Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Castle Craig Hospital, West Linton

Service Provider: Castle Craig Hospital Limited

17–18 September 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 20–21 September 2022

Requirement

The provider must ensure all medicines are held securely and appropriately, including ensuring emergency drugs are held together in the emergency kit, in line with current national resuscitation guidelines.

Action taken

We saw that all medicines were held securely and appropriate medicines, including glycogen had been added to the emergency kit and documentation updated. **This requirement is met**.

What the service had done to meet the recommendations we made at our last inspection on 20–21 September 2022

Recommendation

The service should consider further appropriate ways of engaging with staff to seek their views and demonstrate how their feedback is used to improve the service.

Action taken

Staff meetings were held every 3 months. However, staff surveys had not been recommenced. This recommendation is reported in Domain 3: Co-design, co-production (see recommendation c on page 19).

Recommendation

The service should review cleaning and monitoring procedures to ensure all areas are routinely cleaned and maintained in clean condition, including:

- *cleaning frequency*
- *cleaning schedule documentation*
- *staff provision, and*
- *monitoring that appropriate cleaning is taking place.*

Action taken

A new housekeeper had been appointed and we saw that all cleaning systems and processes had been reviewed and updated to address all areas of identified.

Recommendation

The service should review the use of the cleaning supplies room so that infection prevention and control standards are followed, and a healthy working environment is provided for staff.

Action taken

The cleaning room had been de-cluttered, re-organised and supplies streamlined.

Recommendation

The service should expand its existing patient care record audit to include reviews of the content and quality of patient care records.

Action taken

The service reviewed the content and quality of its patient care records during audits.

Recommendation

The service should ensure that all patient records are clearly dated and signed to comply with professional standards from the Nursing and Midwifery Council about keeping clear and accurate records.

Action taken

Weekly audits had been implemented to check that patient notes were fully completed.

Recommendation

The service should provide naloxone kits to patients and provide training to the patient in its use.

Action taken

Take-home naloxone kits were offered to patients and training was provided to help make sure correct administration was carried out.

Recommendation

The service should keep a record of professional register checks of staff members carried out as part of the recruitment process.

Action taken

We saw that the service's human resources department kept records of professional register checks.

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 Castle Craig Hospital on Tuesday 17 and Wednesday 18 September 2024. We spoke with a number of staff and patients during the inspection. We received feedback from 15 staff members through an online survey we had asked the service to issue for us during the inspection.

Based in West Linton, Castle Craig Hospital is a private psychiatric hospital.

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For Castle Craig 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**
The service's clear mission and vision was demonstrated through staff practice and communications. Management set out objectives in a yearly plan. Regular board reports used a range of data to monitor service performance. Staff told us that senior management was accessible and approachable. A culture of community encouraged staff involvement in service development. Establishing clear annual objectives would help measure service performance more effectively.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patient 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. A formalised quality improvement plan should be developed to capture continuous improvement of the service. Staff feedback should be formally gathered.	✓✓ 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 staff supported them. Safer recruitment processes were followed and the 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.	✓✓ 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 Castle Craig Hospital Limited 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 five recommendations.

Direction	
Requirements	
	None
Recommendations	
a	The service should establish clear annual objectives that are specific and measurable, ensuring they demonstrate progress in fulfilling the service's mission (see page 13). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
b	The service should document staff meetings to ensure a note of outcomes and actions is retained for record and dissemination to staff who were unable to attend (see page 16). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Implementation and delivery	
Requirements	
	None
Recommendations	
c	The service should implement a structured way of seeking the views of staff and using their feedback to make improvements to the way the service is delivered (see page 19). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19 This was previously identified as a recommendation in the September 2022 inspection report for Castle Craig Hospital.
d	The service should develop its quality improvement plan to capture and measure the impact of service changes and demonstrate a culture of continuous improvement (see page 24). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Results	
Requirements	
	None
Recommendation	
e	The service should ensure consent to share information with patients' next of kin is consistently documented in the patient care records (see page 27). 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]

Castle Craig Hospital Limited, the provider, must address the requirement and make the necessary improvements as a matter of priority.

We would like to thank all staff at Castle Craig 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

The service's clear mission and vision was demonstrated through staff practice and communications. Management set out objectives in a yearly plan. Regular board reports used a range of data to monitor service performance. Staff told us that senior management was accessible and approachable. A culture of community encouraged staff involvement in service development. Establishing clear annual objectives would help measure service performance more effectively.

Clear vision and purpose

Castle Craig Hospital provides an abstinence-based approach specialist addiction treatment for those suffering from a range of addictions, including:

- alcohol
- drugs, and
- gambling and accompanying complex issues.

