Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

# Unannounced Inspection Report: Independent Healthcare

**Service:** Albyn Hospital, Aberdeen

**Service Provider:** Circle Health Group Limited

14–15 November 2023

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 5 October 2021

### Requirement

*The provider must ensure that at all times suitably qualified and competent persons are working in the service in such numbers as are appropriate for the health, welfare and safety of service users.*

### Action taken

We saw evidence that the service used the provider's safer staffing tool to review staffing levels. Activity and staffing levels were discussed weekly, at department huddles and the hospital daily huddle. Vacancies were actively managed and bank and agency staff were used to maintain safe staffing levels. **This requirement is met.**

## What the service had done to meet the recommendations we made at our last inspection on 5 October 2021

### Recommendation

*The service should ensure that safety huddles are carried out consistently.*

### Action taken

We observed and saw evidence that daily department huddles were held and any actions were recorded.

### Recommendation

*The service should improve communication with all staff regarding the decisions made when theatre lists are created and ensure that staff are aware that capacity or staffing is part of that decision-making.*

### Action taken

We saw evidence of weekly meetings about theatre lists and the outcomes were communicated to staff. Daily huddles which discussed theatre case, staffing, equipment and allowed staff to voice any concerns were also held, where the outcomes and discussions were recorded.

### Recommendation

*The service should improve communication to staff about recruitment issues in the service.*

### Action taken

A newsletter was shared with staff every 2 months. Weekly heads-of-department meetings discussed recruitment and the outcome of this meeting was shared with staff.

### Recommendation

*The service should ensure that patient care records are fully completed or unused parts are removed or marked as not applicable.*

### Action taken

The patient care records reviewed were fully and accurately completed.

# 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 Albyn Hospital on Tuesday 14 and Wednesday 15 November 2023. We spoke with a number of staff and patients during the inspection We received feedback from 30 staff members through an online survey we had asked the service to issue for us during the inspection.

Based in Aberdeen, Albyn 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 Albyn Hospital, the following grades have been applied.

| **Direction** | *How clear is the service's vision and purpose and how supportive is its leadership and culture?* |
|---|---|
| **Summary findings** | **Grade awarded** |
| The hospital had a well-defined and measurable vision and purpose, with a clear strategy and defined key performance indicators to achieve it. Key principles and values had been identified in line with the vision and purpose. Values and principles were displayed in the hospital for staff and patients to see. Key performance indicators were regularly monitored and reported.<br><br>The leadership team worked well together and was open to ideas for improvement. Staff were empowered to speak up. Operational issues were managed appropriately in a clear governance structure. | ✓✓ Good |
| **Implementation and delivery** | *How well does the service engage with its stakeholders and manage/improve its performance?* |
| The hospital actively sought patient and staff feedback, using it to continually improve the way the service was delivered. We saw good levels of patient and staff satisfaction. Staff were recognised in a variety of ways. Patient feedback outcomes were shared and staff received regular feedback. Staff were recruited safely and recognised in a variety of ways. Systems were in place to manage risks. A formal process for clinical supervision for trained nursing staff should be implemented.<br><br>Comprehensive policies and procedures supported staff to deliver safe, compassionate and person-centred care.<br><br>Comprehensive risk management and quality assurance processes and a quality improvement plan helped staff to continuously improve service delivery. | ✓✓ Good |

| Results | *How well has the service demonstrated that it provides safe, person-centred care?* |
|---|---|
| The care environment and patient equipment were clean, equipment was fit for purpose and regularly maintained. Staff described the provider as a good employer and the hospital as a good place to work. Patients were very satisfied with their care and treatment. Sinks should be cleaned with cleaning in line with national guidance. | ✓✓ Good |

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

More information about grading can be found on our website at: http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/ihc_inspection_guidance/inspection_methodology.aspx

Further information about the Quality Assurance Framework can also be found on our website at: https://www.healthcareimprovementscotland.org/scrutiny/the_quality_assurance_system.aspx

## What action we expect Circle Health Group 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 two recommendations.

| Implementation and delivery | |
|---|---|
| **Requirements** | |
| | None |
| **Recommendation** | |
| **a** | The service should implement a formal process for clinical supervision of trained staff (see page 22).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.1 |

| Results | |
|---|---|
| **Requirements** | |
| | None |
| **Recommendation** | |
| **b** | The service should ensure that appropriate cleaning products are used for the cleaning of all sanitary fittings, including clinical wash hand basins, in line with national guidance (see page 27).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11 |

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/find_a_provider_or_service.aspx

We would like to thank all staff at Albyn Hospital for their assistance during the inspection.

