Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: St. Ellen's Private Hospital, Livingstone

Service Provider: Cosmedicare UK Ltd

27–28 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 30 May 2023

Requirement

The provider must review its policies and procedures to ensure the content of each one aligns with relevant legislation and, where appropriate, Scottish guidance.

Action taken

The majority of policies had been reviewed in the last 12 months and a plan was in place to review the rest of the policies. All policies had a consistent format, approval and sign-off process, as well as individual review timescales. **This requirement is met.**

Requirement

The provider must implement robust governance processes that demonstrate appropriate oversight of how the service is being delivered. This must include:

(a) the review of all risk assessments to ensure all relevant risks have been assessed and each assessment is appropriate to the way the service operates.
(b) the development of a risk register containing the key operational risks (clinical, financial and organisational) that threaten the objectives of the organisation.
(c) the implementation of regular formalised governance meetings, where the leadership team review operational issues and key documents (including the risk register) and record what actions will be taken, the timescale and the person responsible for taking them.

Action taken

The service had appointed a compliance manager in November 2023. All existing risk assessments had been reviewed and new risk assessments carried out where appropriate. All risk assessments had been added to the service's new risk management database and shared with staff, who had signed to declare their understanding of each one. A process was in place for reviewing each risk assessment and sharing updates with staff. A risk register had been developed to identify key risks in the service. This was monitored and reviewed at new clinical governance and senior management team every 3 months. These meetings included standing agenda items, such as policy review, operational procedures, risk assessments, complaints and patient feedback. **This requirement is met**.

What the service had done to meet the recommendations we made at our last inspection on 30 May 2023

Recommendation

The service should develop its participation policy and process to provide a more structured way of seeking, monitoring, evaluating and using patient feedback to drive improvement in the way the service is delivered.

Action taken

A service user involvement policy was in place that described how the service engaged with patients to encourage feedback and how this was used to make improvements. Another patient participation policy had recently been developed that set out the introduction of a patient participation group to the service.

Recommendation

The service should ensure that staff receive training in duty of candour principles and publish a duty of candour report each year, even if there is a nil return.

Action taken

A duty of candour policy was in place, staff had received training in candour principles and a duty of candour report was in the process of being displayed in the service.

Recommendation

The service should carry out regular staff surveys and demonstrate how the results are used to make improvements. Results should be shared with staff.

Action taken

We saw that a yearly staff survey had been carried out.

Recommendation

The service should implement action plans following audits so that a proactive approach to improvement can be demonstrated.

Action taken

Audit action plans were in place.

Recommendation

The service should have an appropriate medicines management lead in place to cover the whole service.

Action taken

A medicines management lead was in place and the service had also employed a pharmacist.

Recommendation

The service should make enquiries with the Information Commissioner's Office to see if it needs to register.

Action taken

The service was registered with the Information Commissioner's Office.

Recommendation

The service should ensure that all staff have completed mandatory training in line with the provider's training and education policy.

Action taken

Staff records we reviewed demonstrated that mandatory training had been completed.

Recommendation

The service should implement a formal process for clinical supervision of trained staff.

Action taken

A process for clinical supervision was in place. However, we did not see any evidence that clinical supervision was carried out. This recommendation is reported in Domain 4: Quality improvement (see recommendation f on page 25).

Recommendation

The service should obtain two references for new members of staff, in line with safe recruitment practice.

Action taken

The service requested two references and the new members of staff had two references in their staff files.

Recommendation

The service should develop a formal quality improvement plan to formalise and direct the way it drives and measures improvement.

Action taken

A formal quality improvement plan had been developed and we saw evidence that actions had been taken to improve quality in the service.

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 St. Ellen's Private Hospital on Wednesday 27 and Thursday 28 November 2024. We spoke with a number of staff and patients during the inspection. We received feedback from 12 staff members through an online survey we had asked the service to issue for us during the inspection.

Based in Livingstone, St. Ellen's Private Hospital is an independent hospital providing non-surgical and surgical treatments.

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For St. Ellen's Private Hospital, the following grades have been applied.

