Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: House of Ikigai, Dunfermline

Service Provider: Kevin Kit

30 August 2023

NHS SCOTLAND

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First published November 2023

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Contents

1 Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 18 June 2019

Recommendation

The service should develop action plans in response to feedback collected, including a review of effectiveness.

Action taken

We saw various ways the service used to collate, review and analyse patient feedback, in line with its participation policy. Outcomes from patient feedback were documented in action plans.

Recommendation

The service should develop a programme of audits to cover key aspects of care, treatment and record keeping, including patient care records. Audits should be documented and improvement action plans implemented.

Action taken

Although we saw evidence of some audits being carried out, there was no process or plan in place to demonstrate the frequency of audits taking place such as an audit programme. This recommendation is reported in Domain 5 (Planning for quality) (see recommendation f on page 20).

Recommendation

The service should have all policies and procedures immediately available in the clinic.

Action taken

All policies and standard operating procedures were available to view on the day of inspection. This information was contained in a folder in the reception area.

Recommendation

The service should clearly record the meaning of annotations on photographs.

Action taken

Patient care records reviewed on the day of inspection contained information on the meaning of annotations on all photographs taken before and after treatments for patients.

Recommendation

The service should develop and implement a quality improvement strategy.

Action taken

The service had still not developed a quality improvement plan. This recommendation is reported in Domain 5 (Planning for quality) (see recommendation g on page 20).

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 announced inspection to House of Ikigai on Wednesday 30 August 2023. This service was previously known as Smile with Kev. We spoke with two members of staff, including the service manager, who was also the main practitioner. We received feedback from 14 patients through an online survey we had asked the service to issue to its patients for us before the inspection.

Based in Dunfermline, House of Ikigai is an independent clinic providing non-surgical treatments.

The inspection team was made up of one inspector.

What we found and inspection grades awarded

For House of Ikigai, the following grades have been applied.

Direction	*How clear is the service's vision and purpose and how supportive is its leadership and culture?*
Summary findings	**Grade awarded**
The service's leadership structure and governance framework helped deliver safe and effective person-centred care in line with best practice. Staff felt valued, respected and supported. The service had a clear vision and mission statement which was available on its website. Staff meetings should take place on a regular basis.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patients were fully informed about treatment options and involved in all decisions about their care. Patient feedback was used to help continually improve the service. Clear procedures were in place for managing complaints. Medication was in-date and checked regularly. Maintenance contracts were in place. Healthcare Improvement Scotland's notification guidance must be followed. The audit programme should be further developed and expanded. All appropriate background safety checks must be carried out as part of the recruitment process. Certain key policies should be developed, and all policies should reflect current Scottish guidance. A risk register must be produced and implemented in the service.	✓ Satisfactory
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The environment was clean and well equipped. Patients reported good levels of satisfaction and told us they felt safe in the service, and that the service was clean and tidy. Patient assessments were completed and signed consent to treatment forms were in place. However, information about patients' GP, next of kin or emergency contact must be documented in patient care records, and sharing information with other healthcare professionals should also be recorded.	✓ 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: 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 Kevin Kit 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 four requirements and nine recommendations.

Direction	
Requirements	
None	
Recommendation	
a	The service should have a formal schedule of planned staff meeting dates to ensure staff can attend and can contribute in advance to the agenda (see page 13). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Implementation and delivery	
Requirements	
1	The provider must ensure that all healthcare professionals employed in the service are not included on the adults' list in the Protection of Vulnerable Groups (Scotland) Act 2007 (see page 18). Timescale – immediate *Regulation 9(2)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
2	The provider must notify Healthcare Improvement Scotland of specific events that occur in its premises, as required in Healthcare Improvement Scotland's notification guidance (see page 18). Timescale – immediate *Regulation 5(1)(b)* *The Healthcare Improvement Scotland (Applications and Registration) Regulations 2011*
3	The provider must develop, implement and maintain a risk register to ensure effective oversight of how the service is delivered (see page 20). Timescale – immediate *Regulation 3(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
b	The service should develop and implement an information management policy to ensure the confidentiality of patient and staff information (see page 18). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
c	The service should develop a chaperone policy to ensure patient safety in the service (see page 19). Health and Social Care Standards: My support, my life. I am fully involved in all decisions about my care and support. Statement 2.8

