patients.

About our inspection

This inspection report and grades are our assessment of the quality of how the service was performing in the areas we examined during this inspection.

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.

We carried out an unannounced inspection to The Priory Hospital – Glasgow on 9–10 January 2018

The inspection team was made up of two inspectors and a public partner. A key part of the role of the public partner is to talk to patients and relatives and listen to what is important to them.

We assessed the service against ten quality themes related to the Healthcare Improvement Scotland (Requirements as to Independent Healthcare Services) Regulations 2011 and the National Care Standards. We also considered the Service Risk Assessment (SRA). We use this information when deciding the frequency of inspection and the number of quality statements we inspect.

Based on the findings of this inspection, this service has been awarded the following grades:

Quality Theme 0 – Quality of information: (aggregated score) 5 - Very good

Statement 0.2 – service information: 6 - Excellent

Quality Statement 0.3 – consent to care and treatment: 5 - Very good

Quality Theme 1 – Quality of care and support: (aggregated score) 5 - Very good

Quality Statement 1.4 – medicines management: 5 - Very good

Quality Statement 1.6 – risk management: 5 - Very good

Quality Theme 2 – Quality of environment: (aggregated score) 4 - Good

Quality Statement 2.2 – layout and facilities: 5 - Very good

Quality Statement 2.4 – infection prevention and control: 4 - Good

Quality Theme 3 – Quality of staffing: (aggregated score) 4 - Good

Quality Statement 3.3 – workforce: 4 - Good

Quality Statement 3.4 – ethos of respect: 6 - Excellent

Quality Theme 4 – Quality of management and leadership: 5 - Very good

Quality Statement 4.3 – leadership values: 5 - Very good

Quality Statement 4.4 – quality assurance: 5 - Very good

The grading history for The Priory Hospital – Glasgow and more information about grading can be found on our website at:

http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/providers_and_services.aspx

Before the inspection, we reviewed information about the service. During the inspection, we gathered information from a variety of sources. We spoke with a number of people during the inspection.

What the service did well

Excellent communication systems had been developed with the services who referred people to it, which included regular updates and feedback. A very good staff team worked well together at the service and valued the leadership of the senior management team.

What the service could do better

The staff training programme should be reviewed to include training for control and restraint, and eating disorders. An infection control audit should be carried out. Actions from the audit should be allocated to a member of staff responsible for completion in a timescale.

This inspection resulted 16 recommendations. See Appendix 1 for a full list of the recommendations.

Priory Healthcare Limited, the provider, must make the necessary improvements as a matter of priority.

We would like to thank all staff at The Priory Hospital – Glasgow for their assistance during the inspection.

2 Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 28 February–1 March 2016

Recommendation

We recommend that the service should review how information is provided to patients admitted through cross-border transfer arrangements and look at ways to improve this.

Action taken

The service employed a dedicated member of staff to liaise with the referring team. This has increased and improved communication of information. **This recommendation is met.**

Recommendation

Provide education for staff on the mental health legislation in place in the UK and the Republic of Ireland, specifically in relation to cross-border transfer arrangements and requirements for patients detained under mental health legislation.

Action taken

A co-ordinator is responsible for all cross-border transfers. They explained the process and showed examples of how the service had addressed the mental health legislation for cross-border transfers. **This recommendation is met.**

Recommendation

Develop a formal patient and relative's participation strategy.

Action taken

The service has developed a system of participation for patients and their families. This can include teleconferencing for patients' families who stay far away from the service. **This recommendation is met.**

Recommendation

Implement a system to ensure that physical assessments carried out by junior doctors are fully completed.

Action taken

The medical director audited physical assessments that junior doctors carried out every month. The medical director addressed any issues highlighted. **This recommendation is met.**

Recommendation

Review the quality of care plans to ensure inclusion of clinical interventions and measurable goals.

Action taken

Care plans were evaluated weekly and constructed to show the clinical problem and how this would be addressed. **This recommendation is met.**

Recommendation

Review the current local care plan audit to ensure inclusion of clinical content.

Action taken

The care plan audit tool now includes entries from medical personnel and any clinical interventions. **This recommendation is met.**

Recommendation

Review current use of the risk assessment tool to include the specific detail of the actual risks.

Action taken

Risk assessments we saw were comprehensively completed and actual risks specified. **This recommendation is met.**

Recommendation

The service should ensure clinical equipment is suitable for the purpose it is being used.

