Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Shawfair Park Hospital, Edinburgh

Service Provider: Spire Healthcare Ltd

24–25 September 2024

NHS SCOTLAND

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1 Progress since our last inspection

No requirements or recommendations were made at our last inspection on 2 November 2021.

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 Shawfair Park Hospital on Tuesday 24 and Wednesday 25 September 2024. We spoke with a number of staff and patients during the inspection

Based in Edinburgh, Shawfair Park Hospital is an independent hospital.

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For Shawfair Park 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 hospital had a well-defined and measurable vision and purpose, with a clear strategy and defined key performance indicators to achieve it. Key principles and values had been identified in line with the vision and purpose. Values and principles were displayed in the hospital for staff and patients to see. Key performance indicators were regularly monitored and reported. Staff were aware of how to raise any concerns. Good governance arrangements were in place, accessible and staff understood them. The hospital's leadership team was visible throughout the hospital and staff spoke very positively about the working in the hospital.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patient experience was regularly assessed and used to continually improve how the service was delivered. Appropriate policies and procedures supported staff to deliver safe, compassionate and person-centred care. Comprehensive risk management and quality assurance processes were in place for patient and staff safety. Improvement projects involved all departments. Yearly staff surveys helped the service plan and develop staff. The effectiveness of improvements made as a result of patient feedback should be evaluated. The quality improvement plan should be maintained, updated and completed timeously.	✓✓ Good

Results	*How well has the service demonstrated that it provides safe, person-centred care?*	
The care environment and patient equipment was clean, equipment was fit for purpose and regularly maintained. Medicines management was good. Staff described the provider as a good employer and the hospital as a good place to work. Patients were very satisfied with their care and treatment. Staff must comply with the service's infection prevention and control policy. Healthcare staff working under a practicing and privileges contract should have at least two references on file.		✓✓ 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 Spire Healthcare 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.

Implementation and delivery	
Requirements	
	None
Recommendations	
a	The service should monitor and evaluate improvements made as a result of patient feedback, to determine whether actions taken have led to the improvement anticipated (see page 17). 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 ensure that the quality improvement plan is maintained, updated and completed timeously (see page 22). 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 compliance with all standard infection prevention and control precautions as detailed in Health Protection Scotland's National Infection Prevention and Control Manual, in particular: *(a) linen management, and* *(b) use of personal protective equipment (see page 27).* Timescale – immediate *Regulation 3(d)(i)(iii)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
	None

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

Spire Healthcare 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 Shawfair Park 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 hospital had a well-defined and measurable vision and purpose, with a clear strategy and defined key performance indicators to achieve it. Key principles and values had been identified in line with the vision and purpose. Values and principles were displayed in the hospital for staff and patients to see. Key performance indicators were regularly monitored and reported.

Staff were aware of how to raise any concerns. Good governance arrangements were in place, accessible and staff understood them. The hospital's leadership team was visible throughout the hospital and staff spoke very positively about the working in the hospital.

Clear vision and purpose

Shawfair Park Hospital is part of Spire Healthcare, the provider. The provider's purpose had been clearly set out in several key documents as making a positive difference to peoples' lives through outstanding personal care. It was stated along with the provider's vision and mission:

- To be recognised as world class healthcare business.
- To bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care.

The hospital had also identified key principles and values in line with its purpose, including making sure patients come first and valuing people that are compassionate and committed. Copies of the provider's purpose, vision, mission and values were displayed for staff and patients in the theatre department, wards and outpatient department.

The hospital's business plan and 5-year strategy plan set out how the provider's purpose and vision would be achieved. Key performance indicators (KPIs) were used to make sure the provider's purpose was measurable. This document was reviewed regularly at leadership forums and used to inform the next strategy,

with KPIs continually monitored in a variety of ways. These included monthly site reviews from the provider and monitoring through data analysis from:

- a centralised clinical governance framework
- assurance tools, and
- business intelligence systems that monitored workforce, audits, safety alerts, risk and incident reporting and complaints.

The provider's purpose and the hospital's strategy plan were clear and measurable. We saw evidence of regular monitoring, recording and reporting through appropriate governance structures.

The hospital's 'strategy plan' set out its 5- year strategic and how these would be achieved. It included issues, such as:

- 'Be clinically excellent in all areas.'
- 'Be the inclusive employer of choice in Edinburgh and the Lothians.'
- 'Exceed the expectations of our patients, consultants and partners.'
- 'Grow our hub, hospital and services.'
- 'Improve overall efficiency and maximise our capacity.'
- 'Work in a sustainable way.'

