Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Surehaven Hospital, Glasgow

Service Provider: Surehaven Glasgow Ltd

7-8 May 2024

NHS SCOTLAND

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Contents

1 Progress since our last inspection

What the provider had done to meet the requirement we made at our last inspection on 15-16 February 2022

Requirement

The provider must ensure that all notifiable incidents, events and specific circumstances are notified to Healthcare Improvement Scotland as required.

Action taken

The provider had been notifying Healthcare Improvement Scotland of relevant changes or events in the service, as required. **This requirement is met.**

What the service had done to meet the recommendation we made at our last inspection on 15-16 February 2022

Recommendation

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

Action taken

We saw all patients' food was labeled and dated in the fridges.

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 Surehaven Hospital on Tuesday 7 and Wednesday 8 May 2024. We spoke with a number of staff and four patients during the inspection. We received feedback from 22 members of staff through an online survey we had asked the service to issue for us during the inspection.

Based in Glasgow, Surehaven Hospital is a private psychiatric hospital.

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For Surehaven Hospital, 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**
Measurable objectives and key performance indicators were used to evaluate the service. A clear leadership structure and clinical governance processes were in place. Structured meetings helped with effective team communication. The service's aims and objectives should be more widely shared with patients, carers and the public.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patient, staff and carer feedback was actively encouraged. Policies and procedures set out the way the service delivered care, including processes to manage and reduce complaints and incidents. Risk assessments and audits were in place for all environmental and clinical activities, and a quality improvement plan supported continuous improvement of the service.	✓✓ Good
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
Patients spoke positively about their experiences, and said they felt supported by staff. Safer recruitment processes were followed and the majority of staff described the provider as a good employer. Patient care records demonstrated a person-centred approach to care with patients' needs regularly assessed. Consent to share information with patients' next of kin should be consistently documented and patient care records should be fully completed. Cleaning equipment and waste bins must be fit for purpose.	✓✓ Good

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 Surehaven Glasgow Ltd 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 one requirement and two recommendations.

Direction	
Requirements	
None	
Recommendation	
a	The service should share its aims and objectives with patients, carers and the public (see page 10). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Results	
Requirement	
1	The provider must ensure that equipment and the environment can be effectively cleaned to meet infection prevention and control standards (see page 22). Timescale – by 1 August 2024 *Regulation 3(d)(i)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendation	
b	The service should ensure consent to share information with patients' next of kin is consistently documented in the patient care records and ensure patient care records are fully completed (see page 22). Health and Social Care Standards: My support, my life. I am fully involved in all decisions about my care and support. Statement 2.14

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website: Find an independent healthcare provider or service – Healthcare Improvement Scotland

Surehaven Glasgow Ltd, the provider, must address the requirement and make the necessary improvements as a matter of priority.

We would like to thank all staff at Surehaven Hospital 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

Measurable objectives and key performance indicators were used to evaluate the service. A clear leadership structure and clinical governance processes were in place. Structured meetings helped with effective team communication. The service's aims and objectives should be more widely shared with patients, carers and the public.

Clear vision and purpose

A statement of purpose policy developed by Shaw Healthcare described the service's aims and objectives and included:

- providing a bespoke service
- assessing and adapting to clinical needs and security of the patients, and
- providing a safe, structured, responsive environment.

Staff were made aware of the service's aims and objectives, including its statement of purpose policy, through the 'MyShaw' app. The app could be accessed on the service's computers, and included service and staff related information, including policies, wellbeing and safety information, employee matters and news.

The patient booklet described how the service worked to the principles of the national health and social care standards. Information on the standards was given to all patients.

To evidence how well the service was meeting its objectives, its performance was assessed against key performance indicators. This included safety criteria, staffing, and patient, staff and carer satisfaction. Progress against key performance indicators was available to all staff on an online system which provided oversight of the service, and was discussed during clinical governance and management meetings.

A business plan was produced detailing actions to meet the planned objectives for the year which included actions from regulatory inspections.