The service has a strongly embedded mission and values statement 'to provide compassionate care to those suffering from addiction and its related mental and physical health problems.' From discussions with patients and staff, as well as observing meetings and groups, we found that staff demonstrated the organisational values in their work. The service mission and values statement were included in the staff handbook and publicly available on the service's website. The mission and values were repeated at each patient community meeting and included in service information.

Staff comments we received on leadership included:

- 'I have always found them to be supportive and demonstrating a clear vision in achieving our goal.'

The board of directors was responsible for the service’s strategy and direction. We were told that staff involvement helped inform this at special events and meetings. Staff involvement was encouraged to strengthen the purpose and value of the work carried out.

The hospital manager had set out objectives for the year, based on the service’s most recent ‘strengths, weaknesses, opportunities and threats’ (SWOT) analysis, last reviewed in May 2024. As well as building on areas the service did well, the objectives considered outcomes of:

- areas of risk
- complaints
- quality assurance activities, and
- regulatory activity.

The hospital senior management team was relatively new and continuously developing. We found a clear aim to deliver quality care was evident. Quality and risk management systems were in place to provide assurance.

What needs to improve

Some objectives set out in the yearly plan were not specific or time-bound. This meant it would be difficult to measure progress against these objectives through the 3-monthly board reporting system (recommendation a).

- ■ No requirements.

Recommendation a

- ■ The service should establish clear annual objectives that are specific and measurable, ensuring they demonstrate progress in fulfilling the service’s mission.

Leadership and culture

Castle Craig Hospital provided a highly specialised service and the staff skill mix was representative of the complex needs of the patients. It employed a variety of staff to provide care and support to its patients, including:

- housekeeping staff
- maintenance staff
- nurses
- psychiatrists
- recovery support staff
- specialist doctors, and
- therapy staff.

Staffing levels were continually under review to make sure appropriate levels of cover were in place. Staffing numbers were adjusted where appropriate, such as in response to the number of patient admissions and clinical, therapeutic activity.

The chief executive officer, medical director and the operations manager provided senior hospital management. The service was in the process of recruiting other key posts, such as a development manager and a therapy programme manager to strengthen the senior management team. This was a new management structure after the previous hospital manager had left. Staff we spoke with told us that the management team was very supportive and accessible.

One staff member commented:

- 'Leadership has changed in the past few months with a new medical director and operations manager. They are both working hard to make improvements and lead by example.'

Governance processes in place included a range of meetings and committees, such as:

- health and safety committee
- the clinical governance group, and
- therapy management meeting.

All groups reported to the board and a 3-monthly board report provided current information on operational aspects of the hospital. We saw that agenda items included discussions of:

- audit outcomes and actions
- complaints
- incidents, and
- staffing including training.

Policies and procedures in place reflected all aspects of service delivery and were reviewed regularly, following a fixed schedule and were signed off at board level.

Staff meetings took place regularly and staff who completed the online questionnaire were largely positive about communication and culture in the service. Staff told us:

- 'The culture is unique, I can't think of another place I have worked in that had such a community feel.'
- 'The focus is always about best practice and achieving excellence.'

Day-to-day communications with staff were effective and handover procedures in place allowed for patient progress and operation issues to be passed on for continuity. Other clinical meetings included a daily multidisciplinary meeting and weekly ward round where all patient care matters, progress and treatment plans were discussed.

What needs to improve

While staff meetings were held in each area, these were often not documented. A written note of staff meetings would help make sure that discussion points are actioned and tracked (recommendation b).

The service had a range of policies and procedures in place, some of which were similar. This could be problematic for staff wishing to access a particular policy quickly. The service told us that the need to review, consolidate and rationalise policies and procedures for easier staff use had already been identified. We will follow this up at future inspections.

- ■ No requirements.

Recommendation b

- The service should document staff meetings to ensure a note of outcomes and actions is retained for record and dissemination to staff who were unable to attend.

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 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. A formalised quality improvement plan should be developed to capture continuous improvement of the service. Staff feedback should be formally gathered.

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.

A board with staff photographs was on display for patient and visitor information.

The service used a variety of ways to gather feedback from patients, including:

- community group meetings
- complaints
- focus groups, and
- patient satisfaction surveys.

From the most recent patient satisfaction survey carried out in February 2024, we saw high satisfaction levels reported. The survey asked patients about:

- accommodation
- catering
- introduction to the service
- medical and nursing care
- privacy and dignity, and
- the therapy programme.

The service set up focus groups for any issues identified that would benefit from wider input from patients. A recent group had focused on the quality of catering after results from the survey had been analysed.