Direction	*How clear is the service's vision and purpose and how supportive is its leadership and culture?*
Summary findings	**Grade awarded**
The service had a clear vision, purpose and values. A clinical governance manager had been appointed and we saw progress in developing the service's clinical governance systems and processes. Staff told us leadership was approachable and proactive. The strategic plan should be developed to include aims, objectives and measurable key performance indicators.	✓ Satisfactory
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patient experience was gathered, assessed and used to improve the service. Appropriate policies and procedures supported staff to deliver safe, compassionate and person-centred care. Risk management and quality assurance processes were in place for patient and staff safety. Yearly staff surveys helped the service plan and develop staff. The effectiveness of improvements made as a result of patient feedback should be evaluated. Information on how to complain must be published on the service's website. The location of COSHH assessments should be easily accessible to all staff.	✓ Satisfactory
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The care environment and patient equipment was clean. Equipment was regularly maintained. Medicines management was in place. Appropriate recruitment checks were carried out for staff. Patients were very satisfied with their care and treatment. The provider must document when a water flushing regime is carried out. External clinical waste bins must be kept locked at all times. Medication fridge temperatures should be checked daily.	✓ Satisfactory

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 except Cosmedicare UK 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 two requirements and nine recommendations.

Direction	
Requirements	
	None
Recommendations	
a	The service should 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 summarised on the service's website for patients and stakeholders so there is a shared sense of direction (see page 16). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
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). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.20

Implementation and delivery	
Requirements	
	None
Recommendations	
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). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
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. Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
e	The service should follow its own systems and processes and implement clinical supervision of trained staff included formal recording of it (see page 25). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14 This was previously identified as a recommendation in the 30 May 2023 inspection report for St. Ellen's Private Hospital
f	The service should ensure that COSHH assessments are easily accessible to all staff (see page 26). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.27

Results	
Requirements	
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 *Regulation 3 (d)(i)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
2	The provider must ensure that external clinical waste bins are kept locked at all times (see page 31). Timescale – immediate *Regulation 3 (d)(i)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
g	The service should monitor fridge temperatures daily to comply with national guidance for temperature-sensitive medicines (see page 31). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
h	The service should establish an effective stock checking process where medications are stored medicines (see page 31). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
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). Health and Social Care Standards: My support, my life. I am fully involved in all decisions about my care and support. Statement 2.19

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

Cosmedicare UK Ltd, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at St. Ellen's Private Hospital for their assistance during the inspection.

3 What we found during our inspection

Key Focus Area: Direction

Domain 1: Clear vision and purpose	Domain 2: Leadership and culture
How clear is the service's vision and purpose and how supportive is its leadership and culture?	

Our findings

The service had a clear vision, purpose and values. A clinical governance manager had been appointed and we saw progress in developing the service's clinical governance systems and processes. Staff told us leadership was approachable and proactive.

The strategic plan should be developed to include aims, objectives and measurable key performance indicators.

Clear vision and purpose

The service's vision was a commitment to being 'the most trusted and accessible private health care provider in Scotland.' This vision was reinforced through its mission and purpose of providing access to affordable, private healthcare, delivering safe and compassionate treatment to the communities it served.

Between May 2024 and the time of our inspection in November 2024, the service had developed a set of company values to expand on its vision and purpose. These values were:

- Integrity – upholding professional and ethical standards in a trusting and nurturing environment that promotes personal growth, transparency and accountability.
- Compassion – delivering patient-centred care with professionalism and kindness while safeguarding patient dignity, autonomy and preferences.
- Respect – considering and serving patients and colleagues in a way that values their humanity and uniqueness, treating individuals with honour, privacy, and empathy.

The managing director had developed a strategic plan, which set out the service's vision over the next 5 years. This was a live document that was updated regularly and discussed at senior management team and clinical governance meetings.

What needs to improve

The service's senior management team understood the long-term vision for the business. However, the strategic plan did not include formalised aims, objectives or key performance indicators that linked to the service's vision, purpose and values. In its self-evaluation provided to us before inspection, the provider had identified that information about the service's vision, purpose and values had not been shared with staff (recommendation a).

- No requirements.

Recommendation a

- The service should 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 summarised on the service's website for patients and stakeholders so there is a shared sense of direction.

Leadership and culture

The registered manager of the service was also the managing director. A new compliance manager had been appointed in November 2023. This new post holder had made significant progress in developing the service's clinical governance systems and processes.

