Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: St. Columba's Hospice Care, Edinburgh

Service Provider: St. Columba's Hospice Care

17–18 April 2024

NHS SCOTLAND

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1 Progress since our last inspection

What the provider had done to meet the requirements we made at our last inspection on 19 January 2021

No requirements were made at our last inspection.

What the service had done to meet the recommendations we made at our last inspection on 19 January 2021

Recommendation

The service should ensure consent to share information is recorded in a consistent way in patient care records.

Action taken

We reviewed five patient care records and saw that consent to share information with the next of kin and other healthcare professionals was clearly documented in all.

2 A summary of our inspection

Background

Healthcare Improvement Scotland is the regulator of independent healthcare services in Scotland. As a part of this role, we undertake risk-based and intelligence-led inspections of independent healthcare services.

Our focus

The focus of our inspections is to ensure each service is person-centred, safe and well led. We evaluate the service against the National Health Services (Scotland) Act 1978 and regulations or orders made under the Act, its conditions of registration and Healthcare Improvement Scotland's Quality Assurance Framework. We ask questions about the provider's direction, its processes for the implementation and delivery of the service, and its results.

About our inspection

We carried out an unannounced inspection to St. Columba's Hospice Care on Wednesday 17 and Thursday 18 April 2024. We spoke with a number of staff, patients and carers during the inspection. We received feedback from 32 staff through an online survey we had asked the service to issue to staff during the inspection.

Based in Edinburgh, St. Columba's Hospice Care is a hospice providing palliative care/end of life care.

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For St. Columba's Hospice Care the following grades have been applied.

Direction	*How clear is the service's vision and purpose and how supportive is its leadership and culture?*
Summary findings	**Grade awarded**
The service has a strategic plan, which clearly sets out the hospice strategy, including its culture, values and strategic aims. A performance review system helped measure how the service performed. A governance framework was in place with clear structures. Leadership was visible and staff felt able to speak up. A shared leadership involved all staff participating in a wide range of aspects of the service.	✓✓✓ Exceptional
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
The service has expanded significantly in the last 5 years, initially responding to patients whose care was impacted by the pandemic. It has developed a hospice at home service to respond to patients wanting to be cared for and to die at home. Patients, families and staff are widely engaged. Effective processes and procedures helped support the safe delivery of care. Staff and volunteers were recruited appropriately, with evidence of staff support and training. Risk assessments and an audit programme were in place.	✓✓✓ Exceptional
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The environment was clean, uncluttered and in a good state of repair. Patient and staff areas were decorated to promote a feeling of calm and tranquillity. Staff working in the service spoke positively about their experience of working there and felt supported and valued. All staff we spoke with were enthusiastic about the service. A thorough process was in place of recording the patient's journey while in the care of the hospice. Patients and families told us the care they received was 'excellent'.	✓✓✓ Exceptional

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: Guidance for independent healthcare service providers – Healthcare Improvement Scotland

Further information about the Quality Assurance Framework can also be found on our website at: The quality assurance system and framework – Healthcare Improvement Scotland

What action we expect St. Columba's Hospice Care to take after our inspection

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.
- **Recommendation:** A recommendation is a statement which sets out what a service should do in order to align with relevant standards and guidance.

This inspection resulted in no requirements and no recommendations.

We would like to thank all staff at St. Columba's Hospice Care for their assistance during the inspection.

3 What we found during our inspection

Key Focus Area: Direction

Domain 1: Clear vision and purpose	Domain 2: Leadership and culture
How clear is the service's vision and purpose and how supportive is its leadership and culture?	

Our findings

The service has a strategic plan, which clearly sets out the hospice strategy, including its culture, values and strategic aims. A performance review system helped measure how the service performed. A governance framework was in place with clear structures. Leadership was visible and staff felt able to speak up. A shared leadership involved all staff participating in a wide range of aspects of the service.

Clear vision and purpose

St Columba's Hospice Care provides specialist palliative care for people aged 16 years and over living with a life-limiting illness in North Edinburgh and East Lothian. The service supports people using the service, as well as their families.