# 3 What we found during our inspection

## Key Focus Area: Direction

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

### Our findings

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

**The leadership team worked well together and was open to ideas for improvement. Staff were empowered to speak up. Operational issues were managed appropriately in a clear governance structure.**

#### *Clear vision and purpose*

Albyn Hospital is part of Circle Health Group (the provider). The provider's purpose had been clearly set out in various key documents as:

- 'To provide high quality, safe, accessible and affordable healthcare in a sustainable way.'

It was stated along with the provider's aim:

- 'To be the most innovative and patient focussed healthcare organisation and, by equipping our outstanding people with leading edge technology, deliver the highest quality care.'

The hospital's own purpose was in line with the provider's and was defined as:

- 'To deliver quality care in a timely and effective manner, in a safe environment which would demonstrate to our internal and external customers that they are at the heart of what we do.'

The hospital had also identified key principles and values in line with its purpose. These included making sure patients come first and valuing people that are compassionate and committed. We saw copies of the provider's

purpose, values and principles displayed for staff and patients in the theatre department, wards and outpatients' department.

The hospital's business plan and clinical strategy set out how the provider's purpose and vision would be achieved over the following 12 months, using several key performance indicators (KPIs) to make sure the provider's purpose was measurable. This document was reviewed regularly at leadership forums and used to inform the next year's strategy, with KPIs continually monitored in a variety of ways. These included site reviews from the provider each month and monitoring through data analysis. For example:

- a centralised clinical governance framework
- a 'Hospital Assurance Tool' (HAT), and
- business intelligence systems that monitored workforce, audits, safety alerts, risk and incident reporting and complaints.

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

The hospital's 'Strategic Business Plan 2023' set out its strategic objectives over the next 3 years and how these would be achieved. It included issues such as:

- external accreditation
- expansion project
- patient-focused quality improvement initiatives
- recruitment and retention, and
- staff recognition and reward.

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

It was clear that the hospital had a well-defined and measurable vision and purpose, and its strategy and KPIs helped to achieve these.

- No requirements.
- No recommendations.

### *Leadership and culture*

The hospital had a leadership team made up of the:

- director of clinical services
- director of operations
- executive director, and
- quality and risk manager.

A centralised support team provided the clinical and non-clinical expertise needed to support how the hospital delivered its treatment and care.

The hospital had a governance assurance framework in place that the provider's board had approved. This framework aligned with the provider's vision and strategy for quality assurance in each hospital site. It had been endorsed through the provider's committee structure and supported upward escalation of operational activities to board level.

The hospital had a well-defined programme of committee and staff meetings. These included monthly leadership team meetings where operational, financial, and clinical issues were discussed. This committee had several sub-committees, including a monthly clinical governance committee to:

- manage the delivery of patient care
- monitor compliance with professional standards and legislation, and
- monitor reports from further sub-committees.
-
- The other sub-committees included the:
- health and safety committee
- infection prevention and control committee
- medical advisory committee
- medicines management committee and
- any local sub-committees.

From minutes of these committees, we saw that each one had defined terms of reference and standardised agenda items. We saw that operational issues were also fed through the various committee structures and managed appropriately. For example, through:

- audit results
- complaints
- incidents
- patient and staff feedback, and
- staffing issues.

Other monthly cross-site meetings were also held, where staff attended from each of the provider's hospitals to understand any developments and updates from a corporate perspective. This included clinical updates and sharing any learning across the group. We saw that outcomes from these meetings were shared with hospital staff through heads of department meetings and departmental meetings.

A staff huddle was held each morning between heads of departments to discuss the day's priorities and ongoing issues. We attended the daily huddle on day 2 of our inspection and saw effective communication between heads of department at the meeting.

To keep staff updated, the leadership team received a corporate weekly communication from the provider which highlighted areas for action or information. A weekly news platform on the internal staff intranet also encouraged staff to share achievements and good news stories. A separate newsletter was sent to consultants to keep them updated on safety initiatives, changes to referral criteria and other relevant information.

The hospital had implemented the provider's 'Circle Operating System' approach to leadership, where decision-making is devolved and inclusive to make sure all staff take ownership and accountability. This meant that leaders promoted a culture of staff being empowered to make decisions for patients, knowing their contribution is valued and taking pride in the outcomes achieved. The system contained four elements:

- clinical outcomes
- optimal value
- patient experience, and
- staff engagement.