A variety of meetings were held between different staff groups to discuss key operational issues. Minutes were taken and action points summarised in a meeting register that the clinical governance manager monitored to make sure actions were marked off when complete. Regular all-staff meetings took place, as well as:

- all-staff learning and sharing meetings
- clinical staff meetings
- theatre meetings, and
- outpatient meetings.

The infection prevention and control steering group, the operations and compliance team, as well as the patient care co-ordinator team held separate monthly meetings. The senior management team, clinical governance team and the quality improvement team held meetings separate every 3 months. This made sure that key issues were regularly monitored, such as:

- complaints
- finance
- health and safety
- patient feedback,
- policies
- quality improvement
- risk management, and
- staffing.

Staff told us they attended meetings, minutes were emailed to them and displayed in the staff room. They could attend meetings in-person or virtually, which allowed as many staff as possible to attend. We saw that attendance had increased since our last inspection in May 2023. We saw that staff were also involved in improvement actions identified in the various governance meetings.

We also saw evidence of a daily theatre huddle with:

- anaesthetists
- healthcare support workers
- the operation department practitioner
- the theatre manager
- theatre nurses, and
- surgeons.

Issues discussed included procedures planned for the day and any patient concerns or specific needs, as well as:

- any incidents that had occurred since the last huddle
- capacity and flow
- equipment and consumables
- staffing
- training and education, and
- who would be responsible for resuscitation.

We were unable observe the huddle during our inspection as no surgery was scheduled during the time of our inspection. However, staff we spoke with told us they could raise patient concerns during the huddle and we saw that the service addressed concerns highlighted from feedback.

Staff told us the senior management team was approachable and proactive and that they felt able to contribute suggestions for improvement in a variety of ways.

The service proactively managed its staffing complement to help make sure that an appropriate skill mix and safe staffing levels were always provided. We saw that the service used minimal agency and bank staff, only when it was clinically required to cover staffing gaps and maintain safe and effective staffing levels.

What needs to improve

The 'Freedom to Speak Up' initiative was designed for staff to speak up about any concerns or anything that gets in the way of them doing a good job. 'Freedom to Speak Up Guardians' are nominated in an organisation, to support staff to speak up when they feel unable to do so. The service did not have a freedom-to-speak-up system in place (recommendation b).

- No requirements.

Recommendation b

- The service should implement a Freedom to Speak Up Guardian to make it easy for staff to raise any concerns or queries.

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 gathered, assessed and used to improve the service. Appropriate policies and procedures supported staff to deliver safe, compassionate and person-centred care. Risk management and quality assurance processes were in place for patient and staff safety. Yearly staff surveys helped the service plan and develop staff.

The effectiveness of improvements made as a result of patient feedback should be evaluated. Information on how to complain must be published on the service's website. The location of COSHH assessments should be easily accessible to all staff.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The service gathered feedback from patients about their experience after consultations and used this information to improve the way the service was delivered. We saw that patients had follow-up calls following treatment to find out how they felt and to provide an opportunity to raise any issues at the same time.

Patients were given a feedback survey to complete after their consultation. We saw that patients could leave feedback on the service's website, which the service responded to directly. Feedback was analysed monthly and results were shared at staff meetings. We looked at a selection of surveys the service had carried out, which showed good levels of patient satisfaction.

An example of service improvement as a result of patient feedback included the introduction of a separate seating area for relatives and friends who were waiting to collect patients.

A staff survey was carried out every year, which asked a comprehensive set of questions. Results from the most recent survey showed a good level of satisfaction, which had improved from previous surveys. 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. We saw 'you said, we did' boards for staff displayed in the staff room, showing improvements made for staff as a result of their suggestions. These included:

- You said - 'Lack of space for files.'
- We did - 'larger filing cabinets purchased.'
- You said - 'More opportunities for training.'
- We did - 'More training being approved.'

We were told that the service planned to introduce 'listening sessions' as another way to allow staff a safe space for feedback about the work environment, which would be respectfully shared with the senior management team. Management action plans would be created from these sessions and progress would be monitored against any managerial commitments to workplace and procedural improvements.

Staff received emails and monthly newsletters to keep them updated with any operational changes. Staff told us they received information and training on new initiatives and policy updates.

The service recognised its staff in a variety of ways. This included communicating with staff to acknowledge positive feedback from patients and celebrating staff birthdays, as well as bringing in food from the local takeaway van. A benefits programme was in place for staff, which included discount on healthcare and wellbeing support.