Implementation and delivery (continued)	
Recommendations	
d	The service should ensure that all policies reflect Scottish legislation and best practice guidance (see page 19). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
e	The service should ensure the correct details for patients to complain to Healthcare Improvement Scotland are included on its website (see page 19). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.8
f	The service should develop a more detailed programme of regular audits to cover key aspects of care and treatment such as infection prevention and control, the clinic environment and patient care records. Audits must be documented and improvement action plans implemented (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19 This was previously identified as a recommendation in the June 2019 inspection report for Smile with Kev.
g	The service should develop and implement a quality improvement plan to formalise and direct the way it drives and measures improvement (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19 This was previously identified as a recommendation in the June 2019 inspection report for Smile with Kev.

Results	
Requirement	
4	The provider must ensure patients' GP details, next of kin or emergency contact details are documented appropriately in patient care records. If the patient refuses to provide this information, this should also be documented (see page 22). Timescale – immediate *Regulation 4(1)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
h	The service should record patient consent for sharing information with their GP and other medical staff in an emergency, if required, in patient care records (see page 23). Health and Social Care Standards: My support, my life. I am fully involved in all decisions about my care and support. Statement 2.14
i	The service should ensure it carries out a psychological assessment on all patients to ensure their expectations are managed appropriately (see page 23). Health and Social Care Standards: My support, my life. I experience high quality care and support that is right for me. Statement 1.12

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

Kevin Kit, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at House of Ikigai for their assistance during the inspection.

3 What we found during our inspection

Key Focus Area: Direction

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

Our findings

The service's leadership structure and governance framework helped deliver safe and effective person-centred care in line with best practice. Staff felt valued, respected and supported. The service had a clear vision and mission statement which was available on its website. Staff meetings should take place on a regular basis.

Clear vision and purpose

The service's vision and purpose was to offer and provide the best possible treatments to its patients in a safe and secure environment. There was clearly stated information about the service's vision available on its website. The aims and objectives of the service were to ensure an all-encompassing mindful medical approach leading to agreed realistic outcomes for all patients.

The service had identified a number of key performance indicators, including encouraging a patient-centred approach, patient reviews and continuous professional development of its staff members. These key performance indicators were measured, and results were then shared with patients online using various dedicated service online platforms.

The service produced an annual report identifying actions and timelines. We were told this report will be reviewed in December 2023 to ensure the service maintains a cycle of continuous improvement.

- No requirements.
- No recommendations.

Leadership and culture

The service had adequate staff numbers who were suitably qualified to carry out all treatments offered to patients. This included a number of clinical (dental and nursing) healthcare professionals, some of whom were independent nurse prescribers.

The service had an effective leadership structure with well-defined roles, responsibilities and support arrangements. All staff reported to the service manager (main practitioner). The service manager met with individual staff members every day and as a group to give updates on any changes to clinics, staffing or resources, and to review workload.

We saw evidence of meetings taking place where all members of staff attended. Set agendas for these meetings included staff feedback and ideas, opportunities for training and learning, and action plans from audits. Minutes of meetings were documented and included identifying staff members who would be responsible for taking forward any actions or issues noted.

Staff surveys had recently been introduced due to an increase in the number of staff employed. Survey results showed staff were satisfied at work, had an appropriate work/life balance, felt supported and valued by senior management, and felt able to offer recommendations and suggestions for how to improve the service. Results of this survey were discussed with staff at the daily huddles and monthly 'touchpoint' meetings.

Staff members were consulted on all decisions about improving the service. We saw evidence of improvements made as a direct result of staff feedback, for example a secure online messaging app for staff had been introduced to help promote communication among the team.

What needs to improve

The service manager held 'touchpoint' meetings with staff, usually on a monthly basis. However, there was no formal programme or advance schedule in place for these meetings as the dates and times were arranged on an ad hoc basis (recommendation a).