One example of the system in action was a 'stop the line' approach, which was originally developed by Toyota for bringing car production lines to a standstill when a problem was identified. The provider had adapted this approach to use in healthcare and had made it central to patient safety. Any member of staff

who encountered a situation that may cause patient harm was empowered to immediately request the person in charge to stop what they're doing. The leadership team fully supported staff to allow them to do this. Staff told us they felt able to use this process if needed and described an example where it had been used to draw attention to a potential safety issue. This had resulted in key staff meeting to assess the circumstances and manage the situation before care delivery continued safely.

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

### What needs to improve

While staff meetings were held regularly in most departments, the theatre departments had not held a monthly staff meeting since August 2023. We were told this was due to operational issues occurring in September, October and November 2023 which had led to late cancellations of the staff meetings. Regular staff meetings are an important way for staff to communicate issues and discuss improvement. We were told the next meeting was scheduled to take place in December 2023. We will follow this up at future inspections.

- 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

**The hospital actively sought patient and staff feedback, using it to continually improve the way the service was delivered. We saw good levels of patient and staff satisfaction. Staff were recognised in a variety of ways. Patient feedback outcomes were shared and staff received regular feedback. Staff were recruited safely and recognised in a variety of ways. Systems were in place to manage risks. A formal process for clinical supervision for trained nursing staff should be implemented.**

**Comprehensive policies and procedures supported staff to deliver safe, compassionate and person-centred care.**

**Comprehensive risk management and quality assurance processes and a quality improvement plan helped staff to continuously improve service delivery.**

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

The hospital actively sought feedback from patients about their experience of treatment and care and used this information to continually improve the way its service was delivered. Information leaflets were available for patients throughout the hospital and were available in different formats. Information boards with comprehensive and inclusive information were also displayed in an accessible format. We saw that patients could leave feedback on the hospital's website, which the hospital then responded to directly. Feedback was analysed every month and results were shared at staff meetings. We saw good levels of patient satisfaction, especially in patient care and individual staff members.

'You said, we did' boards were displayed through the hospital, detailing examples of improvements made as a result of feedback. For example, a patient made a complaint and as a direct result the hospital had changed the provision of care in the department to improve the delivery of care. The improvement activity had been shared with the patient in a meeting and the changes had been evaluated to make sure they met patient needs. The complainant had given the hospital excellent written feedback about the handling and subsequent outcome of the complaint.

The hospital recognised its staff in a variety of ways, including:

- cards acknowledging positive feedback from patients
- staff birthday celebrations, and
- the leadership team giving staff pizza and ice cream.

A ‘long service award’ was also given to staff that had worked in the hospital for 5 years or more. Recipients were given a certificate of recognition, a voucher to spend and had their photo displayed. Further awards were given with every extra 5 years of service. A benefits programme was in place for staff, which included private healthcare, access to savings schemes and wellbeing support.

A staff survey called ‘Be Heard’ was carried out every year, which asked a comprehensive set of questions. Results from the most recent survey showed a high level of satisfaction, which had improved from previous surveys and this had been acknowledged across the provider’s organisation. Results were shared with staff at monthly staff meetings. Staff we spoke with in the wards also confirmed that meetings were held regularly. Minutes were displayed and stored in ward folder after the next meeting. Staff received emails and monthly newsletters to keep them updated with any operational changes.

While the staff we spoke with understood the provider’s purpose and shared values, the results from the most recent staff survey showed that awareness was lower than the previous year. The provider had already identified its intention to profile individuals in monthly newsletters to help increase staff knowledge of the provider’s purpose, values and principles. This improvement action had been recorded in an action plan and was self-reported in its self-evaluation.

The hospital recognised the importance of supporting charities. We saw an ongoing collection for a local children's charity and many staff had contributed to this.

- No requirements.
- No recommendations.

### *Quality improvement*

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

Comprehensive policies and procedures set out the way the hospital supported staff to deliver safe, compassionate, person-centred care for example:

- consent
- duty of candour
- health and safety
- infection prevention and control
- medicines management, and
- safeguarding.

A process was in place for writing all policies, submitting them to appropriate corporate groups and approving them through the medical advisory committee. Policies and procedures were updated regularly or in response to changes in legislation, national and international guidance and best practice. To support effective version-control and accessibility, policies were available electronically on the hospital's staff intranet.

The operations manager looked after the day-to-day management of the building and its specialist equipment. An on-site engineering and maintenance team took care of all routine maintenance and any repairs that staff reported. We saw comprehensive policies and procedures in place to manage the facilities. This included schedules for managing routine issues, such as:

- electrical safety
- fire safety, and
- gas safety.

It also included more specialist risk assessments and operational plans for managing key building risks, such as legionella and ventilation.

