Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Kings Park Hospital, Stirling

Service Provider: Circle Health Group Limited

24–25 October 2023

NHS SCOTLAND

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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 13 April 2021

Recommendation

The service should ensure that the works identified in its refurbishment plan are completed in the documented timescales.

Action taken

We saw evidence that the initial refurbishment plan had been completed in the documented timescales.

Recommendation

The service should continue to review its cleaning schedules and assurance systems to make sure patient equipment is always clean and ready for patient use.

Action taken

We saw that cleaning schedules were in place and that systems and processes including audits were in place to make sure that patient equipment was clean and ready for use. We saw that all patient equipment was cleaning and ready for use.

Recommendation

The service should follow the guidance in Health Protection Scotland's National Infection Control Manual for the recommended product for cleaning sanitary fittings.

Action taken

We observed that staff were cleaning sanitary fittings with an appropriate chlorine solution.

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 Kings Park Hospital on Tuesday 24 and Wednesday 25 October 2023. 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 Stirling, Kings Park Hospital is an independent hospital providing non-surgical and surgical treatments.

The inspection team was made up of four inspectors, one of whom was observing.

What we found and inspection grades awarded

For Kings Park 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 and purpose, with a comprehensive strategy and defined objectives with measurable key performance indicators for continuous improvement. Leadership is visible, supportive and staff felt valued and supported. Governance arrangements were in place and accessible. Staff understood the governance arrangements.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patient experience was regularly assessed and used to continually improve how the service was delivered. 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. The effectiveness of improvements made as a result of patient feedback should be evaluated. The service should implement clinical supervision for trained staff.	✓✓ Good
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The care environment and patient equipment was 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. Cleaning checklists in theatre should record that sinks are cleaned 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 Limited to take after our inspection

The actions that Healthcare Improvement Scotland expects the independent healthcare service to take are called requirements and recommendations.

- **Requirement:** A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the National Health Services (Scotland) Act 1978, regulations or a condition of registration. Where there are breaches of the Act, regulations or conditions, a requirement must be made. Requirements are enforceable.
- **Recommendation:** A recommendation is a statement which sets out what a service should do in order to align with relevant standards and guidance.

This inspection resulted in three recommendations.

Implementation and delivery	
Requirements	
	None
Recommendations	
a	The service should monitor and evaluate improvements made as a result of patient feedback, to determine whether actions taken have led to the improvement anticipated (see page 14). 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 (continued)	
b	The service should implement a formal process for clinical supervision of trained staff (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 3.14

Results	
Requirements	
	None
Recommendation	
c	The service should record that cleaning checklists include cleaning products and processes for clinical hand wash sink that reflect best practice guidance (see page 24). 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 Kings Park 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 and purpose, with a comprehensive strategy and defined objectives with measurable key performance indicators for continuous improvement. Leadership is visible, supportive and staff felt valued and supported. Governance arrangements were in place and accessible. Staff understood the governance arrangements.

Clear vision and purpose

We saw that the service's vision and values statement informed its strategic plan for 2023–2026. Kings Park Hospital is part of Circle Health Group, its provider. The vision was a statement of how it would provide care to patients. Staff we spoke with understood the values, which were clearly stated. The vision and values informed the objectives that had been clearly laid out in the strategic plan. The document also set out its key performance indicators for the following year and direction over the next 3 years. The plan was comprehensive and set out clear and measurable indicators. We saw that the senior management team (SMT) and the provider's senior leadership team regularly evaluated the indicators. These were separated into four main categories:

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

Each category had specific, measurable objectives. Each objective was formally evaluated and any ongoing actions were identified, which helped to demonstrate a culture of continuous improvement. Reports were produced every month, documenting how well the service was performing against each of the objectives. This report was submitted to the clinical governance group.

- No requirements.
- No recommendations.

Leadership and culture

The service had a highly skilled staffing resource made up of:

- catering staff
- healthcare support workers
- house-keeping staff
- laboratory staff
- medical staff
- pharmacy staff
- physiotherapists, and
- registered nurses.

The hospital had an effective leadership structure in place through its SMT, which consisted of the:

- director of operations
- head of clinical services
- hospital director, and
- heads of departments.

The SMT had well-defined roles, responsibilities and support arrangements. This helped to provide assurance of safe and consistent patient care and treatment. The hospital's governance framework detailed all the committees, which included:

- medical advisory committee (MAC)
- clinical governance committee
- quality forum and,
- heads of department meeting.

The governance structure also set out how often the groups met (monthly, every 3 months and every 6 months). We saw a hospital meeting schedule spreadsheet, which showed all the internal groups and how often they met (monthly and every 3 months). From reviewing recent agendas and minutes for all these meetings, we saw good representation from all staff groups.