Action taken

The service made sure that patients' own equipment, such as blood glucose monitors, were not used to take samples from any other patient. Where patients did not have their own blood glucose monitor, the staff used a hospital monitor to retrieve blood samples. **This recommendation is met.**

Recommendation

The service should ensure that specific training is given to staff for dealing with patients with an eating disorder.

Action taken

All nursing staff received basic training to support them to manage care for patients who had eating disorders. **This recommendation is met.**

3 What we found during this inspection

Quality Theme 0 – Quality of information

Quality Statement 0.2

We provide full information on the services offered to current and prospective service users. The information will help service users to decide whether our service can meet their individual needs.

Grade awarded for this statement: 6 - Excellent

Patients were given comprehensive information before admission, during their stay and on discharge.

The hospital's contact details, location and information about the services offered are provided on its website, where information leaflets could also be downloaded. A variety of information leaflets included a list of the service's staff and their roles, a list of the treatments provided and the service's most recent satisfaction survey.

On admission, each patient received an information pack and had a named nurse allocated. Their named nurse shows a patient round the hospital and explains the call bell system and visiting times. Named nurses also explained to their patients how they could communicate with their families and were available to help with any other queries. Giving patients this information about the hospital routine helped them settle in.

The hospital displayed a lot of information for patients about advocacy services, the treatment programme, patients' legal rights and how any information held about them is used. We also saw that the hospital provided feedback from the patients and how the hospital had responded on the 'you said, we did' information boards. Community meetings helped to allow the patients express their views about the hospital in a supportive environment. Minutes of these community meetings were displayed.

Patients were invited to attend their own multidisciplinary team review where they received feedback on their progress and could contribute their own views. We saw these were very well attended and patients we spoke with valued this opportunity.

A dedicated member of staff communicated with organisations who referred patients to the hospital. These organisations were referred to as 'the home team' and the service provided them with a written weekly update and there is a teleconference held monthly. The information supplied gives the home team information about their patients' progress and allows the team to prepare for their discharge from hospital.

Area for improvement

We saw that the service had a booklet issued by Priory Healthcare Limited, the provider, which explained how to make a complaint. It did not make it explicitly clear to the patient that they could make a complaint about the service to Healthcare Improvement Scotland at any time during the process. The same information was on the hospital's website (recommendation a).

- No requirements.

Recommendation a

- We recommend that the service should change the wording in the complaints booklet and website to inform prospective complainants that they can contact Healthcare Improvement Scotland at any stage in the complaints process.

Quality Statement 0.3

We ensure our consent to care and treatment practice reflects Best Practice Statements (BPS) and current legislation (where appropriate Scottish legislation).

Grade awarded for this statement: 5 - Very good

We examined the service's consent policy and saw that it referred to the appropriate legislation and guidance. The policy was clearly written and the service had made sure that any policies or procedures affecting patients followed best practice guidelines.

On admission, the doctor on duty assessed each patient's ability to give informed consent. Patients were then asked to sign a form giving consent:

- to have their photograph taken
- for the hospital to ask for and share their information with other agencies directly linked with their care, and
- to the treatment they will receive.

Staff we spoke with were very well informed about how the Mental Health (Care and Treatment) (Scotland) Act 2003 impacted on patient care. They gave excellent examples of how they provided the least restrictive interventions when dealing with people detained in the hospital.

A patient's named person is someone they trust to make decisions for them if they become unwell. The service had went to great lengths to make sure each patient had a named person.

We saw that all patients had consent to treatment forms contained in their personal care plans and medicine recording sheets. We saw that they were up to date and forms which were close to expiring had been highlighted.

The hospital audited its consent to treatment forms monthly. Any discrepancies were highlighted and forwarded to an identified member of staff to be dealt with. We saw a clearly defined process for any transfers from outside Scotland, which included the necessary legal documentation. This was audited weekly.

Area for improvement

The service had a separate file for its patients' legal documentation. This also contained the remaining parts of the patients' original admission pack. This had resulted in some members of staff completing some of the admission details in the electronic records. This had resulted in some confusion and duplication of work (recommendation b).

We saw that the company policy referred to English mental health legislation (recommendation c).

Consent forms should indicate that a staff member has witnessed and confirmed that the patient fully understands what they are signing. The service's consent forms did not indicate this (recommendation d).

- No requirements.

Recommendation b

- We recommend that the service should review the contents of the mental health legislation folder allocated to each patient.