Incidents were recorded and managed through an electronic incident management system. Each one was reviewed and reported through governance groups. The outcomes of the discussions from these meetings were fed back through regular staff meetings.

The hospital's infection prevention and control policies and procedures were in line with Health Protection Scotland's *National Infection Prevention and Control Manual*. Procedures were in place to help prevent and control infection. Cleaning schedules were in place for all clinical areas. The hospital had an infection control nurse who participated in visual audits, formal audits and training opportunities on-site.

We saw that the hospital had a laser policy and an agreement in place with a laser protection advisor. The laser protection advisor had written a set of local rules for the laser, which stated that authorised users of laser equipment must complete 'Core of Knowledge' training every 3 years. We saw that the consultants had completed this training in the last 3 years.

We looked at five paper-based patient care records. Some patients had self-referred. All consultations included details of the treatment risks and benefits discussed with patients. We saw evidence that treatment options had been discussed. All patient care records we reviewed included:

- aftercare and follow-up
- consent to treatment and sharing of information
- medical history, with details of any health conditions, and
- patient risk assessments.

We saw good compliance with patient risk assessments, including falls, nutrition and pressure care and venous thromboembolism (VTE).

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. Patients we spoke to told us their consultant had visited them during their stay and were clear about what to expect and who to contact after discharge.

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

The leadership team was aware of its duty to report certain matters to Healthcare Improvement Scotland as detailed in our notification guidance. The hospital's complaints procedure was prominently displayed in the hospital and published on the provider's website. We saw evidence that complaints were well managed, and lessons learned were discussed at staff and

management meetings. The hospital was subscribed to the Independent Sector Complaints Adjudication Service (ISCAS), 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). Staff we spoke to fully understood their duty of candour responsibilities and had received training in it. The hospital had experienced several candour events over the past year, which were reflected in its yearly duty of candour published report. We saw evidence that the hospital had followed its own procedure when dealing with these incidents and shared learning with staff and consultants.

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

The hospital's recruitment policies described how staff would be appointed. Appropriate pre-employment checks were 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 hospital). Staff files contained a checklist to help make sure that appropriate recruitment checks had been carried out.

The hospital used a safe staffing tool to proactively manage its staffing compliment to ensure that an appropriate skill mix and safe number of staffing was always provided. The hospital was actively trying to recruit to vacancies and to recruit more than the minimum amount of staff needed as a contingency, to provide some flexibility. We were told and saw that the hospital used minimal agency and bank staff and only when clinically required to cover staffing gaps to maintain safe and effective staffing levels. The hospital's future-proofing approach also included recruiting staff from overseas who had obtained their nursing qualification in their home country. The hospital had supported these staff to settle in the area and arranged further advanced training in order to qualify to be registered on the Nursing and Midwifery Council (NMC) professional register.

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 that appropriate recruitment checks had been carried out, including:

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

All employed staff had completed an induction, which included an introduction to key members of staff in the hospital, mandatory training and role-specific 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.

All staff were allocated mandatory and role-specific online learning modules. Mandatory training included safeguarding of people and duty of candour. Team leaders, heads of departments and the leadership team used an online platform to monitor compliance with mandatory training completion. Staff told us they received enough training to carry out their role. We saw evidence in staff files and training reports of completed mandatory training, including medical staff with practicing privileges.

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

Clinical supervision was provided for physiotherapists. However, we saw no formal process in place for providing clinical supervision to nursing staff at the time of our inspection (recommendation a).

The hospital's most recent Electrical Installation Condition Report (EICR) had resulted in an 'unsatisfactory' rating for the hospital's electrical installation. While the remedial work highlighted in this report had been completed, a further EICR had not been carried out to determine whether the electrical installation was now in satisfactory condition. After our inspection, the leadership team informed us that an EICR was due to be carried out in

December 2023 and that a copy would be forwarded to us. We will follow this up at future inspections.

- No requirements.

### Recommendation a

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

### *Planning for quality*

The hospital's risk management system was comprehensive and included corporate and clinic risk registers. These documents detailed the actions that would be taken to mitigate risk and reduce harm. The hospital had recorded a number of ongoing key business risks that it monitored regularly. These included:

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

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

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

The hospital was carrying out extensive expansion and refurbishment to increase capacity. We saw that the building works were being well managed, despite the impacts of a temporary reduction in storage and inpatient areas. Patients were kept informed before and during their visit that work was being carried out and staff were regularly updated on progress made. This helped minimise the impact of the work and reduce the number of complaints.