- No requirements.

Recommendation a

- The service should have a formal schedule of planned staff meeting dates to ensure staff can attend and can contribute in advance to the agenda.

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

Patients were fully informed about treatment options and involved in all decisions about their care. Patient feedback was used to help continually improve the service. Clear procedures were in place for managing complaints. Medication was in-date and checked regularly. Maintenance contracts were in place.

Healthcare Improvement Scotland's notification guidance must be followed. The audit programme should be further developed and expanded. All appropriate background safety checks must be carried out as part of the recruitment process. Certain key policies should be developed, and all policies should reflect current Scottish guidance. A risk register must be produced and implemented in the service.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The service had a comprehensive website with detailed information on various aspects of the service, including the range of treatments available. Patients could book appointments with individual practitioners through the service's website or social media app, or could telephone the service for appointments and any enquiries.

The service encouraged patients to leave feedback and/or suggestions using a variety of methods, in line with its participation policy. For example, feedback was collected both formally and informally, including verbal feedback, bespoke patient questionnaires emailed to patients routinely 24-48 hours after receiving treatment, and through online apps the service had developed. This helped to encourage patients to participate in the future direction of the service. This information was reviewed every month by the service manager using a service specific digital tool developed to analyse the collected data and promote continuous assessment of the service and care delivered. Accompanying action plans were then developed, identifying areas of possible, probable and actual changes taking place in the service. Feedback was shared with staff during daily huddles or at the monthly touchpoint meetings.

This information was also available on the service's website detailing any changes that had taken place as a result of feedback. For example, following suggestions from patients, the option to have a follow-up review appointment using an online video messaging service had been introduced. Patient testimonials were also available on the service's website.

We were told patient feedback had also led to:

- changes being made to the reception area, providing a more comfortable and relaxing environment with comfortable seats, pleasant reading materials and all patients greeted with a complementary glass of water on arrival
- a revised appointment scheduling process allowing patients to book appointments independently accommodating patient preferences as to what member of staff would carry out their treatments, and
- an increased number of resources on the website for pre-, during and post-treatments, and an interactive webchat function.

We noted changes were made to patient appointment times to allow staff time to prepare the room and have necessary breaks, as well as changes to the lengths of working days for staff to ensure a life work balance. These changes were driven by staff and were formally documented in the minutes of staff meetings and in staff records.

- No requirements.
- No recommendations.

Quality improvement

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

A clear governance structure was in place with the majority of policies setting out ways of working and supporting the service to deliver safe, compassionate, person-centred care, in line with current guidance and guidelines. We saw policies and procedures in place for:

- medicine management
- health and safety
- emergency arrangements
- infection prevention and control, and
- safeguarding (public protection).

All accidents and incidents were recorded on the service's risk management system. These were reviewed and investigated in line with the service's policies and procedures. During the inspection, we noted the service had not experienced any incidents or accidents that should have been notified to Healthcare Improvement Scotland.

Patients routinely received information on how to make a complaint following their treatment. This information was also available on the service's website and made clear that patients could contact Healthcare Improvement Scotland at any point of the complaints process. All complaints were entered onto the service's risk management system. We saw evidence that complaints were well managed, with complaints and lessons learned discussed at the weekly management meetings and disseminated to staff. Staff had received training in complaints handling.

Duty of candour is where healthcare organisations have a professional responsibility to be honest with patients when something goes wrong. Staff we spoke with fully understood their responsibilities for this and the service had published an annual duty of candour report on its website.

Staff were also aware of the service's safeguarding policy, had received training and knew the procedure for reporting concerns about patients at risk of harm or abuse.

The service had a medicines management policy to ensure safe management processes were in place for ordering, storing, prescribing and administering all medicines. We noted the service only used medication that did not need to be kept in a medical refrigerator.

Arrangements were in place to make sure that staff could quickly support patients in the event of a medical emergency. This included mandatory staff training and the availability of emergency medication and first aid supplies kept in an emergency bag.