We attended a community meeting with patients and staff where patients were encouraged to:

- discuss issues about their stay
- provide feedback about aspects of care, including staff, and
- speak about any concerns.

Patients were invited to further discuss any issues they had outside of the meeting. Notes of the meeting were produced and implemented actions were included on the agenda for discussion at the next community meeting.

The service had a staff recognition scheme, where colleagues or patients nominated staff in recognition of high standards of care or support. The service also recognised long service and staff had individual accounts with an online gift exchange platform that they could exchange points for vouchers. An all-staff email was sent to formally recognise staff in their achievements.

The chief executive officer led a staff dinner event in January 2024, where service updates were shared with staff. The event's theme was renewal in recognition of the new medical director, new management structure and the review of the therapy programme.

The service was recruiting a new therapy programme manager after staff feedback from stated a preference to have one point of leadership for the therapy team.

The hospital employed 'recovery advocates', who linked patients, therapy and nursing staff. We saw that the role had been further developed after patient and staff feedback.

A regular staff newsletter provided information on Castle Craig Hospital and updates on provider's other services in the UK and Europe.

What needs to improve

Staff surveys had not been carried out in over 2 years (recommendation c).

The staff intranet only provided information about policies and procedures. We discussed the opportunity to further develop this and provide a variety of information for staff. We were told that the service planned to review the information that the intranet provided for staff. We will follow this up at future inspections.

- No requirements.

Recommendation c

- The service should implement a structured way of seeking the views of staff and using their feedback to make improvements to the way the service is delivered.

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 current policies and standard operating procedures in place. This included those for:

- handling emergencies
- health and safety
- infection prevention and control, and
- medicine management.

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. Cleaning schedules were also displayed in the housekeeping office.

Incidents were systematically recorded and managed using an electronic incident management system. A structured process for review and discussion was implemented, allowing for the examination of learning outcomes with relevant staff. We observed various examples of reported incidents and confirmed that the service's established processes were followed in each instance. Additionally, a comprehensive fire risk assessment was conducted, and all checked fire equipment was found to be in date. During our inspection, a water supply inspection was also underway, and an action plan had been developed in response to this assessment.

In the absence of the pharmacist, we spoke with the nursing staff about to medicines management during our inspection. The service had a contract in place with an external pharmacy to supply a pharmacist each week. The pharmacist worked with the nursing staff to make sure that a thorough process of safe management of medicines was in place, which included:

- medicine reconciliation
- regular checks of medicine expiry dates
- safe disposal of medicines
- safe storage of medicines, and
- the process of controlled drug orders.

The service regularly audited the prescribing practices and medicines used. Medicines were stored appropriately and securely in the medical centre. A lockable medicines trolley was used to dispense oral medicines directly to patients and this was kept locked in the medical centre when not in use. The medicines fridge temperature was monitored to maintain the appropriate temperature for temperature-sensitive medicines storage. Emergency medicines and equipment in place were easily accessible and checked every week.

Training in medicine administration was part of the staff induction program and staff attended refresher training.

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 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.

A process was in place for assessing patients before they were admitted, with a focus on identifying the patient's individual needs and potential risks. The admissions process was thorough, with a dedicated admissions team managing the initial referral and suitability of the hospital for the patient to receive treatment. Once the clinical lead had approved the admission, patients received further assessments from a psychiatrist, a therapist and a nurse.

Patients' medical records and confirmation of their medication history were sought during the assessment. This was with the aim of having these available at the point of admission to allow for safe care and detoxification planning.

Confirmation of the patient's prescribing history was also sought from the dispensing pharmacy or the community addiction team, with the patient's consent.

Patients were allocated a named therapist as their main point of contact throughout their treatment. Daily handovers were carried out between nursing staff and therapists. Weekly multidisciplinary meetings were also held to review patients' progress. Although patients were not routinely involved in the multidisciplinary meetings, arrangements to see the psychiatrist were determined individually.

Discharge planning began at admission and patients could receive follow-up care from the service as an outpatient. Patients could also be linked with local groups to their area, such as Alcoholics Anonymous.

Processes were in place to provide patients with any relevant discharge medication and copies of this information was provided to relevant community treating teams. Patient discharge letters included current medications, recommendations for ongoing support and the patient's treatment progress.

Policies for the management of information were in place. Patient care records were in electronic format and stored securely with password protection. 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. The service had dedicated human resources based on-site who supported the service with the recruitment process. Systems were in place to make sure all staff had up to date Protecting Vulnerable Groups (PVG) background checks.