What needs to improve

The aims and objectives, as described in the statement of purpose policy, were not shared with patients, carers and the public, such as on a website or being displayed or available in the service (recommendation a).

- No requirements.

Recommendation a

- The service should share its aims and objectives with patients, carers and the public.

Leadership and culture

Clinical staff working in the service included the service manager, psychiatrist, psychologist, occupational therapists and registered nurses. They were supported by healthcare support workers, activities co-ordinators, administration and domestic teams, and chefs.

Staffing levels were assessed based on the clinical risk of patients. When staff shortages were identified, bank staff, who worked regularly in the service, were used to ensure all staff were familiar with the service and patients. Patients could also access other services and resources in addition to the staff in the service such as a GP, dietitian, speech and language therapist, and a local minister.

We saw a clear organisational structure in place. The service had defined principles, one of which was to 'ensure our staff have the right leadership'. We were told good corporate support was available from Shaw Healthcare.

A service manager and clinical nurse specialist were responsible for oversight of the clinical governance processes in place to maintain patient safety, such as:

- clinical audits
- patient feedback and complaints management, and
- staff performance and management.

Monthly clinical governance meetings with minutes and a set agenda covered clinical governance items, such as:

- medicines management
- health and safety, and security
- infection prevention and control
- staff development and healthy working lives
- complaints and feedback
- incidents
- policies and procedures, and
- audits.

Minutes of meetings were available to all staff on a shared internal intranet system. Additional oversight and support was provided by a clinical governance team from Shaw Healthcare.

Other meetings between staff groups were held to manage the day-to-day working of the service. These meetings included:

- ward meetings
- charge nurse meetings
- incident review meetings, and
- health and safety meetings.

The service's whistleblowing process was displayed in the staff offices. This process included information about how staff could raise a concern internally, and how to seek external advice and support.

Support was offered for the wellbeing and mental health of staff. There was a national support telephone line for staff and a confidential counselling support service on site with the psychologist. Mindfulness and massage sessions were organised and team building initiatives such as cycle weekends and other staff group social get togethers were arranged.

- 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

Patient, staff and carer feedback was actively encouraged. Policies and procedures set out the way the service delivered care, including processes to manage and reduce complaints and incidents. Risk assessments and audits were in place for all environmental and clinical activities, and a quality improvement plan supported continuous improvement of the service.

Co-design, co-production *(patients, staff and stakeholder engagement)*
An information pack about the hospital was available on the service's website for patients, as well as one for carers about what to expect during admission, including:

- therapies and activities
- the environment, and
- staff working in the service.

Patients were encouraged and supported with all aspects of their care and in helping to continually improve the service. For example, the community meetings attended by staff included the activities co-ordinator and patients. These meetings were held every week for female patients and every 2 weeks with male patients. During this meeting, patients were encouraged to discuss any concerns about the service and to offer suggestions for therapeutic activities, future projects or improvements. During one of these meetings, patients had requested complementary therapies and, as a result, mindfulness and massage sessions were now offered. Patients also requested more variation in the menu with the chef invited to a community meeting to discuss further. We saw minutes of these meetings were displayed in easy read format and could be easily accessed on the patient noticeboard. Examples of improvements included:

- breakfast groups with a healthy theme
- suggestions to upgrade ward areas such as new curtains, and
- suggestions for new activities such as cinema trips.

A patient questionnaire was issued every month to all patients to gather their views on the service, provide suggestions for improvement or raise a concern. The questionnaire also asked patients if they wished to acknowledge the efforts of individual members of staff. This patient recognition was fed back to staff during their one-to-one meetings with their line manager. When possible, patients were included in the panel selection of prospective staff.

Patients were also encouraged to complete an external services satisfaction audit questionnaire. This provided an insight into how patients rated the external services such as the GP, podiatry, dentist, opticians and interpreter services (when required).

An annual survey was sent to patients from Shaw Healthcare seeking their views on their care and treatment. All patient feedback was discussed during the clinical governance meetings. Actions taken as a result of patient feedback were displayed on the ward noticeboards.