The service had a clear strategic plan for 2020–2023 published on its website. The strategic plan clearly set out the hospice strategy, including its culture, values and strategic aims. It set out how the hospice would monitor its progress against the strategic plan. The strategic plan was developed in partnership with a wide range of stakeholders. The stakeholders were involved through:

- a research study to understand how inpatient beds were being used
- board workshops
- focus groups with families
- interviews with patients and families
- professional events
- staff workshops, and
- volunteer engagement questionnaire.

The service had three strategic aims and mapped all of its strategic activities against them. A performance review system was in place and was linked to its strategic aims and values. Each team had developed a quality commitment statement and key performance indicators (KPIs) for each team sat under each quality commitment statement.

The KPIs for each team were designed in partnership with hospice staff, the hospice leadership team and the board. At each board meeting, a quality report was discussed. The quality report included reporting against each team's KPIs and provided information on each team's:

- impact
- participation and feedback
- quality improvement
- strategic development
- work with external partners, and
- work with volunteers.

The hospice had shared these KPIs with all other Scottish hospices, with the aim of helping develop a more consistent approach to national data collection. Some other hospices were using parts of these.

The service reported on the progress it had made against its strategy in a yearly interim report. These interim reports were discussed at the board meeting and clearly displayed on the hospice's website.

The service had been awarded the 'Gold Investors in People Award' following a review how it involved people in the development, monitoring and review of its strategy, processes and procedures.

The service was developing a new strategy at the time of our inspection, which will launch in autumn 2024. The service had engaged with a variety of stakeholders to consider the views of those who work in, use, work with or regulate the service.

- No requirements.
- No recommendations.

Leadership and culture

The service provided a 15-bed inpatient service, however the majority of its care was carried out in patients' own homes or on an outpatient basis. The hospice had dedicated, free-of-charge services for patients and their families, including:

- chaplaincy
- complementary therapy
- counselling
- family support, and
- hairdressing.

Over 200 employed or contracted clinical and non-clinical staff and 500 volunteers worked to provide the service. The hospice also had dedicated teams for:

- Quality Improvement Support
- education
- practice development, and
- research.

The service used an electronic system to make sure it had the correct skill mix for nursing and medical staff. The system allowed the service to:

- access workforce planning advice
- discuss staffing ratios with staff, and
- understand staffing challenges that individual teams faced or that the whole service faced at some times of the day or week.

A hospice leadership committee, made up of the senior leadership team was responsible for the service. Groups, including those for risk management, clinical governance and research reported to the hospice leadership committee.

A board of governors supported the hospice leadership committee and met five times a year. Sub-committees reported to the board of governors, including sub-committees for:

- audit and risk
- education
- investments, and

- research.

In 2022, the service redesigned its internal leadership structure in partnership with staff and moved to a model of distributed shared leadership. The service's aim in using this model was to modernise its leadership to reflect the way the service is now delivered, through:

- empowering staff
- enhancing integrated working
- enhancing shared decision-making, and
- reducing duplication of effort.

As part of the shared leadership the service operated a 'cluster system', where teams worked together in clusters and met monthly to progress work and deliver cluster objectives. The cluster leads then reported to the hospice leadership committee. For example, the clusters had recently started to review the service's current strategy to consider what might be included in the next strategy.

The service had also started to review and evaluate how well the cluster system was working, using a survey and 'confidence scores' at each cluster meeting. The service planned to carry out more formal evaluation work to review the shared leadership model in the service.

We saw agendas, minutes and supporting documents in place for a variety of governance meetings during our inspection, which demonstrated awareness, discussion and action on matters as they progressed through the governance system.

The service's values were incorporated in recruitment processes and staff performance reviews.

Staff we spoke with during the inspection who responded to our online survey, told us that the senior leadership team and department leads in general were very approachable and visible. Staff told us that they felt empowered to speak up and safe to do so.

Comments we received from staff conversations and from our online survey included:

- ‘There is a positive culture at the hospice. I believe this is shown working with our colleagues we are interested in supporting each other and our wellbeing.’
- ‘I believe we are given opportunities to voice our thoughts and concerns and that we are listened to.’
- ‘Staff are routinely asked to shape the services we have.’