Formal consultations with patients were carried out on their first visit to the service, with an appropriate cooling-off period included to allow them time to consider the treatment options. If patients experienced an adverse event following treatment, they could contact clinical staff by telephone or by social media app outwith clinic times and emergency appointments were offered, if required. This information was detailed in the aftercare leaflets and discussed with patients during and after treatments.

Patient care records were kept electronically on designated, secure equipment. Only staff issued with passwords could access patient information. This ensured the confidentiality of patient details.

The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights). A dedicated data protection officer was responsible for information governance to make sure the service complied with data protection regulations.

The service employed an external human resource company which was responsible for the safe recruitment of staff to the service, in line with the service's processes and procedures. These checks included staff members' ID, professional indemnity insurance, ability to work in the United Kingdom, qualifications and fitness to practice.

All new members of staff underwent an induction programme and were issued with a staff handbook to complete. This contained service-specific information about:

- the service's vision, mission, aims and objectives
- policies and procedures
- annual leave and sick leave arrangements
- staff training, and
- learning and development opportunities.

On completion of this handbook, the service manager would formally review and agree staff competence. Staff files were kept on an electronic database and were only accessible to the service manager and the individual staff member who was responsible for updating their own file, as required.

The service kept up to date with changes in legislation and best practice through training sessions, peer group meetings, seminars and membership of an online aesthetic complications group. We were told the service manager mentored aesthetic practitioners from other services.

All members of staff were checked to ensure they had up-to-date registration with their professional regulatory organisations.

What needs to improve

The recruitment process carried out by the external human resource company included the majority of necessary background and safety checks, such as proof of identification, professional registration review and revalidation dates.

However, there was no evidence of a Protecting Vulnerable Group (PVG) check being carried out for staff recently employed by the service (requirement 1).

Although the service manager told us they were aware of the notification process to Healthcare Improvement Scotland, the service had recently changed its legal entity from an individual practitioner to a limited company. However, they had not submitted a notification to Healthcare Improvement Scotland as the independent healthcare regulator (requirement 2).

There was no evidence of an information management policy (recommendation b).

There was no evidence of a chaperone policy (recommendation c).

Although the service updated its policies every 2 years, or in response to changes in national guidance and best practice, we noted some policies did not reflect the correct Scottish legislation or best practice. For example, the infection prevention and control policy did not reference Health Protection Scotland's *National Infection Prevention and Control Manual* or Healthcare Improvement Scotland's *Healthcare Associated Infection (HAI) Standards (2022).* The safeguarding policy did not reference the Adult Support and Protection (Scotland) Act 2007 (recommendation d).

Although information about making a complaint was available on the service's website, the details for patients who wish to make a complaint to Healthcare Improvement Scotland was incorrect (recommendation e).

Requirement 1 – Timescale: immediate

- The provider must ensure that all healthcare professionals employed in the service are not included on the adults' list in the Protection of Vulnerable Groups (Scotland) Act 2007.

Requirement 2 – Timescale: immediate

- The provider must notify Healthcare Improvement Scotland of specific events that occur in its premises, as required in Healthcare Improvement Scotland's notification guidance.

Recommendation b

- The service should develop and implement an information management policy to ensure the confidentiality of patient and staff information.

Recommendation c

- The service should develop a chaperone policy to ensure patient safety in the service.

Recommendation d

- The service should ensure that all policies reflect Scottish legislation and best practice guidance.

Recommendation e

- The service should ensure the correct details for patients to complain to Healthcare Improvement Scotland are included on its website.

Planning for quality

The service had an identified procedure for reviewing risks in the service. This involved identifying, assessing and mitigating risks promoting a culture of safety and continuous improvement. Risk assessments included:

- clinical procedures
- use of equipment
- staff training
- patient interactions, and
- data management.

The service manager was the designated risk officer and was responsible for overseeing and co-ordinating the risk reporting process.

Maintenance contracts for fire safety equipment, the fire detection system and the ventilation system were up to date. Water testing and fire safety checks were monitored regularly. A fire risk assessment was in place. We saw that the service had clinical and domestic waste containers and an appropriate clinical waste contract was in place.