A family and carer involvement policy laid out how the service would provide support to patients and their families to encourage them, as far as possible, to be involved in discussions and decisions about their own care and treatment. We saw evidence of this through the carer's forum meetings. Patients had a named nurse who telephoned patients' nominated named person to update them at agreed times and frequencies. Carers could join the patient's multidisciplinary team meetings online if they were unable to be there in person.

The service also received feedback from the carer's questionnaire. This provided information on how effectively the service engaged with patients' named persons. We were told that the service's carer champions staff communicated with families at carers' events to tailor carer support to their individual needs and signpost additional support where required.

A folder of photographs was available in reception for carers to see the patient areas that they could not access during visiting times due to visitor access restrictions to some areas. Feedback forms were also available that could be posted in a suggestion box.

Staff were requested to complete a survey twice a year. Feedback from the last survey in January 2024 included that clinical staff wanted further role-specific training. As a result, Monday face-to-face teaching sessions were set up and additional role-specific training modules on the MyShaw app were added. Student nurses also gave feedback following a learning placement in the service. One student nurse had suggested that support workers should be included in the face-to-face training, and they now also attended the teaching sessions.

The service had an 'Employee of the Month' scheme where staff were nominated by colleagues or patients for their high standards of care or support. We were also told about the annual 'Star Awards' which also recognised excellence in each staff group.

- 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 was aware that, as a registered independent healthcare service, it had a duty to report certain matters to Healthcare Improvement Scotland, as detailed in our notifications guidance.

Appropriate policies, procedures and processes were in place to deliver safe, person-centred care, such as prohibited and restricted items, management of violence and aggression, and search procedures. We saw that a formal sign-off process took place for all policies and procedures.

A safeguarding policy described the actions staff should take in case of an adult protection concern. Contact information for the local police and the Health and Safety Executive for out-of-hours emergencies such as discovering a critical incident was displayed in the staff offices.

While in the service, patients were temporarily registered with a local GP and medication was supplied by a local pharmacy. We saw clear policies in place for the prescribing, ordering and administering of medication for registered nursing staff. Standard operating procedures were also available for registered nursing staff covering all aspects of medicine management. Medicines were stored in locked cupboards and fridges and the fridge temperature was monitored to make sure medicines were stored at the appropriate temperature. Emergency medicines and equipment were easily accessible and checked every week.

Incidents and accidents were recorded using an electronic incident reporting system. These were also reported to Shaw Healthcare's clinical governance team who had access to the system. They could track and input further queries directly to the service's senior management. The information recorded included:

- a description of the incident and immediate actions taken
- an action plan for learning and improvement, and
- staff debriefing and support.

An infection prevention and control policy described the precautions in place to prevent patient and staff harm from avoidable infections. Appropriate products were used to clean equipment and the environment, and cleaning schedules were displayed in the cleaners rooms.

A planned preventative maintenance programme that included safety testing for equipment covered:

- the gas boiler and system
- fixed electrical wiring and portable appliance testing of electrical equipment
- security and fire system and equipment, and
- water safety.

A fire safety log held maintenance reports for all fire safety equipment, a fire emergency plan, fire risk assessment, record of fire alarm testing and fire drills, and an incident report for any fire safety related events.

A water risk assessment had taken place and less frequently used water outlets were flushed, by running of the taps, to reduce the risk of waterborne bacteria.

The complaints policy set out timeframes and expectations for how complaints would be managed. Information on making complaints to Healthcare Improvement Scotland was available on the service's website and in the patient information booklet.

We saw evidence that complaints were managed in line with the service's own policy. Complaints were collated in a complaints log and included:

- evidence of investigation
- identified areas for improvement, and
- implementation of changes as a result.

Duty of candour is where healthcare organisations have a professional responsibility to be honest with patients when something goes wrong. The service had a duty of candour policy, and an annual report was available on the service's website. The service had not had any duty of candour incidences. Staff also had training on duty of candour principles as part of their training schedule.

