Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: The Priory Hospital Glasgow

Service Provider: Priory Healthcare Limited

19-20 November 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 16-17 November 2022

Requirement

The provider must notify Healthcare Improvement Scotland of certain matters as noted in the notification guidance and within the specified timeframes.

Action taken

All notifiable incidents were now being reported to Healthcare Improvement Scotland within the required timeframes. **This requirement is met.**

Requirement

The provider must ensure that:

a) clinical hand wash basins installed in the recent refurbishment are replaced with sanitary fittings compliant with current guidance

b) all other non-compliant clinical hand wash basins are added to the risk register, and

c) a risk assessment is produced for the continued use of any non-compliant clinical hand wash basins.

Action taken

Most clinical hand wash basins had been replaced and now met current guidelines for sanitary fittings in healthcare premises. The remaining non-compliant clinical hand wash basins were listed on the service's risk register and had a risk assessment for their use in place. **This requirement is met.**

Requirement

The provider must ensure that appropriate cleaning products and processes are being used to decontaminate the environment in line with national guidance.

Action taken

The cleaning products now being used were in line with national infection prevention and control guidance. **This requirement is met.**

Requirement

The provider must ensure that controlled drugs ordering books and prescription-only medicines are stored securely and a record of key holders is kept.

Action taken

Controlled drugs are medications that require to be controlled more strictly, such as some types of painkillers. All medications and controlled drugs ordering books were now securely stored and a record of key holders was kept. **This requirement is met.**

What the service had done to meet the recommendations we made at our last inspection on 16-17 November 2022

Recommendation

The service should update the complaints policy and any information in relation to complaints to include the correct contact details for Healthcare Improvement Scotland.

Action taken

The service's complaints policy and all information about how to make a complaint now included the correct contact details for Healthcare Improvement Scotland.

Recommendation

The service should review and update the patient information pack to be more tailored to the patient group.

Action taken

Patient information had been updated and was now specific to the ward and patient group.

Recommendation

The service should improve the facilitation of online meetings between staff, patients and their carers to ensure that meaningful patient-centred discussions can take place.

Action taken

Updated IT technology was now in place to allow more meaningful discussions about patient care to take place with care teams and relatives.

Recommendation

The service should produce and publish an annual duty of candour report.

Action taken

The service's duty of candour report was now available on its website.

Recommendation

The service should ensure that regular ward staff meetings take place. Minutes should be recorded including any actions taken and those responsible for the actions. Minutes should be shared with all staff.

Action taken

Ward staff meetings were now held every month and all staff were sent minutes of these meetings.

Recommendation

The service should follow national guidance for the management of sharps.

Action taken

We found that all sharps were being managed appropriately in line with national infection prevention and control guidance.

Recommendation

The service should ensure that all policies and documentation used in the service are based on and refer to Scottish legislation and to Healthcare Improvement Scotland as the regulatory body.

Action taken

All policies had been reviewed and updated by the provider's Scottish planning group. These were now based on Scottish legislation and referred to Healthcare Improvement Scotland as the regulatory body.

Recommendation

The service should ensure a planned process of evaluating new services and strategies is in place.

Action taken

Evaluation of new services and strategies was recorded in the service's site quality improvement plan, and data was gathered and recorded to develop and improve best practice.

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 The Priory Hospital Glasgow on Tuesday 19 and Wednesday 20 November 2024. We spoke with a number of staff and patients during the inspection. We received feedback from 20 staff members through an online survey we had asked the service to issue for us during the inspection.

Based in Glasgow, The Priory Hospital is a private psychiatric hospital.