This document also set out KPIs. These KPIs were linked to the strategic objectives and showed current and target performance. We noted that the 'Quality Quartet' featured in monitoring documents, as a way of recording progress against KPIs and reporting this through governance structures.

The hospital strategy plan was reviewed and discussed regularly at leadership forums and multidisciplinary team meetings. A comprehensive 6-month review had been carried out. From the minutes of meetings we reviewed and staff we spoke with during our inspection, we saw that the hospital was making good progress in achieving its KPIs. The hospital had a well-defined and measurable vision and purpose. Its strategy and KPIs helped to achieve these. Values and principles were displayed in the hospital for staff and patients to see.

The service had temporarily increased its inpatient provision from three to 20 beds. We saw that plans were in place a for a permanent structure to house overnight bedrooms. We will follow this up at future inspections.

- No requirements.
- No recommendations.

Leadership and culture

The hospital's staffing resource was made up of:

- allied health professionals
- catering staff
- estates staff
- healthcare support workers
- house-keeping staff
- medical staff
- reception and administrative staff, and
- registered nurses.

The hospital had an effective leadership structure in place through its senior management team, which was made up of the:

- director of clinical services
- director of operations
- hospital director, and
- heads of department.

Regular meetings were held with all heads of departments. The minutes showed that information and strategic plan updates were shared at these meetings. We saw evidence that the meetings allowed comprehensive discussions between each department. Actions and updates on previously agreed actions were recorded. Service improvements were also discussed at the different management and governance meetings.

The hospital had a comprehensive and inclusive programme of departmental and staff meetings. It covered the topics of:

- health and safety
- infection prevention and control
- managing patient care
- medical advisory committee
- medicines management committee, and
- monitoring compliance with professional standards and legislation.

A leadership programme, called ‘Mastering Management’ was available to staff at levels three and five (depending on job role, personal and professional development requirements). The provider had a sponsorship programme in place for some qualifications for staff, such as operating department practitioner training and anaesthetic training. The staff member would identify and discuss this with their line manager and the clinical services manager before the hospital director reviewed the proposal. We saw that one member of staff had completed this programme.

Staff we spoke with were clear in their roles and how they could impact change in the hospital. They reported that they felt the senior management team listened to and valued them.

The service proactively managed its staffing compliment based on patient-dependency model to help make sure that an appropriate skill mix and safe staffing was always provided.

We attended the main ‘daily huddle’. We saw that this was well attended with representatives from all departments attending. The meeting was managed efficiently, with each department reporting on:

- staffing levels
- whether it was safe to carry out the day’s business, and
- whether the department had experienced, or was expecting any issues that may compromise the safety of patients in the hospital.

On the day we attended the huddle, no adverse incidents had been reported.

We also attended a daily huddle which took place in the theatre department. This was also well attended by the theatre staff and other relevant staff. Each theatre discussed:

- staffing levels
- theatre lists and an overview of theatre cases being undertaken
- management of the blood fridge and equipment being used.

A ‘freedom to speak up’ system had been introduced, where staff could speak with a nominated freedom-to-speak-up ‘ambassador’ in confidence if they had any concerns. A freedom-to-speak-up ‘guardian’ oversaw the freedom-to-speak-up ambassadors. Staff we spoke with were clear about their roles, responsibilities and how they could raise any concerns they had. The freedom-

to-speak-up guardian held a weekly drop-in session for staff to raise any concerns.

Staff were kept up to date through:

- email
- newsletters
- safety briefs, and
- ward staff meetings every 6 weeks.

For staff not on shift at the time, a link was sent so they could join the meeting remotely if they wish. This time was then added to their timesheet.

The leadership team worked well together and was open to ideas for improvement. The team engaged well in the inspection process and shared all information we asked for. Staff told us they felt empowered to speak up and felt safe to do so.

- 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 experience was regularly assessed and used to continually improve how the service was delivered. Appropriate policies and procedures supported staff to deliver safe, compassionate and person-centred care. Comprehensive risk management and quality assurance processes were in place for patient and staff safety. Improvement projects involved all departments. Yearly staff surveys helped the service plan and develop staff.

The effectiveness of improvements made as a result of patient feedback should be evaluated. The quality improvement plan should be maintained, updated and completed timeously.