We saw clear policies and checklists in place to make sure all aspects of induction were covered for new staff. All staff members completed an induction programme which was tailored to the staff member's job role. Staff were clear about their - and other team members' - responsibilities and knew who to contact for information or to resolve an issue. They kept up to date with changes in legislation and best practice through online training courses and continuous professional development. The operations manager co-ordinated the training matrix and we saw that staff had shown a high uptake of all general as well as role-specific training.

Staff appraisals were carried out every 6 months and those we reviewed were comprehensively completed.

- No requirements.
- No recommendations.

Planning for quality

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. 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
- slips, trips and falls, and
- water systems.

The service manager 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 and patients were able to access easily. In addition to this system, formal walkrounds of the premises took place regularly which allowed any concerns or issues to be identified timely and managed appropriately. The service's gardener managed the extensive gardens and grounds team the external facilities which were well maintained with support from patients who volunteered as part of their recovery. These gardens provided a calm and reflective environment which helped support healing and recovery.

We saw clinical audits were regularly completed to make sure the service delivered consistent, safe care for patients and identified any areas for improvement. 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 included:

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

Any issues identified were raised with staff and reported at the clinical governance meetings.

We found a range of improvements prompted through audit and feedback, including:

- a bed replacement programme to allow for effective cleaning of beds
- developing easily-accessible therapeutic guidelines for staff
- leadership coaching for staff, and
- moving the gym to larger facilities and further developing the exercise programme.

The service had its own quality management system that was accredited to internationally recognised quality management standards. The most recent independent audit report had not identified any required actions, and we saw the report findings were very positive.

What needs to improve

We saw evidence of a culture of continuous improvement. However, the service did not have a central documented improvement plan in place. An improvement plan would help to define and track improvements and would include prioritisation, set goals, allocation of responsibility and timeframes (recommendation d).

- No requirements.

Recommendation d

- The service should develop its quality improvement plan to capture and measure the impact of service changes and demonstrate a culture of continuous improvement.

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 staff supported them. Safer recruitment processes were followed and the 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.

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 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 of cleaning products and equipment were available. We saw the service used appropriate cleaning solutions, including chlorine-based products for sanitary fixtures and fittings. Cleaning schedules were in place and the housekeeping manager was responsible for reviewing these regularly. A communication board was in place in the office and was reviewed at the start of every shift to help make sure any outstanding issues were managed appropriately.

The service had a good supply of personal protective equipment, such as masks and aprons.

We reviewed five patient care records and found these were comprehensive and well organised. We saw evidence of multidisciplinary working, as well as patient and carer involvement. 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
- Protecting Vulnerable Groups (PVG) status, and
- references.

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

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

- 'Castle Craig continues to provide an excellent service to not only patients but to employees - offering support and direction - in particular with on going training courses for therapists.'
- 'I enjoy working at Castle Craig, I'm not just a number, I'm part of a team that makes a difference to people's lives. There is a sense of mission that attracts people to join the team here and stay.'
- 'My three years at CC have been very enjoyable. I have a very busy and demanding role but feeling appreciated and knowing that support is available should I need it, makes dealing with the workload manageable.'
- 'Excellent opportunity to work in a residential addiction treatment unit that firstly excels in the service it provides. Secondly to feel 'part of', proud, of your contribution to the 'whole'. Lastly to have the opportunity to develop your knowledge and skill base, advance in your career, work with a diverse range of skilled clinicians.'

Designated areas for reflection and privacy were comfortable and designed to promote positivity. These areas included:

- a variety of seating inside and outside
- natural light from windows in the premises with views of surrounding gardens and countryside
- provision of musical instruments, access to animals and opportunities for gardening as part of a variety of therapeutic interventions, and
- useful information in posters and leaflets, including a ‘gratitude’ book that recorded the experiences of patients who had used the service.

Patients we spoke with told us:

- ‘I wasn’t sure about sharing a room but it worked out really well and its been a good support.’
- ‘Beautiful setting who couldn’t feel better in a place like this is very peaceful.’
- ‘There are alpacas which I really enjoy and horses which I love.’

What needs to improve

From the patient care records we reviewed, we found that some did not have the patients’ next of kin consent to share information details completed (recommendation e).

Some areas of the hospital were showing signs of wear and tear that required attention. Management staff told us that areas for improvement had been identified a plan was in place to update areas, including some soft furnishings and a bed replacement programme. We will follow this up at future inspections.

- ■ No requirements.

Recommendation e

- ■ The service should ensure consent to share information with patients’ next of kin is consistently documented in the patient care records.

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

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or email his.contactpublicinvolvement@nhs.scot

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