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For The Priory Hospital Glasgow, 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 vision and purpose was shared with patients, carers and staff. Key performance indicators measured the service's success in achieving its strategic goals. A governance structure and processes provided oversight and assurance of the care delivered. This included producing regular reports to monitor how the service was performing, and benchmarking against other services in the Priory Group. Staff felt supported in their roles and thought senior management was approachable. A range of development opportunities was available to staff.	✓✓✓ Exceptional
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patient, carer and staff feedback was actively encouraged through various methods and effectively used to improve the service. Patients and carers were involved in the planning of care and clinical team meetings. Carers were supported in the service. A range of policies and procedures helped to support safe delivery of care, including processes to manage and reduce complaints and incidents. A culture of learning from feedback, complaints, audits and incidents was evident. Risk assessments and audits were in place for all clinical and environmental activities. A quality improvement framework and a quality improvement plan helped to support continuous improvement in the service. The service had received external accreditation and awards for innovative patient practice.	✓✓✓ Exceptional
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
Patients were positive about their stay and were actively consulted and involved, such as with suggestions for the redecoration of clinical areas. Safe recruitment processes were followed, and staff described the provider as a good employer. Patient care records were comprehensively completed and demonstrated a person-centred approach with carer and other agencies involved where appropriate.	✓✓✓ Exceptional

Grades may change after this inspection due to other regulatory activity. For example, if we have to take enforcement action to improve the service or if we investigate and agree with a complaint someone makes about the service.

More information about grading can be found on our website at: Guidance for independent healthcare service providers – Healthcare Improvement Scotland

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

What action we expect Priory Healthcare 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 no recommendations.

We would like to thank all staff at The Priory Hospital Glasgow 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 vision and purpose was shared with patients, carers and staff. Key performance indicators measured the service's success in achieving its strategic goals. A governance structure and processes provided oversight and assurance of the care delivered. This included producing regular reports to monitor how the service was performing, and benchmarking against other services in the Priory Group. Staff felt supported in their roles and thought senior management was approachable. A range of development opportunities was available to staff.

Clear vision and purpose

The service provides addiction rehabilitation and treatment to patients for:

- general psychiatry such as depression and anxiety
- addictions such as drug and alcohol, and
- eating disorders such as anorexia nervosa.

The service had a strongly embedded vision and purpose statement about enabling and supporting patients to live as fully and independently as they can, based on their needs.

The service's vision and purpose statement was included in the patient information pack, and was also displayed on ward noticeboards for staff and patients. This information was also shared with new staff as part of the induction process, together with a set of Priory values for staff that included:

- putting people first
- being supportive
- acting with integrity
- striving for excellence, and
- being positive.

An organisational 3-year strategy consisted of clear strategic goals. Success in achieving these goals was measured by tracking a set of related key performance indicators. These included patient safety outcomes such as reducing the risk of harm to patients, medication management and incident management. Staff-related indicators included training compliance, recruitment and retention, and sickness absence rates.

Staff were asked about the service's purpose and strategy in the annual staff engagement survey. The most recent survey results showed that the majority of staff said they believed in the Priory's purpose and said that the strategy had been made clear to them.

Data about each key performance indicator was entered onto an electronic centralised reporting system. The system produced an overview of the service's position in achieving each key performance indicator for each identified goal. A data and analysis team managed and monitored the data and produced daily, weekly and monthly reports that all staff could access. These reports were reviewed at the local and regional clinical governance meetings. This data was used to benchmark the hospital against other services in the Priory Group. The comparisons were broken down into region and also the type of treatment programme, for example eating disorders. We saw evidence that actions to improve performance had been implemented, measured and the outcomes achieved.

The hospital senior management team, supported by the provider's centralised team, demonstrated a clear focus to deliver safe, quality and evidence-based patient care.

- No requirements.
- No recommendations.

Leadership and culture

The Priory Hospital Glasgow provides a highly specialised service and the staff skill mix was representative of the complex needs of patients. A wide variety of staff were employed to provide care and support to patients, including:

- housekeeping and maintenance staff
- healthcare assistants
- nurses
- therapy staff
- dieticians
- psychologists and psychiatry staff, and
- doctors and consultants.

The hospital director, director of clinical services and therapy manager provided senior hospital management support. Staff we spoke with told us that the senior management team was very supportive and accessible. Most staff members felt supported in their role and commented through our staff survey:

- ‘Always open and approachable.’
- ‘Feel very supported with open door policy. Reasonable requests always accommodated. Supportive in work with work related [issues] and if required on a personal level.’
- ‘Excellent patient care and support to family and friends of the patients we are treating.’
- ‘Leadership team have been more than supportive and still are. Throughout my time working here they have had an open door policy that works well within the hospital.’

We were told that several senior managers, including the regional manager, the managing director and the chief executive officer, all visited the service regularly, and were very visible in the service during their visits.