The providers 'Circle Operating System' included processes to help staff consider the quality of treatment and care being provided at all times. These

processes aimed to make sure that patient experience was central to daily activities in the hospital and that staff had a voice to raise any concerns.

The hospital had a detailed audit programme which helped make sure staff delivered consistent safe care and treatment for patients and identified any areas for improvement. The staff we spoke to participated in audits and were aware of when these were completed. Action plans were produced to make sure any actions needed were taken forward.

The audit programme included:

- environment
- hand washing
- national early warning system (NEWS), and
- patient care records.

Link staff were also identified as champions and a list of champions was available in the staff room.

The hospital had several clinical accreditations, including:

- Association for Perioperative Practice (AfPP), which reflects the hospitals commitment to high levels of peri-operative care.
- VTE Exemplar status, demonstrating the hospital's excellent track record in venous thrombo-embolism prevention in care.

It had also achieved the McMillian Quality Environment Mark (MQEM) in the oncology department. MQEM recognises and celebrates environments that meet the standards required by people living with cancer.

Part of the hospital's improvement plan was to implement a 'Patient Hour,' a Quality Improvement Project (QiP) that the hospitals' quality and risk manager had developed. This initiative would be dedicated to exploring patient feedback and experience as a hospital team and would take the form of a huddle or an item on a regular team meeting agenda. The aim would be to answer the following questions:

- 'Did our patients receive the best experience possible?'
- 'Have we gained/retained our patients' loyalty?'
- 'If yes, what have we done that we should continue doing?'
- 'If no, what do we need to improve?'

Another example of a QiP that had been introduced was the 'Breast Friends' forum that had been set up in oncology department. This group met monthly and had developed a leaflet providing practical help for cancer patients on things like hair loss.

- 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

**The care environment and patient equipment were clean, equipment was fit for purpose and regularly maintained. Staff described the provider as a good employer and the hospital as a good place to work. Patients were very satisfied with their care and treatment. Sinks should be cleaned with cleaning in line with national guidance.**

Every year, we ask the service to submit an annual return. This gives us essential information about the service such as its composition, activities, incidents and accidents, and staffing details. The hospital 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 hospital submitted a comprehensive self-evaluation.

The environment and equipment we saw were clean, well maintained and we saw that the hospital used a labelling system to identify clean equipment. Labels were dated and applied to equipment after cleaning so that staff knew it was ready for use again. Patients we spoke with commented that the hospital and equipment was clean. Toilets were provided throughout the hospital, including facilities for people with disabilities. Housekeeping staff cleaned these facilities regularly. We saw that checks were carried out on these facilities regularly through the day and recorded.

The five electronic patient care records we reviewed showed that appropriate records had been kept for patients, including:

- assessment and consultation
- documentation of the discussion about the treatment plan, including the risks and benefits of each treatment offered, and
- patient consent to treatment and to share information with their GP or other relevant healthcare professional where appropriate.

We also saw evidence that treatments plans, options and aftercare had been discussed with the patient before they were discharged from the hospital.

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

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

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

Staff told us the leadership team was approachable and they felt valued and well supported by them. 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 treatment delivery, with effective oversight from a supportive leadership team.

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

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

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

- ‘Helps work around my childcare.’
- ‘The patient care is of a high standard. Patients are very well looked after from start to finish and feedback from patients is typically very positive.’
- ‘Expressed a few concerns recently and they were resolved. Feels like we matter and are being listened to.’
- ‘In my department, patient care and welfare is clearly at the forefront of everyone's minds.’
- ‘Departmental managers look after their teams and appreciate/listen to them.’

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

- ‘Attended pre-op and the staff couldn’t have been nicer.’
- ‘Housekeeping have been excellent, always busy.’
- ‘Attended to quickly, everyone has been great.’
- ‘Recovery staff and housekeeping need a special mention.’
- ‘Everything has been explained.’
- ‘Would highly recommend the service.’

### What needs to improve

We observed and saw evidence from completed cleaning checklists that the sinks in the theatre areas were regularly cleaned with a chlorine solution in line with the *National Infection Control Manual* and the provider’s housekeeping manual. However, we found that the sinks in the inpatient ward area and day case area were not cleaned with a chorine solution (recommendation b).

- No requirements.

### Recommendation b

- The service should ensure that appropriate cleaning products are used for the cleaning of all sanitary fittings, including clinical wash hand basins, in line with national guidance.

## 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: https://www.healthcareimprovementscotland.org/scrutiny/the_quality_assurance_system.aspx

## 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

**Telephone:** 0131 623 4300

**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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