    - No requirements.
    - No recommendations.

Key Focus Area: Implementation and delivery

Domain 3: Co-design, co-production	Domain 4: Quality improvement	Domain 5: Planning for quality
How well does the service engage with its stakeholders and manage/improve its performance?		

Our findings

The service has expanded significantly in the last 5 years, initially responding to patients whose care was impacted by the pandemic. It had developed a hospice at home service to respond to patients wanting to be cared for at home. Patients, families and staff are widely consulted. Effective processes and procedures helped support the safe delivery of care. Staff and volunteers were recruited appropriately, with evidence of staff support and training. Risk assessments and an audit programme were in place.

Co-design, co-production *(patients, staff and stakeholder engagement)*

The service website detailed the variety of services offered to patients and their families, how the public could volunteer and general information about the service. Paper copies of key information were also available in the service.

The service had a participation policy in place which detailed how it would involve:

- families
- members of the public
- patients
- staff and
- volunteers in improving the quality and the further development of services provided.

The service had embedded participation in each of its clusters. We saw examples of patient, family and volunteer participation in the interview process for appointing new senior staff to the service. We saw that the service demonstrated wide engagement with patients, staff and other stakeholders as part of its current and new strategy development, as well as in everyday service provision.

Patients who used the service were given the opportunity to provide feedback in a variety of ways, including questionnaires and telephone surveys. Wellbeing volunteers offered support to do this, if required.

All feedback was reviewed, actioned and shared in the 3-monthly quality report through the governance structure. Patients we spoke with during our inspection were very positive about the service and their experiences in it.

The service relied heavily on volunteers to provide assistance to staff in all aspects of service delivery, including assisting in:

- a ‘compassionate neighbours’ scheme
- charity shops
- inpatient unit support
- staff dining room
- the on-site café, and
- wellbeing service.

Volunteers we spoke with during our inspection told us they felt supported and listened to and that they had regular communication with staff they reported to. Volunteers told us they really felt valued and that the support they gave made a real difference to patient and family experience.

The service held twice-yearly ‘Volunteer Thank You’ events and provided regular newsletters to volunteers to help them keep in touch. All volunteers and staff were offered exit interviews on leaving the service.

All staff told us they felt listened to and could approach their department leads and leadership committee at any time. Opportunities were available for professional development and ongoing support for staff wellbeing. Staff told us they met regularly in teams and the staff in the inpatient unit had a dedicated weekly newsletter. The newsletter helped disseminate information, as the team was large and it was difficult to get the whole team together regularly, due to shift patterns. Another monthly hospice-wide newsletter, called ‘Grapevine’ was also produced.

In 2020, the hospice had developed a ‘hospice at home' service. The hospice recognised that patients were more confined to home as a result of COVID-19 measures and guidelines. This had meant that they had missed out on vital healthcare and support during their illness. While patients often wish to be cared for or to die at home, families had previously not felt able or supported to provide this in the home. The new hospice at home service is a responsive,

flexible service which helped make sure that people living at home requiring hospice input had the right level of support. The 'hospice at home' service aimed to:

- facilitate discharge from, and to prevent admissions to, hospital or hospice.
- provide respite for families.
- provide management of increasing symptom crisis for the patient, and
- support patients at home, at the end of their life.

The hospice at home service had recently developed five 'virtual beds.' This meant that hands-on, clinical care could be provided in the patient's own home. This often resulted in patients having complex symptom management at home and avoiding admission to hospice or hospital. Staff we spoke to told us that the patient's wishes were at the centre of any intervention offered in the hospice at home service. We were told that the service aimed to make sure that regular conversations were held with the patient and family and their wishes were always observed. It was recognised that the patients' and their families' wishes may change throughout their care.

Staff, patients and families participated in the ongoing evaluation process of the pilot service. Showing a positive response from patients, families and staff.