A quality and governance framework included a clear organisational structure, as well as a schedule of meetings and reporting pathways, and details of quality performance monitoring systems used in the service, including how the risk register was reviewed and managed.

The service’s clinical governance meeting was held directly after the regional clinical governance meeting so that information could be cascaded down to staff in the service. All directors of the Priory Group, including the service’s directors, met every week.

Staff meetings took place regularly, and these were documented to ensure a note of outcomes and any actions to be taken was recorded. Minutes were held on an internal intranet system, which was accessible to all staff. Staff who completed our online survey responded positively about communication and culture in the service.

Staff told us communication was effective. For example, handover procedures allowed for patient progress and day-to-day matters to be shared and passed on for continuity of care. Other clinical meetings included a daily multidisciplinary team meeting and a weekly ward round where all patient care matters, progress and treatment plans were discussed.

A whistleblowing policy detailed how staff could raise any concerns about patient safety. We saw that the service promoted the Freedom to Speak up initiative to promote patient and staff safety, and had developed a freedom to speak up policy. The service's freedom to speak up champions attended national networking events and training. We saw posters with the champions' names displayed in staff areas to inform staff who they could approach for advice and signposting. All staff told us in our survey that their concerns would be taken seriously. Comments included:

- 'I feel that I can raise any issues through different means and it will be taken seriously.'
- 'All concerns are thoroughly investigated.'

A nurse had been designated as the Your Say forum and staff wellbeing lead. This staff representative role aimed to bridge the gap between the senior management team and staff with a focus on improving staff wellbeing. Staff could raise any issues they had with the representative, anonymously if they wished, who then discussed this with the hospital director. Any issues that could not be answered at a local level were discussed at a regional Your Say forum that took place every 2 months. The staff representative also promoted wellbeing and support resources available to staff such as the confidential colleague assistance helpline.

Mental health first aiders had been identified who could be the first point of contact if a member of staff was experiencing a mental health issue or emotional distress. These support staff were trained to provide a confidential listening ear and to signpost colleagues to the most appropriate support.

It was clear that the service was committed to providing opportunities for growth and development to all staff. A learning and development team delivered different types of training to ensure staff were trained to provide care and support to patients. The team also offered apprenticeships and career development opportunities. For example, healthcare assistants could be nominated for sponsored apprenticeships for registered nurse training. These staff members could then continue to work in the service while they learn and could then be offered a nurse role in the service once they graduate. Staff had access to a career pathways website for information on ways to progress within the Priory Group.

Development opportunities were discussed during staff performance and development reviews. The service ensured succession planning by providing opportunities for staff such as staff nurses progressing to a deputy ward manager role. Career opportunities were also available for maintenance and

catering support staff. Many staff who responded to our survey referred to the training and development opportunities as a positive of working in the service.

Leadership development programmes within the Priory Group were available to deputy ward managers, ward managers and heads of departments. These helped to enable them to gain further knowledge and skills to lead their service and departments more efficiently and effectively.

- 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, carer and staff feedback was actively encouraged through various methods and effectively used to improve the service. Patients and carers were involved in the planning of care and clinical team meetings. Carers were supported in the service. A range of policies and procedures helped to support safe delivery of care, including processes to manage and reduce complaints and incidents. A culture of learning from feedback, complaints, audits and incidents was evident. Risk assessments and audits were in place for all clinical and environmental activities. A quality improvement framework and a quality improvement plan helped to support continuous improvement in the service. The service had received external accreditation and awards for innovative patient practice.

Co-design, co-production *(patients, staff and stakeholder engagement)*
Information about the service and treatments provided was available on posters and leaflets in the hospital and was also detailed on the provider's website.

A patient information pack included information on:

- patients' rights about consent to care and treatment
- seeking a second opinion on their diagnosis or treatment options
- access to advocacy services, and
- how to complain.

A folder in the wards included information for patients to get to know more about staff members and their roles.

A variety of methods was used to gather feedback from patients and carers, in line with the service's service user and carer involvement strategy. This included patient forums and patient satisfaction surveys.

We saw minutes from patient forum meetings where patients were encouraged to discuss any concerns, ideas, suggestions or complaints. We were told that any issues that could not be rectified at ward level were escalated through clinical governance meetings to the senior management team to be actioned.