Recommendation c

- We recommend that the service should amend its policies to include Scottish mental health legislation.

Recommendation d

- We recommend that the service should amend its consent forms to ensure that a staff member can confirm that informed consent has been obtained.

Quality Theme 1 – Quality of care and support

Quality Statement 1.4

We are confident that within our service, all medication is managed during the service user's journey to maximise the benefits and minimise any risk. Medicines management is supported by legislation relating to medicine (where appropriate Scottish legislation) and current best practice.

Grade awarded for this statement: 5 - Very good

The service's medicine administration policy was comprehensive and staff involved in administering medicines showed very good awareness of it.

A large pharmaceutical company supplied the service's medication and quality assured its medication administration. A pharmacist from this company visited the hospital to audit medication administration and storage and produce a report every week. They also highlighted any consent to treatment forms close to expiring. The clinical governance meeting received a 3-monthly report which showed these audit results and highlighted any trends.

Patients we spoke with knew the medications they had been prescribed and were aware of why it had been prescribed. They also told us they had been consulted about their prescribed medications at their multidisciplinary team review. Leaflets that explained the different types of medication were available and patients told us that if they had any questions they felt confident enough to ask one of the nurses.

We saw that any medicines that patients had brought from home were recorded and stored in a separate area in the pharmacy. These medicines were clearly bagged and labelled with the patient's name and date of birth.

When a patient was admitted to the service, a doctor recorded their prescribed medication and decided if it was still needed. Patients were told the reasons why any medicines were no longer needed.

When a patient is so unwell that they may not understand the need to take a certain type of medication, a consent to treatment form is created for it. This is where a doctor will make a decision to prescribe the medicine and another doctor must countersign the form. We saw that these forms were all completed and up to date.

Areas for improvement

We saw from the pharmacist's audits that some administration errors were happening repeatedly. The service should consider assessing each nurse's competencies on medicines administration yearly (recommendation e).

The medicines recording sheet folders held a lot of information relating to patients' mental health legal status. Some of this information was out of date or had no direct bearing on their medicines administration.

To help identify patient's the service could consider placing a photograph of each patient on their respective medicines administration chart.

On the first day of our inspection, the pharmacy rooms were cluttered and untidy. We passed this information on at feedback at the end of the day and saw that they were clean and tidy on day 2 of our inspection.

- No requirements.

Recommendation e

- We recommend that the service should make sure the competencies of each member of staff who administers medication are assessed yearly.

Quality Statement 1.6

We ensure that there is an appropriate risk management system in place, which covers the care, support and treatment delivered within our service and, that it promotes/maintains the personal safety and security of service users and staff.

Grade awarded for this statement: 5 - Very good

The service had a risk management policy in place for the environment, patient care and financial or adverse events which would affect the running of the hospital.

The doctor on duty risk assessed patients on their admission to the hospital. This risk assessment focused on the patient's:

- eating disorders
- mental health
- physical impairments, and
- social circumstances.

We saw extremely good care plans which took account of highlighted risks and the steps taken to address or lessen the risk. Care plans documented a comprehensive range of interventions which showed that each patient's individual needs had been addressed.

Some patients' assessments, such as some with eating disorders, had shown they needed additional observation. This could be for their own safety or to make sure that they complied with a specific therapeutic programme and the level of observations was reviewed at least weekly.

Closed circuit television surveillance was in place in the communal areas of the hospital. The service had also introduced a key pad entry system for the eating disorders ward. Staff who were assigned to observe patients showed excellent awareness of:

- who the patient was
- why they had been asked to carry out this piece of work, and
- what to do if the patient became unwell.

Notices throughout the hospital advised visitors whether they were allowed to bring in certain items or not and advised them to check with a staff member. Some items had to be recorded in the patient's file.

The service's risk register was comprehensive. The hospital manager talked through the register, showing us how it influenced patient care and the security of the hospital. For example, the number of patients absconding had increased so a new security measure to help alert staff quicker had been introduced. The manager also explained that, as a result of recent risk assessments, two safer rooms had been created for people who required more intensive observation in the service. Patients could be allowed a period of time spent out with the hospital either accompanied or unaccompanied. Each patient was risk assessed before this was allowed.

The process to report accidents and incidents and escalate concerns was very clear. We were shown minutes of meetings where concerns had been discussed and actions were noted.

A risk assessment was completed for every patient before their discharge from the hospital. This was passed on to the receiving care team to carry on with the patient's care plan if this is required.