As part of the hospice at home team, the clinical nurse specialists maintained a case load of patients living with life-limiting conditions, providing advice and support to them, their GPs and community teams. The clinical nurse specialists we spoke with told us they felt supported in their role and part of the new expanded community service. They also told us that they had access to advice and support in their role. We also spoke with other staff involved in the virtual beds. These members of staff also told us they enjoyed their role, felt part of the development of the new service and felt heard as part of the larger community team.

The service had developed a single point of access for all clinical care, called the Access Team where staff responded to telephone calls through the day. They received calls from healthcare professionals, patients and families. The Access Team was made up of non-clinical and clinical staff. All calls were triaged as urgent or routine, with a same-day response for all urgent calls.

Staff completing the online survey told us:

- ‘I work in a very open team and make regular suggestions to my managers about our team processes’.
- ‘I find the management are always open to ideas and honest with their feedback.’

- No requirements.
- No recommendations.

Quality improvement

We saw that the service clearly displayed its Healthcare Improvement Scotland registration certificate and was providing care in line with its agreed conditions of registration.

The service fully understood Healthcare Improvement Scotland’s notification process and the need to inform Healthcare Improvement Scotland of certain events or incidents occurring in the service. A process of recording and investigating incidents and accidents was in place.

The service had a wide range of up-to-date policies and standard operating procedures. This included those for:

- health and safety
- infection prevention and control
- medicine management, and
- safeguarding.

Incidents were recorded and managed through an electronic incident management system. A process of review and discussion was in place and learning outcomes from incidents were discussed. We saw different examples of incidents that staff had reported and saw evidence that the service’s process had been followed in each case. We were told that the service had a good relationship with the local fire department. The fire department would carry out ‘intelligence visits’ in the service and offer training and advice to hospice staff.

The service’s complaints policy set out the processes and procedures to follow in the event of a complaint or concern being raised. Information on how to make a complaint was displayed in the hospice and published on the website and included information on how to contact Healthcare Improvement Scotland. We reviewed two complaints the service had received. We saw evidence that

both the complaints had been managed in line with the service's policy and procedures. We noted that responses to complaints were handled sensitively, clearly demonstrating an empathetic and person-centred approach.
Lessons learned were discussed at staff and leadership meetings. Duty of candour is where healthcare organisations have a professional responsibility to be honest with patients when things go wrong. The service had an up-to-date duty of candour policy in place. The service published a report every year on its website. Senior staff were trained in duty of candour. Staff we spoke with during the inspection were aware of the processes and procedures involved.

We spoke with the service's pharmacy team during our inspection. The team consisted of a pharmacist and pharmacy technician who were both employed by NHS Lothian. The pharmacy team made sure that a thorough process of safe management of medicines was in place, which included:

- discharge prescriptions
- medicine prescription charts
- medicine reconciliation
- regular checks of medicine expiry dates
- safe storage of medicines, and
- the process of controlled drug orders.

The service regularly audited the prescribing practices and medicines being used. Medicines were stored appropriately and securely in the inpatient unit. Training in medicine administration was part of the staff induction program and staff completed refresher training every year.

Patient care records were held electronically on a password-protected, secure system. The local NHS board and primary care teams also used the same electronic platform that the service used. This meant that patient information between all healthcare professionals was accessible and that patients did not have to repeat information about their condition. A detailed process of communication and assessment showed a comprehensive documentation of care from admission to discharge.

A variety of members of the multidisciplinary team inputted to the patient care records, such as chaplain and the social work team. The service had developed a patient-centred care plan, which held information about the patient's goals and their preferred place of care and death. A treatment plan was available for highlighting what the patient would wish should their condition deteriorate and a 'do not attempt cardiopulmonary resuscitation' (DNACPR) document was

completed where applicable. This relates to the emergency treatment given when a patient's heart stops or they stop breathing.

Assessments and care plans completed on admission included:

- an assessment to make sure the patient fully understood information.
- falls risk.
- nutritional assessment, and
- pain assessment.

The provider organisation was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights).

Safe recruitment processes were in place. Appropriate background checks were carried out, including an ID check, references and immunisation history. Employees had up-to-date Disclosure Scotland Protecting Vulnerable Group (PVG) checks in place.