We saw an analysis of the results from an annual patient satisfaction survey in September 2024. All actions to be taken forward had been added to the service's site quality improvement plan. The survey asked patients about their experience of the service, including:

- if they were treated with dignity and respect
- if they felt listened to and involved in their care planning
- quality of the food
- the environment, and
- if they felt safe.

Patients were also given the opportunity to feedback through one-to-one sessions with nursing, psychology and occupational therapy staff. Patients could also leave reviews on online review sites by scanning QR codes displayed on the ward.

A patient representative role was carried out by a former patient, who current patients could speak with and have any issue passed to staff on their behalf. We were told this role was currently vacant due to retirement. However, we were told a new volunteer had been identified and would be starting soon, following mandatory training to help support them with this role.

We saw evidence that feedback from patients had been acted on by the service. For example, patients had stated that the therapy rooms were too clinical. As a result, the rooms had been decorated, lighting changed, and wall motifs and pictures displayed. During the inspection, we saw contractors on site repairing the hot water system following complaints from patients about issues with the hot water supply.

Family members and carers were also encouraged to give feedback using carer feedback forms and an annual carer survey. They were asked for their opinions on areas such as:

- the care their family member was receiving
- the opportunities for the carer to be involved in care planning
- communication from the service, and
- the care environment.

An annual staff engagement survey was sent to all staff in the Priory Group. We saw the latest survey results report from May 2024. This summarised areas to celebrate, investigate and improve, and included a detailed action plan.

All feedback, including surveys, emails, verbal and thank you cards, was logged on an electronic reporting management system which all staff had access to. This included details about the feedback received, the actions taken, and how the actions were fed back to staff and patients. Staff were made aware of feedback during staff meetings, handovers and by thank you cards from patients and families forwarded to relevant teams. If any actions were required, this was discussed at the clinical governance meeting and information then fed back to teams by ward managers. Patient feedback and actions taken by the service was displayed on 'you said, we did' posters in the wards.

- ■ No requirements.
- ■ No recommendations.

Quality improvement

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

The service fully understood Healthcare Improvement Scotland's notification process and the need to inform Healthcare Improvement Scotland of certain events or incidents occurring in the service.

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

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

A process for recording and investigating incidents and accidents was in place. All incidents were documented on the electronic reporting management system. A clear process was in place to fully investigate and review incidents, and we saw examples where incidents had been managed in line with this process. An investigation form included details of:

- general patient information
- incident details

- immediate action taken (such as physical interventions/behaviour management), and
- assigned incident category.

Serious incidents were escalated to the regional and executive teams, and the local and centralised quality and compliance teams. The chief executive officer also received notifications. Reviews of incidents were carried out by the ward manager and individuals involved, and covered actions taken and lessons learned. Entries on the electronic reporting management system also detailed any external agencies that had been informed such as Police Scotland and Healthcare Improvement Scotland, and if it was considered a duty of candour incident.

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.

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, in the patient information booklet, and displayed in the wards and hospital reception area. We saw that patients were given opportunities to raise issues or make complaints, either informally at ward level or more formally. The senior management team was available to meet with patients to discuss their complaint.

We saw evidence that complaints were managed in line with the service's policy. Complaints were collated in a complaints log on the electronic reporting management system and included:

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

Immediate actions in response to a complaint were shared in the daily 'flash meeting'. This short meeting was attended by the multidisciplinary team to share any current or emerging safety issues. Lessons learned from complaints were shared with staff in the monthly divisional cascade communication presentation used to update staff about any changes, learning and initiatives.

The service was also registered with the Independent Sector Complaints Adjudication Service (ISCAS). If patients were not satisfied with the service's response to a complaint, ISCAS can provide an independent adjudication service.

A contract was in place with an external pharmacy to supply a pharmacist to visit the service each week. The pharmacist worked with nursing staff to make sure that a thorough process for the safe management of medicines was in place. This included:

- medicine reconciliation (checking patients' current medication to ensure their medication list is up to date)
- regular checks of medicine expiry dates
- safe storage and disposal 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 ward dispensaries, and in lockable medicine cupboards. The medicines fridge temperature was monitored to maintain the appropriate temperature for temperature-sensitive medicines.