Area for improvement

Nursing staff told us they had to use control and restraint techniques to manage patient care safely. Training was not consistently offered for this during induction, so staff were not always prepared for events that required patients to be restrained (recommendation f).

- No requirements.

Recommendation f

- We recommend that the service should ensure staff receive control and restraint training during their induction. This will help manage patients' care safely.

Quality Theme 2 – Quality of environment

Quality Statement 2.2

We are confident that the design, layout and facilities of our service support the safe and effective delivery of care and treatment.

Grade awarded for this statement: 5 - Very good

The service was made up of two adjoining converted houses on three floors. An internal lift allowed patients with ambulatory needs easy access to all areas. Gardens were to the front and rear of the service and patients had a designated smoking area.

Most of these areas were clean and in good state of repair. Patient bedrooms were a good size with double beds and adequate storage. All rooms had en-suite facilities, including a bath or walk-in shower. Patients told us they could bring their own belongings with them to personalise their bedrooms. One of the patients said: 'They let me bring in lots of my own things which makes me feel nice, it's like my own room, not a hospital room.'

The service used risk assessments and audit programmes to monitor and reduce risk in:

- the control of substances hazardous to health (COSHH)
- fire safety
- general maintenance and equipment, and
- water safety.

Clinical governance meetings discussed the progress of a yearly audit programme. While the maintenance manager told us about some existing repairs still to be carried out, the audit programme was up to date. The maintenance manager was well-organised and prioritised improvements and repairs and maintenance team carried out simple repairs and basic equipment checks. More serious repairs or work that required experts were sub-contracted to appropriate professionals. Regular practice fire evacuations were held and signs showed people where the nearest evacuation points were. All 10 patients we asked told us that they felt safe in the service.

Areas for improvement

The service's building had experienced some subsidence. While all major repair work had been completed, some skirting was damaged and required replacing. The maintenance manager said they planned to wait and observe for further subsidence before carrying out these repairs. However, the dining room ceiling was water damaged due to a flood above and this looked unsightly and needed repair (recommendation g).

Although there was a well maintained garden at the front of the service, patient's privacy was not protected there. The rear garden was more private but less inviting. Improvements could be made to allow patients to enjoy the garden. The senior management team agreed to consider ways in which this could be achieved.

- No requirements.

Recommendation g

- We recommend that the service should carry out repairs as soon as possible.

Quality Statement 2.4

We ensure that our infection prevention and control policy and practices, including decontamination, are in line with current legislation and best practice (where appropriate Scottish legislation).

Grade awarded for this statement: 4 - Good

The senior management team recognised that legislation was different across England, Ireland, Scotland and Wales. To deal with this, staff implemented the provider's infection control policy as well as national guidance and best practice to promote infection control.

A charge nurse was also the infection control lead. The charge nurse had completed comprehensive infection control training and met with staff to discuss infection control procedures and offer support with training. The charge nurse told us the service planned to make sure all nursing staff completed the national Scottish Infection Prevention and Control Education Pathway in the future. All staff completed infection control training as part of their induction.

The staff used Healthcare Improvement Scotland's Healthcare Associated Infection (HAI) audit tool to evaluate standard infection control precautions. The charge nurse was responsible for carrying out the yearly audit, last completed in July 2017. All staff helped to complete assessments to support audits, which promoted teamwork and compliance.

We saw that housekeeping staff were busy keeping wards clean and tidy. All staff wore personal protective equipment when necessary and a good supply was available throughout the service. Alcohol-based hand rub dispensers were available in corridors and communal areas.

An external contractor laundered most of the service's bedding and linen. The service was aware of best practice in relation to the safe handling of laundry and

decontamination processes. The manager had asked for written confirmation of the contractor's laundry decontamination procedures to make sure they were in line with best practice. Patients were supported to wash their own items of clothing in domestic washing facilities in the service. Contaminated items of clothing were washed in line with national guidance to make sure decontamination was achieved. Parents and carers were also invited to take laundry home to wash if they preferred.

Good systems were in place to promote the safe management of waste and sharps. Colour-coded bags were used to make sure staff disposed of waste correctly. Sharps bins were assembled, signed and closed appropriately.

Areas for improvement

Clutter makes it difficult for staff to clean rooms effectively. While patient rooms were generally clean and had plenty of storage, we saw some clothing piles on floors, and dressing tables were cluttered. Domestic and nursing staff told us it was difficult to keep patients rooms tidy because of the amount of belongings patients brought in (recommendation h).