Patients had access to an advocacy service, details of which were posted on ward noticeboards. Two identified staff members had been appointed patient rights champions who patients could approach with concerns or issues about their welfare. Patients also had access to legal representation in relation to their rights under mental health legislation.

The clinical nurse specialist had taken a mental health leadership role in the national independent hospital provider network to seek out and develop best practice in the sector and share management initiatives with other independent hospitals in Scotland. This also helped the service keep up to date with evidence-based practice, and changes in best practice and legislation.

All patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 and referred to the service by NHS boards throughout Scotland. Appropriate legal consent and treatment documentation was in place for all patients. Consent and capacity to consent was assessed in line with relevant legislation and best practice. An up-to-date admission, transfer and discharge policy helped to ensure that correct processes were followed throughout the patient's admission.

All patients were reviewed by the multidisciplinary team every week, or if the patient's condition changed and they had to be reviewed sooner. Patients were also reviewed every 6 months under the 'care programme approach'. This involved multidisciplinary care plan meetings with health and social care professionals involved in the patient's care.

We saw a range of activities and therapies such as art groups, pool groups and trips to local attractions were available to support and maintain patients' health and wellbeing. Patients were encouraged and supported to attend local amenities such as the local shops. We saw that each patient had been assessed to ensure activities were suitable to meet their needs.

Policies for the management of information were in place. Patient care records were in paper format and stored securely. The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights) to make sure confidential patient information was safely stored.

Policies were in place for recruitment, induction and staff development. Staff files contained a checklist to help make sure that recruitment processes and pre-employment checks had been carried out. Shaw Healthcare's human resources department supported the service with the recruitment process. Systems were in place to ensure all staff had up-to-date Protecting Vulnerable Groups (PVG) background checks.

We saw clear policies and checklists to ensure all aspects of induction were covered for new staff. All staff members completed an induction programme which involved face-to-face training, e-learning and webinars. New staff shadowed a more experienced member of staff to gain practical experience before commencing their role. General induction topics included:

- infection prevention and control
- safeguarding (public protection)
- mental health topics such as psychosis, and
- prevention and management of violence and aggression.

Staff were given additional time at work to attend training sessions and complete online learning modules as part of their mandatory training. We noted that compliance rates were high for completion of mandatory training modules for both employed and bank staff. Additional training opportunities were available for staff and funding applications could be made to access external courses if approved by senior management.

Staff performance and personal development were monitored through supervision meetings every 3 months and yearly appraisals. Staff were asked to reflect on how they met the provider's values, and to set objectives and personal development goals for the year ahead. The appraisals we saw had been comprehensively completed.

What needs to improve

We saw an extensive list of mandatory training for staff to complete. However, staff told us of the considerable time needed to complete the required training and that some modules were not applicable to their roles. Consideration should be given to ensuring mandatory training is service and role specific. We will follow this up at future inspections.

- No requirements.
- No recommendations.

Planning for quality

We saw a risk log of clinical and non-clinical risks in place for risks in the service, such as:

- safety of patients, staff and visitors
- staffing issues
- adverse publicity
- infection control risks, and
- patient activities.

The risk assessments included processes in place to help manage any risks identified.

There was also a corporate risk register to assess all services within the Shaw Healthcare group of services. Each service was assessed on issues including:

- staffing
- audits and regulatory compliance
- complaints management, and
- safeguarding.

We saw evidence that the risk log, risk assessments and the corporate risk register were regularly reviewed by a Shaw Healthcare compliance manager.

As a contingency plan, the service had a formal agreement with another service in case of events that may cause an emergency closure of the hospital. This included full evacuation of patients and staff. Appropriate insurances were in-date, such as public and employer liability insurance.

An audit programme helped to review the safe delivery and quality of the service. The findings were documented, and action plans completed, where required, and these were discussed at relevant staff meetings. Audits carried out included:

- ward level audits including medicines management, and patient care records and care plans
- infection prevention and control audits carried out by the service manager, and
- a full audit carried out by a compliance manager that was aligned to Healthcare Improvement Scotland's quality of care framework.