What needs to improve

From the 'you said, we did' boards, we saw that the service listened to staff feedback and acted on issues raised. However, we saw no evidence that staff feedback was evaluated to assess whether improvements had been effective (recommendation c).

We saw evidence to demonstrate that the service listened to feedback from patients and acted on issues raised. However, information about the resulting improvements was not shared with patients (recommendation d).

While we saw a patient participation policy that set out the introduction of a patient participation group, this was still in the early stages of development. We will follow this up at future inspections.

- No requirements.

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.

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.

Quality improvement

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

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

The new clinical governance manager had reviewed 80% of the service's policies and procedures and had a plan in place for reviewing the remainder. Appropriate key staff had been involved in providing accurate policy content and more policies had been developed than the service previously had in place. The policies we reviewed all contained accurate information in line with appropriate legislation and guidance. The new policies followed a consistent format and a clear review process was in place. The policies had also been added to a policy register to monitor their distribution and review. The service had implemented a new approval process to make sure the senior management team reviewed and signed off all policies before implementation. We also saw that a process was in place where staff signed to say they had read and understood the new policies.

The service was embedding a new culture of shared responsibility for risk management across multiple team members, to reduce person-dependency for risk management. A governance monitoring register had been developed to track key business risks, such as the service's:

- fixtures and fittings servicing
- Healthcare Improvement Scotland registration status
- staff professional registration checks
- supplier contracts, and
- waste carrier license checks.

A new risk register had been developed, and we saw this was regularly discussed at senior management team meetings and clinical governance meetings. This was stored on a new risk management database, accessible to all staff. This database allowed staff access to a central source of information and also stored the service's:

- incidents and adverse events
- policies and procedures, and
- risk assessments.

An equipment asset register had been established to track when each item of equipment was due to be serviced or maintained. We saw evidence that all equipment servicing and maintenance was up to date, examples included:

- clinical and medical equipment
- fire equipment
- gas boilers,
- medical gases, and
- the fixed electrical installation.

Processes were also in place to manage the service's water safety. This included a legionella risk assessment, monthly visits from a specialist water safety management company to carry out water sampling, check the temperature of outlets and storage tanks, as well as perform routine maintenance.

The service used a class 4 laser to carry out some of its patient treatments. We saw that appropriate governance was in place and authorised users of the laser had received appropriate procedural, equipment and laser safety training. The laser had also been appropriately calibrated and serviced.

The medicines fridges were checked regularly, including its contents and daily temperatures. Staff we spoke with knew the process for reporting faults.

We saw emergency equipment was checked daily and these trolleys were kept in accessible locations. Staff we spoke with were familiar with the location of the trolleys. We saw that staff were identified at the start of a shift to respond to medical emergencies and in the event of a fire.

A complaints procedure was in place and this was available on the service's website. We saw evidence that complaints were well managed and lessons learned were discussed at staff and management meetings. The service was

subscribed to an independent adjudication service for complaints about the private healthcare sector.

A duty of candour procedure was in place (where healthcare organisations have a professional responsibility to be honest with patients when things go wrong). This was a new policy that the new clinical governance manager had developed. It included the requirement to publish an annual duty of candour report. The service's first annual report was due to published at the end of the 2024-25 financial year. Staff we spoke to fully understood their duty of candour responsibilities and had received training in it. We saw evidence that the service had followed its own procedure when dealing with these incidents and shared learning with staff and consultants.

Staff told us that patients were given written aftercare instructions when they were discharged and information about any recommended follow-up. Hospital contact details were provided on discharge included in this information in case patients had any concerns or questions. Patient care coordinators acted as a single point of contact for the patients' journey from enquiry to discharge. Patients told us they were clear about their treatment plan and aftercare. Staff also contacted patients over the phone, normally 24–48 hours after discharge to check how they felt and address any concerns they might have at that time.

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

We saw that the service had a deteriorating patient protocol, which included a:

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

The service's recruitment policies described how staff would be appointed. Appropriate pre-employment checks had been carried out for employed staff and healthcare professionals appointed under practicing privileges (staff not employed directly by the provider but given permission to work in the service). Staff files contained a checklist to help make sure that appropriate recruitment checks had been carried out.