One of the carpets in the bedrooms smelled unpleasant (recommendation i).

The hospital's clinical hand wash basins did not comply with Scottish Health Technologies Memorandum 64 (SHTM 64) (recommendation j).

The service carried out a yearly infection control audit. We reviewed the audit checklist and action plan and identified a number of mistakes. The section for hand washing was recorded as 'not applicable'. We were told this was an error as a hand washing audit was about to begin. Some sections were completed incorrectly and others that were appropriate for the service were recorded as 'not applicable'. Action plans from this audit lacked detail.

- No requirements.

Recommendation h

- We recommend that the service should engage with staff and patients to establish an agreed understanding of acceptable levels of patient belongings and how they are stored in patient bedrooms.

Recommendation i

- We recommend that the service should frequently clean all carpets and replace them if they cannot be cleaned effectively.

Recommendation j

- We recommend that the service should replace all its clinical hand wash basins at the next refurbishment so that they comply with SHTM 64.

Quality Theme 3 – Quality of staffing

Quality Statement 3.3

We have a professional, trained and motivated workforce which operates to National Care Standards, legislation and best practice.

Grade awarded for this statement: 4 - Good

Staff we spoke with were motivated and willing to participate in training. New staff completed an induction programme covering mandatory training, including:

- confidentiality
- data protection
- infection control, and
- moving and handling.

Priory Healthcare Limited, the provider, had its own online training academy learning framework which staff completed. Staff were encouraged to access all mandatory training and additional learning to help their continuous practice development. The senior management team and human resources supported nursing and medical staff to maintain their professional registration and revalidation.

Promoting patients' rights was a priority in the service and all staff were aware of the need to put them at the centre of care. Healthcare support workers had recently received training in patients' rights.

The service had several consultants working in it. One of its consultants told us they had provided staff training sessions and hoped to deliver more in the future.

The director audited mandatory staff training which helped to identify when staff had completed it and when mandatory training had lapsed. The clinical manager had started to keep a record of all other training staff had completed, to help make sure they kept up to date with learning and development.

Staff often met with their managers to discuss their learning and development. Yearly appraisals were also held to support more detailed evaluations of staff practice and development.

Areas for improvement

The number of patients admitted to the hospital with eating disorders had increased since our February 2016 inspection. Some patients presented with more complex conditions and staff told us they did not always have the knowledge to manage complex eating disorders. We were advised that expertise was sought from agency or NHS staff to make sure patients' needs were met. Staff told us they would benefit from further training to make sure all patients' needs were managed (recommendation k).

Staff told us they met frequently to discuss workload and patient care. However, no formal system was in place to host staff meetings (recommendation l).

- No requirements.

Recommendation k

- We recommend that the service should develop suitable training for staff which will provide them with the knowledge they need to manage patients who have complex eating disorders.

Recommendation l

- We recommend that the service should develop and implement regular staff meetings. Minutes of the meeting should also be shared with staff in the service.

Quality Statement 3.4

We ensure that everyone working in the service has an ethos of respect towards service users and each other.

Grade awarded for this statement: 6 - Excellent

The service had a positive working culture. Staff inductions and policies had information about what to do in the event of a grievance, complaint or concern. Regular mandatory staff training was also in place on bullying and harassment as well as equality and diversity.

We spoke to a variety of staff from the different teams across the service. All staff we spoke with told us they were happy at work and felt their colleagues, including the senior management team, supported them. Staff said they felt their opinions mattered and they were included in decisions about the service. Catering staff made sure the dining room was a friendly and relaxing place for staff and patients to eat. Domestic staff worked well as a team to support each other's workload. We observed nursing staff communicating well with each other. The deputy ward manager delegated work fairly and respectfully.

We saw lots of evidence to demonstrate staff respected all roles, including those responsible for leading the service. The managers also told us how the service ran smoothly because the staff had a commitment to caring for others.

Quality Theme 4 – Quality of management and leadership

Quality Statement 4.3

To encourage good quality care, we promote leadership values throughout our workforce.

Grade awarded for this statement: 5 - Very good

Leadership in the service was very good. The clinical services manager and the director were passionate about supporting staff, the quality of patient care and were keen to make changes to improve the service.

The senior management team met weekly to discuss the service's operational and strategic management. All staff were involved in decisions about the service and encouraged to share their views about changes they would like to make. Leadership was promoted throughout the service to help make sure teams operated effectively.