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

At the time of our inspection, the hospital's patient engagement lead was also a personal assistant to the hospital director. The service was recruiting a new patient engagement lead to who would deal only with complaints and feedback, with the aim of further developing the role. Patient feedback was asked for in emails and a patient survey sent after discharge in line with the service's participation policy. The latest results of the survey we saw showed 98% of patients rated their experience as good or very good and the survey could be completed electronically or in paper format. The survey also asked patients whether they would like to take part in a patient forum, which discussed different themes and was held three times a year. A member of the senior management team led these patient forums. We were told that the service planned to review patient discharges as part of a quality improvement project after feedback it had received. The patient forum would discuss this as its next topic.

All patient engagement leads in the provider's organisation met monthly to share experiences and share their learning.

‘You said, we did’ boards were displayed through the hospital, with examples of improvements made after feedback. These included:

- improved wi-fi, and
- staff training in British Sign Language.

The hospital’s outpatient department, pre-assessment clinic and wards provided electronic patient leaflets available in different formats and languages, using a QR code.

A staff survey asked a comprehensive set of questions and was carried out every year. Results from the most recent survey showed a high level of satisfaction, which had improved from previous surveys and had been acknowledged across the provider’s organisation. Results were shared with staff through a presentation that included examples of feedback from staff and actions taken as a result. Minutes of monthly staff meetings and daily team briefs demonstrated that staff could express their views freely. Staff we spoke with also confirmed this.

Staff received regular newsletters, regular emails and could attend meetings and forums. This allowed staff to keep up to date with changes in the service. Staff told us they received information and training on new initiatives and when legislation changed, such as data protection. This made sure staff felt part of the service and could discuss improvement suggestions.

We saw that staff could be nominated for an ‘inspiring people’ initiative. Nominated staff were rewarded with vouchers that could be used in retail outlets.

A ‘long service award’ was also given to staff that had worked in the service for 5 years or more. Recipients were given a certificate of recognition and a voucher to spend. Further awards were given with every extra 5 years of service. A benefits programme was in place for staff, which included:

- access to savings schemes
- private healthcare, and
- wellbeing support.

The provider’s human resources department had recently introduced a new initiative at its Scottish hospitals called a ‘people clinic’. We saw that a first session of this had been implemented at Shawfair Park Hospital. Staff could use this clinic to chat with one of the HR advisors about any issues or seek advice.

What needs to improve

We saw evidence to demonstrate that the service listened to feedback and acted on any issues raised as a result, as summarised in the 'you said, we did' boards. However, this information did not include an evaluation of how effective the improvements had been (recommendation a).

Paper information leaflets were only available through patient request. The hospital management team told us that it was updating the patient information leaflet board to make this process clearer to patients. We will follow this up at future inspections.

- No requirements.

Recommendation a

- The service should monitor and evaluate improvements made as a result of patient feedback, to determine whether actions taken have led to the improvement anticipated.

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.

Appropriate policies and procedures set out the way the service was delivered and supported staff to deliver safe, compassionate, person-centred care. A process was in place for writing all policies, submitting them to appropriate corporate groups and approving them through the clinical governance group and medical advisory committee. Policies and procedures were updated regularly or in response to changes in legislation, national and international guidance and best practice. To support effective version control and accessibility, policies were available electronically on the service's staff intranet.

The service's infection prevention and control policies and procedures were in line with Health Protection Scotland's *National Infection Prevention and Control Manual*. We saw that cleaning schedules were in place for all areas and departments.

The hospital had a detailed medicines management policy in place. We saw that the imaging department had standard operating procedures (SOPs) and patient group directives (PGDs) in place for safety and compliance, including the use of controlled drugs. The service's PGDs were developed from national NHS Scotland templates. The lead pharmacist had also developed PGDs for local competencies in line with national guidelines.

The service was aware of the notification process to Healthcare Improvement Scotland. During our inspection, we saw that the service had submitted all incidents that should have been notified to Healthcare Improvement Scotland.

All staff completed a 3-month probation period when they started working in the service, which included a 'check in' with their line manager at 4, 8 and 12 weeks. Staff completed an induction programme tailored to their department, in addition to a 1-day face-to-face welcome event. Members of the senior management team and other managerial staff working in the hospital attended this meeting to introduce themselves and their roles. All new starters were invited to a 'new starter lunch' with the senior management team to help mak sure their induction period was meeting their needs.

Staff completed mandatory and role-specific online learning modules. Mandatory training included safeguarding of people and duty of candour. Team leaders, heads of departments and the senior management team used an online platform to monitor compliance with mandatory training completion. Staff told us they received enough training to carry out their role. We saw evidence in staff files and training reports of completed mandatory training, including for medical staff with practicing privileges (staff not employed directly by the provider but given permission to work in the service).