The hospital provided a leadership programme through the provider organisation to encourage staff empowerment. This included online- and classroom-based training and had recently started up again after COVID-19

restrictions had been lifted. At the time of our inspection, two nurses were completing the leadership course.

A daily huddle took place which we observed during the inspection. A wide range of staff including heads of departments, senior management and estates, radiology and physiotherapy attended. They discussed staffing, capacity and flow, any incidents that had occurred since the last huddle, training, as well as staff responsible for the blood fridge and resuscitation. Staff had an opportunity to raise and discuss patient concerns during the daily staff safety huddle and we saw that the service addressed concerns highlighted from feedback daily.

A 'freedom to speak up' system had been introduced, where staff could speak with a nominated freedom-to-speak-up 'guardian' in confidence if they had any concerns. Clinical staff also had access to link nurses in nominated 'champion' roles, including those for:

- cognitive impairment
- infection control
- moving and handling, and
- pain management.

Clinical staff were encouraged to take responsibility for promoting best practice and improvements in these areas. Staff we spoke with were clear about their roles, responsibilities and how they could raise any concerns they had.

- No requirements.
- No recommendations.

Key Focus Area: Implementation and delivery

Domain 3: Co-design, co-production	Domain 4: Quality improvement	Domain 5: Planning for quality
How well does the service engage with its stakeholders and manage/improve its performance?		

Our findings

Patient experience was regularly assessed and used to continually improve how the service was delivered. 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.

The effectiveness of improvements made as a result of patient feedback should be evaluated. The service should implement clinical supervision for trained staff.

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 the service was delivered. Staff made a point of calling patients after their treatment to find out how they were and to provide an opportunity to raise any issues at the same time. Information leaflets were available for patients throughout the hospital and information boards. Patients were given a feedback survey to complete when discharged. We saw that patients could leave feedback on the service website, which the hospital then responded to directly. Feedback was analysed every month and results were shared at staff meetings. We looked at a selection of surveys the service had carried out, which showed high levels of patient satisfaction, especially in patient care and naming individual staff members for care and attention.

'You said, we did' boards were displayed through the hospital, detailing examples of improvements made as a result of feedback. For example:

- 'You Said: I wasn't sure who to contact after discharge.'
- 'We Did: We reviewed the discharge process to ensure that every patient leaving the hospital is equipped with the correct written information or whom to contact when the hospital is both open and closed.'

- ‘You Said: I wasn’t aware of additional charges for my outpatient minor procedure.’
- ‘We Did: We created fixed price packages to ensure that every patient is fully aware of the cost of their procedure and be given the assurance that there will not be additional charges added.’

A staff survey called ‘b-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 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.

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. They also told us they could attend leadership meetings and forums if they wished. This made sure staff felt part of the hospital and could discuss suggestions for improvement.

The hospital recognised its staff in a variety of ways. This included cards acknowledging positive feedback from patients and celebrating staff birthdays as well as the service bringing in pizza and ice cream for staff. A ‘long service award’ was also given to staff that had worked in the hospital for 5 years or more. Kings Park Hospital also recognised an employee of the month. Recipients were given a certificate of recognition, a voucher to spend and had their photo displayed in the clinical areas for patients to see. 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.

The hospital recognised the importance of supporting charities. We saw that many staff regularly participated in fundraising individually or as part of a team to draw attention to important causes, such as neurodiversity and cancer.

What needs to improve

We saw evidence to demonstrate that the service listened to feedback and acted on any issues raised as a result, as summarised in the ‘you said, we did’ boards. However, this information did not include an evaluation of how effective the improvements had been (recommendation a).

- No requirements.

Recommendation a

- The service should 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.

Comprehensive policies and procedures set out the way the service was delivered and supported staff to deliver safe, compassionate, person-centred care. 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 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.

Incidents were recorded and managed through an electronic incident management system. Each one was reviewed and reported in the:

- departmental team meetings
- heads of department forum
- medical advisory committee meetings, and
- clinical governance meetings.

The outcomes of the discussions from these meetings were fed back through regular staff meetings. Any incidents that an individual member of staff had been involved in were also discussed at their appraisals. Any trends identified were escalated for review to the hospital director, to explore training needs and practicing privileges.

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 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 published a duty of candour 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 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).

The provider and service was 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.

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 they were clear about what to expect after discharge. Staff also contacted patients over the phone, usually 24–48 hours after discharge to check how they felt and address any concerns they might have at that time.

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 during the daily huddle to respond to medical emergencies and 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 proactively managed its staffing compliment to help make sure that an appropriate skill mix and safe staffing was always provided.