Where possible, staff were offered promotion which inspired them to share learning and participate in training.

Senior nurses completed a leadership programme which gave them additional leadership and management skills. This helped to teams operate effectively and meet patients' needs.

Area for improvement

We saw good evidence to demonstrate verbal support was available for all staff, including those who were promoted. However, some management-level staff told us they felt they had not been offered leadership and management training to prepare for a leadership role (recommendation m).

Staff did not have 'champion' roles in the service. Providing staff with opportunities to lead on best practice and policy development could help develop skills and autonomy.

- No requirements.

Recommendation m

- We recommend that the service should ensure staff receive appropriate training to equip them with the skills required to carry out their roles effectively.

Quality Statement 4.4

We use quality assurance systems and processes which involve service users, carers, staff and stakeholders to assess the quality of service we provide.

Grade awarded for this statement: 5 - Very good

The service submitted a basic self-assessment to Healthcare Improvement Scotland. This self-assessment is completed each year and it gives a measure of how the service has assessed itself against the quality themes and national care standards. We found good quality information that we were able to verify during our inspection. We saw the service had a comprehensive auditing and quality assurance system in place.

The senior management team reacted well to any important issues raised from the service's quality assurance systems. For example, we saw that the transfer of patients from outwith Scotland, processes and staff deployment in certain areas to meet these challenges.

The service had carried out a staff satisfaction survey. Minutes from the patients meetings were on noticeboards and any actions resulting from patient suggestions were highlighted using a 'you said, we did' display.

We spoke with two members of the therapy team who explained how they used accredited measuring tools to evaluate a patient's progress throughout their stay. When admitted to the service, patients also completed a questionnaire asking what they thought about their illness, and another questionnaire completed when they

were discharged allowed the therapists to compare any changes. The findings of the questionnaires and measuring tools allowed them to evaluate areas that were challenging to staff. The therapy team told us this had helped to develop and deliver some training to the wider staff team dealing with eating disorders.

Clinical governance team meeting minutes showed that the senior management team reviewed findings from the service's quality assurance systems. We saw how each area had been considered and any areas which required attention resulted in an action plan. We saw that action plans had someone allocated to carry out the recommendations raised.

The hospital has been awarded a Healthy Living Award and is accredited by The Royal College of Psychiatrists for providing services for adults with eating disorders.

Areas for improvement

Some audits had clearly not been reviewed for quality assurance. For example, the infection control audit contained errors which showed it had not been carried out correctly (recommendation n).

Not all actions we saw in action plans had a timescale for completion (recommendation o).

Staff we spoke with were aware that a staff satisfaction survey had taken place. However, they were unaware of its findings (recommendation p).

- No requirements.

Recommendation n

- We recommend that the service should ensure all audits carried out are checked to verify their accuracy.

Recommendation o

- We recommend that the service should allocate a timescale to complete any actions resulting from audits or quality assurance processes.

Recommendation p

- We recommend that the service should make sure it communicates the findings of the most recent staff survey.

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 Act, 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.

Quality Statement 0.2	
Requirements	None
Recommendation	We recommend that the service should:
a	change the wording in the complaints booklet and website to inform prospective complainants that they can contact Healthcare Improvement Scotland at any stage in the complaints process (see page 9). National Care Standards – Independent Hospitals (Standard 5.6 – Planning your care)

Quality Statement 0.3	
Requirements	None
Recommendations	We recommend that the service should:
b	review the contents of the mental health legislation folder allocated to each patient (see page 10). National Care Standards – Independent Hospitals (Standard 14.2 – Information held about you)
c	amend its policies to include Scottish mental health legislation (see page 10). National Care Standards – Independent Hospitals (Standard 14.2 – Information held about you)

Quality Statement 0.3 (continued)

- d** amend its consent forms to ensure that a staff member can confirm that informed consent has been obtained (see page 10).

National Care Standards – Independent Hospitals (Standard 14.6 – Information held about you)

Quality Statement 1.4

Requirements

None

Recommendation

We recommend that the service should:

- e** make sure the competencies of each member of staff who administers medication are assessed yearly (see page 11).

National Care Standards – Independent Hospitals (Standard 10.7 – Staff)

Quality Statement 1.6

Requirements

None

Recommendation

We recommend that the service should:

- f** ensure staff receive control and restraint training during their induction. This will help manage patients' care safely (see page 13).