Staff completed an annual appraisal where aims, objectives and goals were identified and discussed. A process was in place for reviewing the identified aims and objectives in a 6-month period to ensure progress was being made. There was an opportunity at this stage to feedback any issues or to re-negotiate and amend the original details. The appraisals we saw had been completed comprehensively and staff we spoke with told us their appraisals helped them feel valued and encouraged their career goals.

The infection control and prevention nurse also delivered on-site training to staff. Staff told us time for training was usually protected. The lead pharmacist delivered training to hospital staff and had made videos, which staff could view at any time. These videos were part of the induction programme for new staff working in the pharmacy department, along with local competency forms specific to the provider's Scottish services in Edinburgh.

A clear process was in place for managing complaints. Information about how to make a complaint was visible in the hospital and on the website. We were told that when someone made a complaint, they:

- received an acknowledgement letter with a full description of the complaint
- then received a follow-up letter when the complaint had been fully investigated, with the outcome of the investigation, and
- were offered a face-to-face with a member of the senior management team.

We saw these letters were comprehensive and answered the complaints in full, with the actions taken. An electronic system was used to monitor the progress of complaints. We were told that a weekly meeting with the hospital director discussed the progress and any emerging themes. We saw that complaints were discussed at the heads of departments and governance meetings. We saw evidence of changes made in the hospital after complaints had been made.

A duty of candour procedure was in place (where healthcare organisations have a professional responsibility to be honest with patients when things go wrong). Staff we spoke with fully understood their duty of candour responsibilities and had received training in it. The service had published a yearly duty of candour report. We saw evidence that the service had followed its own procedure when dealing with these incidents and shared learning with staff and consultants.

The provider and service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights). We saw that patient care records were stored securely.

Staff told us that patients were given written aftercare instructions and information about any recommended follow-up when discharged. We saw evidence of this recorded in the patient care record. The service's contact details were provided on discharge in case patients had any concerns or queries. Patients we spoke with told us they were clear about what to expect after discharge.

The medicines and blood product fridges were checked regularly, including its contents and daily temperatures. Staff we spoke with knew the process for reporting faults. We saw emergency equipment trolleys were checked daily and kept in accessible locations. Staff we spoke with were familiar with the location of the emergency equipment. We saw that specific staff were identified at the start of a shift during the daily huddle to respond to medical emergencies, such as a deteriorating patient with major haemorrhage and in the event of a fire. We saw that the service had a deteriorating patient protocol, which included a:

- malignant hypothermia procedure
- national early warning score chart (NEWS 2)
- major haemorrhage protocol, and
- ‘sepsis 6’ protocol.

The service’s recruitment policies described how staff would be appointed. We reviewed five files of employed staff and five files of individuals granted practicing privileges. All 10 files were well organised, we saw evidence of clear job descriptions and that appropriate recruitment checks had been carried out, including:

- professional register checks and qualifications where appropriate
- Protecting Vulnerable Groups (PVG) status of the applicant (this was repeated every 3 years), and
- references.

Appropriate pre-employment checks were carried out for employed staff. All staff had completed an induction, which included an introduction to key members of staff in the service and mandatory training. All new staff we spoke with had completed an induction programme. We were told that new staff were allocated a mentor and the length of the mentorship depended on the skills, knowledge and experience of the new member of staff.

What needs to improve

We saw evidence that the service was investigating how to introduce clinical supervision for trained staff, with a training and education package in place along with a formal policy. We will follow this up at future inspections.

- No requirements
- No recommendations

Planning for quality

Accidents and incidents were recorded and managed through an electronic incident management system. Each one was reviewed and reported through the clinical governance framework. Learning was fed back to staff through:

- e-mails
- one-to-one meetings
- staff huddles, and
- team meetings.

The service's risk management process included corporate and clinic risk registers, auditing and reporting systems. These detailed actions taken to mitigate or reduce risk. The service carried out a variety of risk assessments to help identify and manage risk. These included risk assessments for:

- building security
- financial sustainability
- outbreak of infection due to failure of infection control systems and processes, and
- recruitment and retention.

Two designated members of staff reviewed the risk register, which included clinical and non-clinical risks. Review dates 'flagged' up to managers and the provider's central team also reviewed the risks. We saw a programme of maintenance in place for all equipment and areas in the hospital, which the engineering site manager managed. This included maintenance of medical and compressed gases, fire and electricity and legionella risk assessments.

