Healthcare Improvement Scotland

Action Plan

Service Name:	St. Ellen's Private Hospital
Service number:	01976
Service Provider:	Cosmedicare UK Limited
Address:	2 Garbett Road, Livingston, EH54 7DL
Date Inspection Concluded:	27 November 2024

Requirements and Recommendations	Action Planned	Timescale	Responsible Person
Requirement 1: The provider must accurately document when a water flushing regime in undertaken for less frequently used outlets to minimise the risk from legionella (see page 31). Timescale – immediate	The water flushing regime process was already in place and was circa 7-8 weeks underway at the time of inspection. The flushing regime was not being consistently applied at the time of inspection and days / areas were being periodically missed. This has already been addressed since immediately following inspection and the management team is more frequently reviewing records to ensure all flushing is being carried out and identifying quickly if there has been a non-compliance within the process (management checks have increased from monthly to weekly).	Immediate	Amy Panther (Clinical Manager) and Gill Hutton (Compliance Manager)

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Requirement 2: The provider must ensure that external clinical waste bins are kept locked at all times (see page 31). Timescale – immediate	Three clinical waste bins in the external, caged compound had compromised locks. Following inspection (during the second day of inspection) the clinical waste supplier committed to repairing the locks the next day or replacing any bins with locks that could not be repaired. All bins have been kept locked since then and are being monitored. It has been flagged to the clinical team and housekeeper that any future issues with the bin locks are to be reported immediately via the incident management system and logged onto the unplanned maintenance schedule for immediate resolution. Any bins with compromised locks will not be used until it is confirmed the lock has been repaired and the incident closed off on the incident management system by the relevant Team Lead or Manager.	Immediate	Amy Panther (Clinical Manager) and Gill Hutton (Compliance Manager) and Jade Notman (Nursing Team Lead)

Requirements and Recommendations	Action Planned	Timescale	Responsible Person
Recommendation a: The service should develop its strategic plan to identify aims, objectives and key performance indicators that will help it achieve its aims and objectives, and a process for monitoring and measuring these. The plan should be shared with staff and	The Senior Management Team, Clinical, Compliance and HR Managers have drafted aims and objectives and are currently devising measures for KPIs. To be completed by end of quarter 1 (end March). These are to be shared with the wider workforce and organisational KPIs will be clearly cascaded down into individual KPIs, ensuring the whole team understands their contribution to the overall business goals (and successes). To be completed by end of quarter 2 (end June). Once rolled out to the workforce we will work with our web developer and media consultants to incorporate a new page onto the website which includes Vision, Mission Statement, Company Values and Business Strategy Summary, tying all together and presenting a cohesive set of	Q1 Q2 Q3	Gill Baird (MD) and Gabriella Williamson (Hospital Manager) with assistance as required from Clinical, Compliance and HR Managers.

summarised on the service's website for patients and stakeholders so there is a shared sense of direction (see page 16).	information to our patient (and potential patient) co-hort and other stakeholders. To be completed by end of quarter 3 (end September).		
Recommendation b: The service should implement a Freedom to Speak Up Guardian to make it easy for staff to raise any concerns or queries (see page 18).	Introduction of Listening Sessions with "Your Voice" ambassadors (nominated with the workforce in mind as they require to be the most trusted, discreet team members) who will facilitate and gather feedback from the sessions to present to the Senior Management Team. Following presentation of the feedback, the SMT, along with Team Leads and Managers will prepare a 12-month action plan that will be presented to the workforce. The SMT will remain accountable to the workforce for delivery of the action plan and progress will be assessed, either through additional Listening Sessions throughout the course of the 12-month plan period or via further mini-surveys across the year, gathering in workforce assessment of delivery of the plan to date and ongoing feedback on any additional matters that are raised. The "Your Voice" ambassadors would act as the service's Freedom to Speak Up Guardian, as this should fit well alongside the formal role of "Your Voice Ambassador" for the group Listening Sessions.	End of Q1 (end March) to have appointed Ambassadors and held the first Listening Session and end of Q2 to have completed initial Listening Sessions and presented the action plan to the workforce.	Senior Management Team (to kick-off project) – nominated Your Voice Ambassadors