All audits carried out in the service were checked by Shaw Healthcare's compliance team. They also carried out an analysis of audits within the Shaw Healthcare group of services to identify themes. For example, audits had identified an issue with PRN medicines (additional medicines that are taken when required by the patient in addition to their regular medications). As a result of this finding, protocols were reviewed and further training put in place for relevant staff for all of the group's services.

Quality improvement is a structured approach to evaluating performance, identifying areas for improvement and taking corrective actions. We saw that audit actions, complaints and incidents fed into a service improvement plan and a development plan.

- 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

Patients spoke positively about their experiences, and said they felt supported by staff. Safer recruitment processes were followed and the majority of staff described the provider as a good employer. Patient care records demonstrated a person-centred approach to care with patients' needs regularly assessed. Consent to share information with patients' next of kin should be consistently documented and patient care records should be fully completed. Cleaning equipment and waste bins must be fit for purpose.

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 satisfactory self-evaluation.

We saw evidence of a good standard of clinical care, including awareness of risk and how to manage it. Staff we spoke with showed care and compassion as well as a high level of specialist knowledge. They told us they enjoyed working in the service.

The environment was clean and maintained. Adequate supplies for cleaning products and equipment were available. There was a good supply of personal protective equipment such as gloves, masks and aprons.

We reviewed five patient care records and found these were comprehensive and well organised. We saw evidence of multidisciplinary working, and patient and carer involvement. We saw monthly summaries detailing progress for each patient completed by staff and sent to the appropriate NHS board. The care plans all included person-centred strategies for improving and maintaining good physical health.

We reviewed five staff files and found all contained the required background checks to show staff had been safely recruited. This included:

- professional registration checks and qualifications, where appropriate
- references, and
- Protecting Vulnerable Groups (PVG) status.

The staff files also included information on each staff member's induction, supervision and appraisals. We saw a process was in place to ensure ongoing reviews of professional registrations and regular PVG checks were carried out, as required, to ensure staff remained safe to continue working in the service.

As part of our inspection, we asked the service to circulate an anonymous staff survey. The majority of staff who responded said they would recommend the organisation as a good place to work. Comments included:

- 'There is a really positive culture towards providing patient-centered compassionate care to our patients.'
- 'There is a strong feeling of unity and teamwork amongst staff of all levels. Management are very approachable, supportive and flexible.'
- 'I feel that I am listened to and that I am a valued member of staff.'
- 'The service provides a great standard of care for our patient group. We have a diverse range of employees who bring many different skills and attributes to their roles.'

What needs to improve

The cleaning equipment used by the domestic staff was contaminated and in disrepair, such as mops and buckets. Contaminated and damaged cleaning equipment could risk cross contamination and make effective cleaning difficult. The majority of domestic and clinical waste bins in the hospital were in a state of disrepair and could not be effectively cleaned (requirement 1).

From the patient care records we reviewed, we found that some did not have the patients' next of kin consent to share information sheets completed. We also found that some multidisciplinary notes had patient details missing from them. For example, the patient's name, date of birth or their NHS community health index (CHI) number had not been added to individual page headers and only patient's initials were used as identifiers on some pages (recommendation b).

Due to the patient group, the environment required regular repair to walls and fixtures. Maintenance staff attended to these repairs on an ongoing basis. However, some areas of the hospital were showing signs of wear and tear that required refurbishment. We were told this had already been identified during a recent inspection by the Mental Welfare Commission. As a result, the service had produced an action plan and a rolling programme of refurbishment was in place. This included redecoration of patients' bedrooms and ensuites, including new sanitary fittings. We will follow this up at future inspections.

Requirement 1 – Timescale: by 1 August 2024

- The provider must ensure that equipment and the environment can be effectively cleaned to meet infection prevention and control standards.

Recommendation b

- The service should ensure consent to share information with patients' next of kin is consistently documented in the patient care records and ensure patient care records are fully completed.

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

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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