A number of staff that worked in the service were employed by the NHS. An 'honorary contract' was in place which allowed them to also work in the hospice. We saw a checklist completed before they started working that made sure their pre-employment checks were available to the service. For those staff, we saw that a process of assurance was in place between the hospice and the health board. This process helped make sure all appropriate checks were complete and in place. We saw communication between both human resources (HR) departments to confirm this.

All staff completed a generic and role-specific induction program. New staff completed a probationary period which, once compete, resulted in learning objectives for the next year. Appraisals were in place for staff and included individual learning opportunities and asked staff to highlight their accomplishments in the last year. The recruitment of volunteers was fully completed and specific induction programs were in place.

We saw an electronic human resource (HR) 'tracker' that highlighted when yearly professional registration checks were due for staff. The service was in the process of moving to a new HR platform.

The practice development team had recently launched its own online training platform. While this was based on the NHS online version, it was more specific to the organization and included service policies and processes.

Statutory and mandatory training for all staff was completed yearly. Learning sessions, specific to certain staff groups, such as nursing staff were available. A program of talks had been developed, including those from professionals external to the service. The new program had been running since the beginning of 2024 and high levels of participation had been achieved. We saw that each program was developed over a 3-month period. Subjects related to a specific title, such as 'safe ways of working,' which included fire safety and lone-worker learning. Feedback from staff had been constructive and positive.

What needs to improve

While all staff had access to department leads and found them accessible, during the inspection it became clear that not all staff had regular one-to-ones with their department lead. We discussed this with the service and were told that it was aware of the issue. We were told that the service was looking at ways of making sure that one-to-ones were consistently held for staff at all levels, particularly those that are part-time and in more junior positions. We will follow this up at future inspections.

- No requirements.
- No recommendations.

Planning for quality

The service had an extensive business continuity plan in place which the leadership committee reviewed and discussed as part of the risk management group meetings.

We saw a comprehensive electronic risk register in place which formed part of the service's risk management strategy. This demonstrated a proactive approach to identifying and managing risk effectively in the service. Risks were identified in detail, allocated a risk rating status and reviewed regularly at the risk management group meetings held every 3 months. The service carried out a wide range of clinical and non-clinical risk assessments, including those for:

- fire safety
- health and safety
- infection prevention and control
- oxygen supply, and
- water systems.

The operations lead told us that the service provided staff with training on how to identify and manage risk as part of their training at induction and continuing development.

The operations lead looked after the day-to-day management of the building and any specialist equipment. Any incidents were recorded through the service's electronic reporting system, which staff were able to access easily. The service's gardener managed gardens and external facilities, with support from a team of regular volunteers.

A comprehensive quality improvement and audit plan was in place to monitor aspects of service and care delivery and identified any areas for improvement. The plan was reviewed every month by the Quality Improvement Support team and every quarter by the Quality Improvement Support team.

The role of champion was allocated to staff day-to-day, rather than this being a fixed role for an individual in the service. Staff reported this seemed to be working well and covered. several areas of specialist care, such as:

- cognitive impairment
- tissue viability
- Infection prevention and control

The patient safety facilitator carried out regular walkrounds and audits. The audits followed the standard infection control precautions (SICPs) in the *National Infection Prevention and Control Manual*. Examples of areas looked at and reported on were:

- environment
- hand hygiene
- maintenance, and
- waste, including sharps storage and disposal.

Any issues identified from these walkrounds were raised with staff at the time, recorded and monitored weekly. Issues were reported at both the quarterly infection control group meeting and quarterly clinical governance meetings.

- No requirements.
- No recommendations.

Key Focus Area: Results

Domain 6: Relationships	Domain 7: Quality control
How well has the service demonstrated that it provides safe, person-centred care?	

Our findings

The environment was clean, uncluttered and in a good state of repair. Patient and staff areas were bright and peacefully decorated. Staff working in the service spoke positively about their experience of working there and felt supported and valued. All staff were enthusiastic about the service. A thorough process was in place of recording the patient's journey while in the care of the hospice. Patients and families told us the care they received was 'excellent'.