We saw evidence of some audits being carried out in the service, such as medicine management. These audits showed high compliance rates. Action plans were produced for any identified areas of improvement to ensure any actions identified were addressed and rectified and/or completed within set timeframes.

The service had a quality assurance officer who was responsible for producing the 'Transforming care through continuous improvement' document. This outlined the procedures, responsibilities and guidelines for maintaining and

enhancing the quality of services provided to patients, with a focus on patient safety, satisfaction, and adherence to medical and ethical standards. This included regular audits, assessments and evaluations.

What needs to improve

While the service had an identified process for risk management, there was no evidence of a supporting risk register. This would help the service to ensure appropriate processes were in place to help manage any risks identified (requirement 3).

There was no process or plan in place to demonstrate the frequency of audits taking place such as an audit programme. This had been identified as a recommendation at a previous inspection in June 2019. Audits taking place could include infection prevention and control, the clinic environment and patient care records (recommendation f).

A quality improvement plan had still not been implemented. This would help the service to structure and record its improvement processes. This had been identified as a recommendation at a previous inspection in June 2019 (recommendation g).

Requirement 3 – Timescale: immediate

- The provider must develop, implement and maintain a risk register to ensure effective oversight of how the service is delivered.

Recommendation f

- The service should develop a more detailed programme of regular audits to cover key aspects of care and treatment such as infection prevention and control, the clinic environment and patient care records. Audits must be documented and improvement action plans implemented.

Recommendation g

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

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 environment was clean and well equipped. Patients reported good levels of satisfaction and told us they felt safe in the service, and that the service was clean and tidy. Patient assessments were completed and signed consent to treatment forms were in place. However, information about patients' GP, next of kin or emergency contact must be documented in patient care records, and sharing information with other healthcare professionals should also be recorded.

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

The clinic environment was clean and well equipped. Equipment used in the service was clean, well maintained and serviced regularly, where required. All equipment used was single use and disposed of in line with current infection prevention and control guidance. Patients who responded to our online survey also told us they felt safe in the environment and the cleaning measures in place helped reassure them that their risk of infection in the service was reduced. All patients stated the clinic was clean and tidy.

Staff knew which products to use to clean the general environment, with an appropriate chlorine-based solution being used on sanitary fittings. Cleaning schedules were in place for the clinical rooms, which we saw that staff had fully and accurately completed.

Patients who responded to our online survey told us they were extremely satisfied with the care and treatment they received from the service. Some comments we received included:

- 'It is patient focused.'
- 'The manager and his team are effective at explaining the treatment, expected outcomes and side effects.'
- 'There were additions that I've not had elsewhere eg time to relax under a red light afterwards and exceptional aftercare. Staff are really concerned for your welfare.'
- 'I felt very looked after and cared for. I enjoyed my treatment and looking forward to my next visit soon.'

The five patient care records we reviewed showed that patients received a face-to-face consultation. This consultation included gathering information about their expectations before any treatments were administered with an appropriate cooling-off period. Patient and staff members' signatures were visible on all patient care record documentation, including consenting to treatments.

The staff files we accessed contained information on mandatory training, supervision sessions and appraisals with evidence of development opportunities identified. We also saw evidence of additional role-specific online training for staff members.

What needs to improve

While comprehensive assessments and consent to treatment were recorded in the patient care records, the service did not record patients' GP, next of kin or emergency contact details (requirement 4).

Patient care records did not contain information relating to the patient giving consent to share their details with other healthcare professionals in the event of an emergency situation (recommendation h).

There was no evidence to suggest patients received a psychological assessment by practitioners before their treatments were carried out (recommendation i).

Requirement 4 – Timescale: immediate

- The provident must ensure patients' GP details, next of kin or emergency contact details are documented appropriately in patient care records. If the patient refuses to provide this information, this should also be documented.

Recommendation h

- The service should record patient consent for sharing information with their GP and other medical staff in an emergency, if required, in patient care records.

Recommendation i

- The service should ensure it carries out a psychological assessment on all patients to ensure their expectations are managed appropriately.

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

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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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