We saw emergency equipment was checked daily and kept in a secure area that staff could access.

Processes were in place to assess the suitability of patients for admission. This included senior members of the multidisciplinary team undertaking a pre-admission assessment with the patient, where appropriate.

On admission, patients were assessed by a doctor and nursing staff. This included reviewing patients' psychological, physical and emotional needs as well as risk factors. A risk management plan was developed which helped to formulate the patient's 'keeping safe' care plan. This was reviewed regularly at the weekly multidisciplinary review or if any concerns or incidents occurred.

Patients were allocated a named nurse and associate nurse to act as a main point of contact. Patients also met with the therapy teams and consultant psychiatrist throughout their stay, as well as a dietitian should this be required.

The catering department tailored meals and nutrition to patients' requirements. The dining room furniture had recently been upgraded to allow patients and staff to eat together while observation could be maintained for patients being treated for eating disorders.

All patients could attend their own multidisciplinary weekly reviews to discuss their needs and progress. We saw that family members were kept informed of patients’ care and treatment, particularly on the eating disorder unit. As well as the weekly multidisciplinary reviews, monthly meetings were also held for patients admitted with an eating disorder. Referring teams were also involved so that they were kept informed of the patient’s progress and discharge planning. Reports were also sent to the various NHS boards patients were registered with. Families were also part of these meetings and involved in planning for discharge.

We saw patients who were admitted under the Mental Health (Care and Treatment) (Scotland) Act 2003 had all the required paperwork in place related to treatment and medication. This also included paperwork for patients who were cross-border transfers from England and Ireland.

Patients who were admitted for alcohol dependency had appropriate screening questionnaires and monitoring tools completed. Confirmation was also sought, with the patient's consent, for obtaining their prescribing history from their GP. We saw evidence of patients having therapy and education during their stay, as well as being involved in their plans for discharge, including accessing community support groups such as Alcoholics Anonymous and outpatient support from the service.

The service provided reports and held monthly meetings with teams from other NHS boards to update them on patients’ progress within the eating disorder service.

Policies for the management of information were in place. Patient care records were in electronic format, and were 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.

Systems were in place for staff to log maintenance issues, including during out of hours. Any jobs that could not be completed inhouse were assigned to external contractors.

Policies were in place for recruitment, induction and staff development. A centralised human resources department provided support to the service, as well as an administrator 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.

Some healthcare professionals were recruited under a practicing privileges arrangement (staff not employed directly by the provider but given permission to work in the service). A practicing privileges policy was in place.

A face-to-face induction programme was carried out by all staff members relevant to their role. This included:

- safeguarding (public protection)
- physical techniques for staff to use if patients become a danger to themselves or others
- duty of candour, and
- fire safety.

Additional training was also available for staff on topics such as:

- nasogastric tube feeding
- caring for patients with an eating disorder, and
- supportive observation and engagement.

Various training and education courses could be accessed by staff through the service's internal intranet system. We saw evidence that all mandatory training had good rates of completion.

We saw evidence that key clinical staff members were part of the service's professional networking group. This group had links to and attended meetings with other organisations and NHS partners in order to lead and share best practice outside of the service.

In addition to the service's induction programme, newly qualified nursing staff also had access to a 12-month 'preceptorship' course. This helped them with making the transition from student to staff nurse with an identified individual nominated to help build their confidence and professional development.

Staff appraisals were completed every year and those we reviewed were comprehensively completed. We also saw evidence of supervision for all clinical staff being carried out. This involves staff reflecting on their practice and identifying any learning needs.

- No requirements.
- No recommendations.

Planning for quality

A comprehensive risk register was in place as 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:

- fire safety
- infection prevention and control
- health and safety
- water systems, and
- medical gases such as oxygen.

We saw that risks were defined as being either safety, reputational, local or corporate, or financial risks. Risks remained on the risk register until the required actions had been implemented and embedded.

A detailed contingency plan was in place for major incidents that would affect the running of the service and, therefore, impact on patient care. Arrangements were documented for staff to follow in case of events such as a fire, or loss of the water, electrical or gas supplies.