Every year, we ask the service to submit an annual return. This gives us essential information about the service such as composition, activities, incidents and accidents, and staffing details. The service submitted an annual return, as requested.

As part of the inspection process, we ask the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Assurance 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. The service submitted a comprehensive self-evaluation.

We saw that safe, person-centred care was being delivered in a clean and safe environment. Corridors and rooms were free from clutter and all areas we saw were well organised and well maintained. We saw the service used appropriate cleaning solutions including chlorine-based products for sanitary fixtures and fittings and disposable colour-coded mop heads in line with national infection prevention and control guidance.

Supplies of personal protective equipment were readily available throughout the service. Staff had completed infection prevention and control training. Cleaning schedules were in place and the domestic supervisor was responsible for reviewing these regularly. We were told that domestics used a reporting logbook to support communication, raise concerns and record actions when appropriate. The log was reviewed at the start of every shift to help make sure any outstanding issues were managed appropriately. The domestic supervisor also carried out a walk round of the service at the start of each shift as a way to capture any issues identified at that time.

The laundry room had an effective system in place to make sure dirty and clean laundry was kept apart. This area was tidy and well organised. While the service did not routinely launder patient clothing, a system was in place for this to be done if required.

We were told that all equipment was cleaned before and after use. The equipment we saw was clean and well maintained. Toilets were provided throughout the hospice, accessible to people with disabilities. Housekeeping staff cleaned these facilities regularly through the day and kept up to date records.

We reviewed five patient care records and saw patient details were well documented. This included:

- consent to share information with other healthcare professionals and the next of kin
- patient's next of kin contact details
- the GP contact details, and
- the patient's goals of admission.

Before admission, all conversations that the Access Team had with the patient and family were thoroughly documented on the electronic patient care records. We saw evidence that the Access Team had detailed conversations that captured the patients and families consent to the hospice being involved in their care.

From the day of admission, each patient had a thorough medical and nursing assessment documented. This included an assessment of the patient's condition, past medical history and their current medicines. We saw a clear treatment plan in place, which included reviewing current medicines and involvement with other members of the multidisciplinary team and involvement with external healthcare professionals. We saw that each patient was discussed at a weekly multidisciplinary team meeting, with plans documented.

During our inspection, we attended the daily clinical service meeting with the Access Team. This meeting included staff from the hospice at home service and the inpatient unit. At the meeting, we saw a full review of:

- patients in the community
- patients as part of the 'hospice at home' service
- patients in the inpatient unit of the hospice, and

- patients in hospital who were under the care of the hospital palliative care team.

Issues addressed at the meeting included:

- numbers of patients on the waiting list to be seen by hospice staff.
- planned admissions for the day
- patients with concerns (for example, at risk of falling), and
- staffing levels across the services.

The meeting was very active with all staff participating. All relevant staff were sent an email with an overview of patient numbers and issues discussed after the meeting.

Patients and families we spoke with told us:

- 'Staff go out of their way to help you.'
- 'Excellent care.'
- 'A happy place.'

Throughout our inspection, staff spoke enthusiastically about the service, the new developments and how supported they felt. Staff who completed our online survey told us how proud they were to work for the service. Comments included:

- 'I feel extremely proud to work at the hospice and I believe strongly the service we provide is important and delivered to high standards.'
- 'I would whole heartedly recommend the Hospice as a very good place to work.'
- 'I think St Columba's is a brilliant place to work.'

In the service, we saw designated areas for reflection and privacy were bright, well maintained and designed to promote positivity.

What needs to improve

We saw that consent to treatment was obtained for each patient before they were admitted to the service. However, this could be more clearly documented in patient care records. We will follow this up at future inspections.

- No requirements.
- No recommendations.

Appendix 1 – About our inspections

Our quality assurance system and the quality assurance framework allow us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this system 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.

Before

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.

During

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**

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.

After

More information about our approach can be found on our website: [The quality assurance system and framework – Healthcare Improvement Scotland]

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

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

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