All staff were allocated mandatory and role-specific online learning modules. Mandatory training included safeguarding of people and duty of candour. The

theatre manager and the senior management team used an online platform to monitor compliance with mandatory training completion.

Staff appraisals were carried out regularly and recorded on an online appraisal system. 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.

What needs to improve

Staff had yearly appraisals carried out and we saw that the service had a policy and process in place for clinical supervision. However, staff we spoke with were unaware of this and we did not see any evidence of clinical supervision taking place at the time of our inspection (recommendation e).

We saw that the provider was introducing a new competency framework for all staff involved in clinical care. However, staff we spoke with told us that they were unaware of this framework. We discussed this with the senior management team. We saw that training and education was in development to inform staff about the framework, what it offered and how staff could access and complete it. We will follow this up at future inspections.

The clinical governance manager told us that the service had recently put a staff member through training to become its competent person for carrying out portable appliance testing. Plans were in place to purchase a portable appliance testing kit and software to create an asset register. We will follow this up at future inspections.

The service had recently implemented a disaster recovery policy, which described what actions would be taken to protect against data loss in the event of information technology system failure. However, the service did not have a business continuity plan in place that described what actions would be taken in the event of major incidents or natural disasters such as:

- fire
- flood
- pandemic, and
- terrorist threat.

The clinical governance manager was aware of the need for this key operational procedure and in the process of setting up an incident team to manage this. We will follow this up at future inspections.

The service was in the process of publishing its duty of candour report. We will follow this up at future inspections.

The service had developed a corporate website since our last inspection. However, we noted that the old service's website could still be accessed which could be confusing for patients. The service told us that it would deactivate its old website. We will follow this up at the next inspection.

Recommendation e

- The service should follow its own systems and processes and implement clinical supervision of trained staff included formal recording of it.

Planning for quality

A quality improvement team had been set up since our last inspection, made up of staff from all areas of the business. This team developed a formal quality improvement plan, informed from the service's strategic plan, audit outcomes and staff suggestions. The service planned to include patient feedback in developing its improvement plan in the future. Different staff had been assigned responsibilities for quality improvement actions and progress was discussed at quality improvement meetings and all-staff meetings. Examples of actions included increasing the range of services available and creating greater transparency around terms and conditions for patients. It was a live document and monitored regularly as a standing agenda item in operations and compliance meetings and senior management team meetings.

The service was trialing a new artificial intelligence application for consultations, which transcribed the conversation between the patient and the consultant, and documented patient consent. The application then generated a letter to the patient that summarised the outcome of their consultation in easy-to-understand language.

A monthly audit programme was in place. However, at the time of our inspection it was being redeveloped to include all the standard infection control precautions. We were told audit action plans were shared with the senior management team. If an audit scored below 95%, it would be repeated weekly until the score improved. At the time of our inspection, one member of staff was completing the audits. However, the service planned to share this responsibility among all staff after the new programme was embedded.

What needs to improve

While we were shown safety data sheets for chemicals used in the service, staff were unable to produce Control of Substances Hazardous to Health (COSHH)

assessments. After our inspection, the service sent us its COSHH register and examples of its COSHH assessments. It is important that staff have ready access to this information at all times (recommendation f).

The service's pharmacist had a planned programme of audits. The pharmacist had carried out a controlled drug audit and developed an action plan, which had been shared with the management team and staff. The pharmacist planned to carry out a medication audit next. We will follow this up at future inspections.

- No requirements.

Recommendation f

- The service should ensure that COSHH assessments are easily accessible to all staff.

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 regularly maintained. Medicines management was in place. Appropriate recruitment checks were carried out for staff. Patients were very satisfied with their care and treatment.

The provider must document when a water flushing regime is carried out. External clinical waste bins must be kept locked at all times. Medication fridge temperatures should be checked daily.

Every year, we ask the service to submit an annual return. This gives us essential information about the service such as composition, activities, incidents and accidents, and staffing details. The service submitted an annual return, as requested. As part of the inspection process, we ask the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Assurance Framework and ask the service to tell us what it does well, what improvements could be made and how it intends to make those improvements. The service submitted a satisfactory self-evaluation.

We saw that care was delivered in a clean hospital environment and theatre suite with equipment that was fit for purpose and regularly maintained. The overnight rooms and overnight ward environment were in good condition, tidy and clean. Cleaning schedules were in place and each area had an opening and closing checklist. The appropriate cleaning equipment and products were used. Clinical waste was managed in line with national guidance and clean linen was stored correctly.