The service had a detailed audit programme in place, which helped make sure it delivered consistent safe care and treatment for patients and identified any areas for improvement. All staff we spoke with participated in audits and were aware of when these were completed. Action plans were produced to make sure any actions needed were taken forward. The infection prevention and control nurse for the service carried out extensive audits in all departments and supported areas with any actions arising as a result.

The audit programme included audits of:

- clinical outcomes
- controlled drugs
- health and safety
- infection prevention and control
- lasers
- medication, and
- patient care records.

The service also received 'flash alerts' from the provider's other services. The flash alerts detailed information and advice from incidents or identified risks, as well as steps to take to reduce or remove risk.

A business continuity plan described what steps would be taken to protect patient care if an unexpected event happened, such as power failure or a major incident. An arrangement was in place with another service in the provider's wider organisation in case evacuation of patients became necessary.

Each department had identified an area for improvement. This was demonstrated through individual improvement projects, such as:

- improving physio patients' length of stay
- improving the kitchen menu
- introduction of star rating for cleanliness, and
- use of tablets at the reception area for patients to complete their admission details.

What needs to improve

While we saw quality improvement projects in place in the hospital, we were told and saw that the electronic system was not kept up to date with progress of projects. This had been raised as an issue in a recent audit the provider had carried out. The service was aware of the issue. However, we saw no action plan in place (recommendation b).

The service produced a list of the top five identified hospital risks. The top risk in this list was a lack of space in the pharmacy department, which meant the clinical wash hand basin was difficult for staff to access. This had been discussed at local risk management meetings and escalated to the provider. The service's senior management team had submitted plans to address the immediate risks, review the building and add space to the department. We will follow this up at future inspections.

- No requirements.

Recommendation b

- The service should ensure that the quality improvement plan is maintained, updated and completed timeously.

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 care environment and patient equipment was clean, equipment was fit for purpose and regularly maintained. Medicines management was good. Staff described the provider as a good employer and the hospital as a good place to work. Patients were very satisfied with their care and treatment.

Staff must comply with the service's infection prevention and control policy. Healthcare staff working under a practicing and privileges contract should have at least two references on file.

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.

The ward environment was in good condition, tidy and appeared very clean and fresh smelling. A green sticker was dated and applied to all equipment after it had been cleaned so that staff knew it was ready for use.

Clinical waste was managed effectively and clean linen was stored correctly.

We saw appropriate cleaning solutions were available and used, including chlorine-based products for sanitary fixtures and fittings. All cleaning materials and equipment were stored in appropriate areas in the hospital, with limited access for staff only. This included a locked cupboard for materials under Control of Substances Hazardous to Health (COSHH).

Housekeepers in the ward area used a list showing when and where patients were being admitted or discharged to prioritise the areas to clean. Housekeeping staff checked all water supplies on alternate days, running water from each source for approximately 5–10 minutes. This was documented on the cleaning schedules.

Housekeeping staff also routinely checked bed mattresses and reported any issues to the ward manager. If issues were found, the mattress, mattress cover or both would be replaced.

All areas and departments in the hospital were given a 'star' rating from one to five for cleanliness. The star rating was based on a monthly audit that the department manager and housekeeping supervisor carried out using adapted checklists. Action plans were produced with review and completion dates for any issues or matters arising, with identified persons to address.

Patients that we spoke with told us that they felt safe and that the cleaning measures in place to reduce the risk of infection in the service were reassuring. All patients stated the clinic was clean and tidy. Comments included:

- 'The place is spotless.'
- 'The décor and cleanliness is second to none.'
- 'Couldn't be better.'

We reviewed eight paper-based patient care records - three from the outpatient department and five from the inpatient ward area. Consultations included details of the treatment risks and benefits discussed with patients. We saw evidence that treatment options had been discussed. All patient care records we reviewed included:

- assessment and consultation
- documentation of the discussion about the treatment plan, including the risks and benefits of each treatment offered
- patient consent to treatment and to share information with their GP or other relevant healthcare professional where appropriate
- risk assessments, and
- referral pathways to access other healthcare professionals, for example physiotherapy.

Patients were also given the option of sharing information with their identified next of kin or emergency contact. We also saw evidence that treatment plans, options and aftercare had been discussed with patients before their discharge from the service.

We saw evidence of policies and procedures for emergency situations and for transferring patients to an acute NHS facility if required. Processes and

procedures were also in place to identify patients with deteriorating conditions using the national early warning scoring system.