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

- infection prevention and control
- ligature points
- care planning and risk assessment
- medical assisted withdrawals
- physical health, and
- observation and engagement.

Audits were recorded on the electronic reporting management system. They could then be accessed by the service's quality and compliance team who ensured that audits were completed appropriately, on time and that required actions had been taken. Audit results and actions were discussed at clinical governance meetings.

Quality improvement is a structured approach to evaluating performance, identifying areas for improvement and taking corrective actions. A quality improvement framework detailed the service's approach to support the implementation of quality improvement. This included details about the quality improvement model used, what quality improvement training would be provided and how to carry out a quality improvement project.

The service's site quality improvement plan helped to define and track improvements, and included prioritisation, goals, allocation of responsibility and timeframes. We saw that information from audits, incident reviews, clinical governance, feedback and complaints all fed into this plan.

For example, we saw that improving security had been included on the service's site quality improvement plan to reduce patient absconsions. At the time of the inspection, a secure entry system was being installed at the front entrance. We were told that staff had recently visited a secure hospital to learn more about security measures, as a way of sharing learning with other Priory sites.

We saw examples of staff involved in quality improvement projects such as reducing the need for restraint during nasogastric tube feeding and improving gaps in communication. The centralised quality improvement team was providing training to the staff involved to enable them to use proven quality improvement methodology.

We noted the service had received external accreditation from the Royal College of Psychiatrists for eating disorders which demonstrates good practice. We noted the eating disorder service had also recently won an award for innovative practice.

- 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 were positive about their stay and were actively consulted and involved, such as with suggestions for the redecoration of clinical areas. Safe recruitment processes were followed, and staff described the provider as a good employer. Patient care records were comprehensively completed and demonstrated a person-centred approach with carer and other agencies involved where appropriate.

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 an excellent standard of clinical care, including awareness of patient risk and how to manage this. Staff we spoke with showed care and compassion, as well as a high level of specialist knowledge. Staff told us they enjoyed working in the service.

We found the environment to be clean and tidy. When a bedroom was cleaned following a patient's discharge, the housekeeper left a sign in the room indicating the room was ready for use. The nurse in charge then checked the room and signed the cleaning schedule. We saw the service used appropriate cleaning products and solutions, including chlorine-based products for sanitary fixtures and fittings. Cleaning schedules were in place. The service had a good supply of personal protective equipment such as aprons and gloves.

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.

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

- references
- PVG status, and
- professional registration checks and qualifications, where appropriate.

The staff files also included information on each staff member's induction and appraisals. The service had a process in place for ensuring ongoing reviews of professional registrations took place. We also saw evidence that regular PVG checks were carried out, as required, to make sure staff remained safe to continue working in the service. In the two practicing privileges staff files we reviewed, we found signed agreements were in place and all relevant checks, including medical malpractice insurance cover, had been carried out.

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

- 'I enjoy my role here and feel comfortable approaching all staff and managers. I enjoy learning new things and keeping practice up to date and relevant and feel they give good opportunity for this.'
- 'I think the service does strive to support staff additionally through its 'Your Say Forum' and has started to highlight nationally positive stories and our hospital achievements.'
- 'Ward manager… is exceptional. Very approachable, supportive and recognises staff achievements.'

Patients we spoke with were positive and complimentary about their stay. They told us they were able to personalise their rooms with posters and artwork and had been involved in the redecoration of the nasal gastric feeding room to make this a more therapeutic and calmer environment.

- ■ No requirements.
- ■ No recommendations.

Appendix 1 – About our inspections

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

Our inspectors use this system to check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. Inspections may be announced or unannounced.

We follow a number of stages to inspect independent healthcare services.

Before inspections

Independent healthcare services submit an annual return and self-evaluation to us.

We review this information and produce a service risk assessment to determine the risk level of the service. This helps us to decide the focus and frequency of inspection.

Before

During inspections

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.

During

After inspections

We publish reports for services and people experiencing care, carers and families based on what we find during inspections. Independent healthcare services use our reports to make improvements and find out what other services are doing well. Our reports are available on our website at: **www.healthcareimprovementscotland.org**

We require independent healthcare services to develop and then update an improvement action plan to address the requirements and recommendations we make.

We check progress against the improvement action plan.

After

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

Complaints

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

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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