National Care Standards – Independent Hospitals (Standard 10.7 – Staff)

Quality Statement 2.2

Requirements

None

Recommendation

We recommend that the service should:

- g** carry out repairs as soon as possible (see page 14).

National Care Standards – Independent Hospitals (Standard 15.3 – The Environment)

Quality Statement 2.4

Requirements

None

Recommendations

We recommend that the service should:

h engage with staff and patients to establish an agreed understanding of acceptable levels of patient belongings and how they are stored in patient bedrooms (see page 15).

National Care Standards – Independent Hospitals (Standard 15.3 – The Environment)

i frequently clean all carpets and replace them if they cannot be cleaned effectively (see page 15).

National Care Standards – Independent Hospitals, (Standard 13.1 – Prevention of infection)

j replace all its clinical hand wash basins at the next refurbishment so that they comply with SHTM 64 (see page 15).

National Care Standards – Independent Hospitals (Standard 13.8 – Prevention of infection)

Quality Statement 3.3

Requirements

None

Recommendations

We recommend that the service should:

k develop suitable training for staff which will provide them with the knowledge they need to manage patients who have complex eating disorders (see page 17).

National Care Standards – Independent Hospitals (Standard 10.10 – Staff)

l develop and implement regular staff meetings. Minutes of the meeting should also be shared with staff in the service (see page 17).

National Care Standards – Independent Hospitals (Standard 10.13 – Staff)

Quality Statement 4.3

Requirements

None

Recommendation

We recommend that the service should:

- m** ensure staff receive appropriate training to equip them with the skills required to carry out their roles effectively (see page 18).

National Care Standards – Independent Hospitals (Standard 10.10 – Staff)

Quality Statement 4.4

Requirements

None

Recommendations

We recommend that the service should:

- n** ensure all audits carried out are checked to verify their accuracy (see page 20).

National Care Standards – Independent Hospitals (Standard 12.1 – Clinical effectiveness)

- o** allocate a timescale to complete any actions resulting from audits or quality assurance processes (see page 20).

National Care Standards – Independent Hospitals (Standard 12.1 – Clinical effectiveness)

- p** make sure it communicates the findings of the most recent staff survey (see page 20).

National Care Standards – Independent Hospitals (Standard 12.3 – Clinical effectiveness)

Appendix 2 – Who we are and what we do

Healthcare Improvement Scotland was established in April 2011. Part of our role is to undertake inspections of independent healthcare services across Scotland. We are also responsible for the registration and regulation of independent healthcare services.

Our inspectors check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. They do this by carrying out assessments and inspections. These inspections may be announced or unannounced. We use an open and transparent method for inspecting, using standardised processes and documentation. Please see Appendix 5 for details of our inspection process.

Our work reflects the following legislation and guidelines:

- the National Health Service (Scotland) Act 1978 (we call this ‘the Act’ in the rest of the report),
- the Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011, and
- the National Care Standards, which set out standards of care that people should be able to expect to receive from a care service. The Scottish Government publishes copies of the National Care Standards online at: www.scotland.gov.uk

This means that when we inspect an independent healthcare service, we make sure it meets the requirements of the Act and the associated regulations. We also take into account the National Care Standards that apply to the service. If we find a service is not meeting the requirements of the Act, we have powers to require the service to improve.

Our philosophy

We will:

- work to ensure that patients are at the heart of everything we do
- measure things that are important to patients
- are firm, but fair
- have members of the public on our inspection teams
- ensure our staff are trained properly
- tell people what we are doing and explain why we are doing it
- treat everyone fairly and equally, respecting their rights
- take action when there are serious risks to people using the hospitals and services we inspect
- if necessary, inspect hospitals and services again after we have reported the findings
- check to make sure our work is making hospitals and services cleaner and safer
- publish reports on our inspection findings which are always available to the public online (and in a range of formats on request), and
- listen to your concerns and use them to inform our inspections.

Complaints

If you would like to raise a concern or complaint about an independent healthcare service, we suggest you contact the service directly in the first instance. If you remain unhappy following their response, please contact us. However, you can complain directly to us about an independent healthcare service without first contacting the service.

Our contact details are:

Healthcare Improvement Scotland

Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Telephone: 0131 623 4300

Email: comments.his@nhs.net

We can also provide this information:

- by email
- in large print
- on audio tape or CD
- in Braille (English only), and
- in community languages.



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Gyle Square
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The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium (SMC) are part of our organisation.