We saw evidence of good standards of medicines management. This included completed records of stock checks and medicines reconciliation (the process of identifying an accurate list of the patient's current medicines and comparing it with what they are actually using).

The hospital's Home Office certificate for stocking, prescribing and dispensing controlled drugs was valid and in-date.

We saw that the pharmacy department issued private prescription pads, including the prescribing of controlled drugs. The medical staff used these prescription pads in the outpatient department. Prescription pad information was documented, with the dates and times of use and returned to the department when the department closed for each day. The lead pharmacist checked this information daily.

Take-home medication for patients was ordered in advance of their discharge from the main pharmacy department at Spire Murrayfield Hospital.

The service had a certified laser protection advisor, with a signed contract detailing dates of their contract with the hospital for the ophthalmology outpatient department and operating theatre departments. All staff operating lasers had updated their core of knowledge training and equipment training. This was kept on file in the prospective departments and available to view on the day of the inspection. The laser protection supervisors worked closely and alongside the laser protection advisor to develop the local rules for all laser equipment being used. Local rules to be followed for the safe use of lasers were in place with a review date every 2 years. This was included as part of the audit schedule. The laser protection policy had recently been reviewed with the next review date scheduled for 2027 or before, pending any legislative changes. The appropriate senior management teams had agreed and ratified this policy.

To help assess the safety culture in the clinic, we followed a patient's journey from the ward through theatre, recovery room and then to the ward. Before the patient arrived in theatre, we observed a pre-safety brief which made sure all staff in theatre were aware of the patient's details, journey and the procedure planned. We saw that staff followed World Health Organization guidelines, such as taking a 'surgical pause' before starting surgery to check they had the correct patient and equipment. We also observed staff following safe procedures for managing swabs and instruments in line with guidelines, including those for tracking and tracing instruments used.

A suitable member of staff accompanied patients to and from the theatre department. Staff took time to talk and listen to the patient at each point in the journey, with various staff introducing themselves and explaining what was happening. The patient was closely monitored while anaesthetised during the operation and then in the recovery room. Patients' privacy and dignity was maintained at all times. We saw effective multidisciplinary working with informative staff handovers and communication at all stages in the patient journey.

Staff told us they felt the approachable leadership team valued and supported them well. Minutes of daily team briefs and monthly staff meetings showed that staff could express their views freely. From our own observations of staff interactions, we saw a compassionate and co-ordinated approach to patient care and hospital delivery, with effective oversight from a supportive leadership team.

As part of our inspection, we asked the hospital to circulate an anonymous staff survey which asked five 'yes or no' questions. The results for these questions showed the following:

- The majority of staff felt there was positive leadership at the highest level of the organisation.
- The majority of staff felt they could influence how things were done in the hospital.
- The majority of staff felt their line manager took their concerns seriously.
- The majority of staff would recommend the hospital as a good place to work.

The final question of the survey asked for an overall view about what staff felt the hospital did really well and what could be improved. Comments were mostly positive and included:

- 'The patient care is given to the highest standards and the patients seem happy with the care that they receive.'
- 'I think we provide great safe care to patients and deliver a caring service - the staff are what make Shawfair great though- both for patients' experience and staff experience - it feels like everyone knows each other, looks out for each other and your always addressed by name.'
- 'Listens to patients and looks after colleague wellbeing.'

Patients we spoke with were extremely satisfied with the care and treatment they received from the hospital. Comments included:

- ‘Everything ran smoothly from beginning to end, even before coming in for the operation.’
- ‘Lovely place, staff very helpful and knowledgeable.’
- ‘If had to go into hospital again wouldn’t think twice about coming here.’

What needs to improve

We saw observed some instances where staff were not following the *National Infection Prevention and Control Manual* these included:

- contaminated linen not being double-bagged, and
- housekeepers not wearing aprons when cleaning sanitary fittings (requirement 1).

For those healthcare professionals appointed under practicing privileges, on review of current documentation we found that only one reference was obtained from their responsible officer. We have since seen evidence that two references would be obtained before granting practicing privileges. We will follow this up at future inspections.

Requirement 1 – Timescale: immediate

- The provider must ensure compliance with all standard infection prevention and control precautions as detailed in Health Protection Scotland’s *National Infection Prevention and Control Manual*, in particular:

  (a) linen management, and
  (b) use of personal protective equipment.

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

Healthcare Improvement Scotland

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