Recommendation c: The service should monitor and evaluate improvements made because of staff feedback, to determine whether actions taken have led to the improvement anticipated (see page 21).	Through the introduction of Listening Sessions we will seek to encourage and include discussion around service improvements which will be included in the documented (anonymised) feedback delivered to the Senior Management Team (SMT) via our "Your Voice" ambassadors. Assessment of effectiveness of actions taken and improvements made (presented within the subsequent action plan) will be measured (and documented) at follow-up Listening Sessions scheduled across the year (intended purpose being to gather feedback on progress of the SMT's delivery of their action plan). The You Said We Did process will be further developed in tandem with the Quality Improvement Plan to ensure that QI evaluations (compiled via staff feedback, internal audit, financial assessment etc) are shared within the You Said We Did project data and will be cascaded more broadly across the workforce through the YSWD posters which are to be updated quarterly. Staff Feedback (evaluation) has been incorporated into the fixed agenda of the SMT and Clinical Governance meetings (occurring quarterly across the year).	Immediate (adjustment of fixed staff meeting agendas) End of Q1 (to commence assessing feedback from Listening Sessions and cross-referencing QI evaluations with You Said We Did programme)	Gabriella Williamson (Hospital Manager), Gill Hutton (Compliance Manager) and Shona Payne (HR Manager) plus the Your Voice Ambassadors (yet to be appointed)
Recommendation d: The service should display, monitor and evaluate improvements made as a result of patient feedback, to determine whether actions taken have led to the improvement anticipated (see page 21.	The You Said We Did process will be further developed in tandem with the Quality Improvement Plan to ensure that QI evaluations (compiled via patient feedback, internal audit, financial assessment etc) are shared within the You Said We Did project data and will be broadcast/published using social media platforms (socials groups), onsite digital (looped) presentations playing within Reception and other gathering areas) and printed media such as onsite posters. Seeking to include patient-focused YSWD information alongside new web page which details the organisational goals, values, strategy etc. Patient Feedback (evaluation) has been incorporated into the fixed agenda of the SMT and Clinical Governance meetings (occurring quarterly across the year). We are piloting use of individualised Get Well Cards presented to our patients (from their dedicated care team) within their patient discharge packages to	Immediate (adjustment of fixed staff meeting agendas) End of Q1 (to commence cross-referencing QI evaluations with You Said	Gabriella Williamson (Hospital Manager), Gill Hutton (Compliance Manager) and Amy Panther (Clinical Manager)

	promote completion of the PROMS survey questionnaire as well as more general feedback on the whole service.	We Did programme) End of Q1 – roll out Get Well Card programme following completion of pilot	
Recommendation e: The service should follow its own systems and processes and implement clinical supervision of trained staff including formal recording of it (see page 25).	During the investigation we discussed with the auditors that there was no structured, formal clinical supervision process in place but that, following any clinical incident, clinical supervision could be carried out as/when necessary. A clinical supervision policy is currently being drafted to include the standard operating procedure and documentation required to commence rolling out the process. The intention at present is to base the supervision process around quarterly reviews with the caveat that supervision can be implemented sooner where a requirement for support is identified (through staff feedback, patient feedback, internal audit, incident reviews, etc).	End of Q2 (to have process ready for roll out)	Amy Panther (Clinical Manager) and Gill Hutton (Compliance Manager)