The equipment we saw was clean and well maintained. Patients we spoke with commented that the service and equipment was clean. A housekeeper cleaned the service regularly and checks were carried out throughout the day to identify any issues and actioned promptly.

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 service, with limited access for staff only. This included a locked cupboard for materials under COSHH.

We looked at five patient care records and saw they all included the patient:

- address
- name
- next of kin, with consent to share information, and
- patient identifier number.

We saw that venous thromboembolism (VTE) risk assessments were completed and the service was in the process of implementing a falls risk assessment for all patients. We saw the consultant and patients had signed and dated consent forms for different procedures carried out, with risks and benefits discussed.

We saw safety measures in place for patients having surgery, including:

- pre-procedure checklist
- theatre peri-operative care plans
- accountable items record
- peri-operative care
- recovery notes, and
- discharge information.

We saw these completed for all five patient notes reviewed.

We saw evidence that medicines were managed appropriately. This included completed records of stock checks in both theatres 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 service had recently employed a pharmacist who visited the service once a week. The service's Home Office certificate for stocking, prescribing and dispensing controlled drugs was valid and in-date.

Staff told us they received adequate training to carry out their role. We saw evidence in staff files and training reports of completed mandatory training, including medical staff with practicing privileges.

Staff also 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.

We reviewed five files of employed staff and five files of individuals granted practicing privileges. All 10 files were well organised and 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.

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 a period of induction and 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.

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

- all staff felt the service had positive leadership at the highest level of the organisation
- the majority of staff felt they could influence how things were done in the service
- the majority of staff felt their line manager took their concerns seriously, and
- the majority of staff would recommend the service as a good place to work.

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

- 'Patient care is exemplary.'
- 'Support their patients through a journey the patient wants to achieve.'
- 'Looks after staff well.'
- 'Patient care and being mindful of delivering the best possible patient experience is top of everyone's agenda regardless of their role. We all seem to want the best for our patients and so pull together really well as a team to make sure that is what we deliver.'

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

- ‘Always treated dignity and respect- they could not do more for me- absolutely fantastic.’
- ‘Everyone from the consultant, patient care coordinators, nursing staff and receptionist have introduced themselves when meeting me.’
- ‘Environment cleanliness has been excellent.’
- ‘Everything was explained thoroughly, through from the pre-op to the aftercare after surgery.’

What needs to improve

As part of the service water management system, we saw that a process was in place for the flushing water outlets and recording when this was done. On reviewing the documentation, we found that not all water outlets were recorded as being flushed (requirement 1).

The large storage bins used to store clinical waste bags were not locked (requirement 2).

The temperatures of the medication fridges in the theatres were not consistently recorded daily (recommendation g).

The ward medication stock was in-date. However, the service did not have a documented medication checklist in place (recommendation h).

While patient care records were well completed and we saw care plans completed for day case patients, we did not see any care plans for patients who required to stay overnight (recommendation i).

Take-home medication for patients was dispensed from a take-home medication cupboard. The service’s pharmacist was reviewing this with a plan to ordering specific medication in advance of patients’ discharge from the service’s external pharmacy. We will follow this up at future inspections.

The service had recently implemented a trial of a competency framework for recovery staff. We saw evidence of competency framework for all other clinical roles, which the service planned to roll out to all staff. We will follow this up at future inspections.

Requirement 1 – Timescale: immediate

- The provider must document when a water flushing regime in undertaken for less frequently used outlets to minimise the risk from legionella.

Requirement 2 – Timescale: immediate

- The provider must ensure that external clinical waste bins are kept locked at all times.

Recommendation g

- The service should monitor fridge temperatures daily to comply with national guidance for temperature-sensitive medicines.

Recommendation h

- The service should establish an effective stock checking process where medications are stored medicines.

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.

Appendix 1 – About our inspections

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

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

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

Before inspections

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

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

Before

During inspections

We use inspection tools to help us assess the service.

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

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

During

After inspections

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

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

We check progress against the improvement action plan.

After

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

Complaints

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

Our contact details are:

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

Email: his.ihcregulation@nhs.scot

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
or email his.contactpublicinvolvement@nhs.scot

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