Recommendation f: The service should ensure that COSHH assessments are easily accessible to all staff (see page 26).	The hard-copy COSHH manual, containing the site's COSHH Risk Register, all risk assessments and material safety data sheets for substances used onsite, has been placed within the dedicated COSHH cabinet which is located centrally within the hospital and all team members made aware of its location. This is in addition to the digital files that are located in the company Health and Safety Sharepoint site, which is fully accessible to all staff members.	Immediate (completed)	Gill Hutton (Compliance Manager) and Amy Panther (Clinical Manager)
Recommendation g: The service should monitor fridge temperatures daily to comply with national guidance for temperature-sensitive medicines (see page 31).	The fridge temperature recording regime process was already in place and was circa 7-8 weeks underway at the time of inspection. The temperature checks were not being consistently recorded at the time of inspection. This has already been addressed since immediately following inspection and the management team is more frequently reviewing records to ensure all daily temperature checks are being carried out and identifying quickly if there has been a non-compliance within the process (management checks have increased from monthly to weekly).	Immediate	Amy Panther (Clinical Manager) and Gill Hutton (Compliance Manager)

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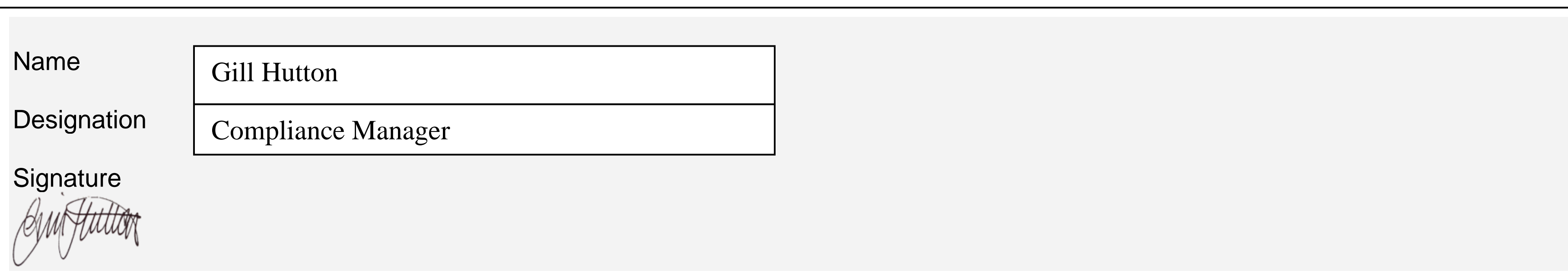
Recommendation h: The service should establish an effective stock checking process where medications are stored medicines (see page 31).	The service performed medication stock checks however there was no formal documentation in place at commencement of inspection. The service does now have a documented medication stock checking process in place and is being consistently applied. This was addressed prior to conclusion of the inspection with the task assigned to specific, competent individuals and oversight of the checking process being provided by the Pharmacist and Clinical Manager.	Immediate	Amy Panther (Clinical Manager) and Jade Notman (Nursing Team Lead)
Recommendation i: The service should ensure that care plans are in place for all patients who require them and that they include input from the patient (see page 31).	Patient record audits identified a gap between digital and paper records leading to overnight patients having less structured documentation of the patient pathway, due to non-permanent employees having restricted access to digital records. Paper-format documents have been devised to enable all staff members (regardless of employment status) to have full access to all patient pathway documents and forms leading to more comprehensive completion of care plans for all patients. Will continue to monitor as part of patient record internal audit regime.	Immediate (completed)	Amy Panther (Clinical Manager) and Gill Hutton (Compliance Manager)



Name: Gill Hutton

Designation: Compliance Manager

Signature

Healthcare Improvement Scotland

04 / 02 / 2025

In signing this form, you are confirming that you have the authority to complete it on behalf of the service provider.

Guidance on completing the action plan.

- **Action Planned**: This must be a relevant to the requirement or recommendation. It must be measurable and focussed with a well-defined description of how the requirement/recommendation will be (or has been) met. Including the tasks and steps required.
- **Timescales:** for some requirements can be immediate. If you identify a requirement/recommendation timescale that you feel needs to be extended, include the reason why.
- **Person Responsible**: Please do not name individuals or an easily identifiable person. Use Job Titles.
- Please do not name individuals in the document.
- If you have any questions about your inspection, the requirements/recommendations or how to complete this action plan, please contact the lead inspector for your inspection.