The hospital was actively trying to recruit to vacancies. We saw that the hospital used minimal agency and bank staff, only when clinically required to cover staffing gaps to maintain safe and effective staffing levels. As well as this, the hospital's future-proofing approach 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 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 employed staff had completed an induction, which included an introduction to key members of staff in the hospital 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.

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 senior management 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. We were told that many of the staff had completed train the trainer courses and were themselves able to then train staff when required. Examples of this were training in:

- basic life support
- intravenous administration
- medical devices, and
- phlebotomy.

The infection control and prevention nurse also delivered on-site training to staff. Staff told us time for training was usually protected.

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.

We were told that staff attended ward meetings and minutes of these were available in written form and sent in email to all staff. Staff were encouraged to attend these meetings and access was available in person or virtually to allow as many staff as possible to attend. We saw that attendance had increased and been sustained since a combination of the two meeting formats had been introduced.

What needs to improve

Staff had yearly appraisals carried out. While the service was investigating how to introduce clinical supervision for trained staff, we saw no formal process in place for implementing clinical supervision at the time of our inspection (recommendation b).

We saw that the provider was introducing a new corporate 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 were told and 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.

- No requirements.

Recommendation b

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

Planning for quality

The service's risk management process included corporate and clinic risk registers. This was evident in all its risk assessments, risk registers, auditing and reporting systems. These detailed actions taken to mitigate or reduce risk. The service carried out a number of risk assessments to help identify and manage risk. These included:

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

The service 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.

Circle Health Group Ltd had developed a quality and safety improvement programme called the 'circle operating system' (COS), which was used in the service. We were told that this was a process to make sure all staff were working in an evidence-based approach to care and we saw this included the service audit and review programmes. The audit programme had a variety of audits, including checking the process of patient discharge and capturing the patient's experience in the service. Safety audits included clinical review of the management of certain clinical aspects, such as sepsis and fasting before surgery.

The COS programme had systems in place to help staff consider the quality of service provided at all times. This aimed to make sure that, as part of the daily activities in the service the patient experience was addressed, staff had a voice and staff could meet with specific patient concerns. COS had four aspects it covered:

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

As part of COS, senior staff told us that any member of staff regardless of grade could speak out safely about any practice if they had concerns. This meant that the process was stopped while it was reviewed. COS also allowed staff time to meet, reflect on the patient experience and learn from it. We saw the processes of COS were included in the agendas of staff safety briefs, senior management team meetings and the corporate board meetings. All staff we spoke with during our inspection were enthusiastic about COS.

Staff had opportunities to meet to de-brief after any incident or error that occurred.

The service had a detailed audit programme which helped make sure the service delivered consistent safe care and treatment for patients and identified any areas for improvement. All 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 infection control and prevention nurse for the service carried out extensive audits in all departments and supported areas with any actions arising as a result.

The audit programme included:

- equipment, including the emergency trolley
- health and safety
- infection prevention and control
- medication (including controlled drugs)
- national early warning system (NEWS), and
- patient care records.

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

The theatre department was in the process of undergoing accreditation through the Association for Perioperative practice to meet the standards reflecting the commitment to high levels of perioperative care. The theatre department had received one visit and a final visit from the assessors had been planned. Once successful in obtaining this accreditation, it planned to apply for accreditation

from the Joint Advisory Group on GI Endoscopy. We will follow this up at future inspections.

The quality improvement plan took account of the service's objectives, and included short-term goals and longer-term projects. For example, a short-term goal was implementation of local training programmes for all staff in the hospital. An example of a longer-term project was increasing the hospital consultant base for specialties to give patients greater choice.

- 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 was 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.

Cleaning checklists in theatre should record that sinks are cleaned 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:

- activities
- composition
- incidents and accidents, and
- staffing details.

The service submitted an annual return, as requested.

As part of the inspection process, we ask the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Assurance Framework and ask the service to tell us what it does well, what improvements could be made and how it intends to make those improvements. The service submitted a comprehensive self-evaluation.

We saw that safe, person-centred care was delivered in a clean hospital environment and theatre suite with equipment that was fit for purpose and regularly maintained.

The equipment we saw was clean, well maintained and we saw that the hospital used a labeling 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. Housekeeping staff cleaned the service regularly and checks were carried out throughout the day to identify any issues and actioned promptly.

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

- assessment
- consent, including the risks and benefits of each treatment offered, and
- consultation
- treatment, and
- aftercare

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 service, we followed a patient's journey from the ward through theatre, recovery room and then to the high dependency unit. 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 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 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.

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:

- all staff felt there was positive leadership at the highest level of the organisation
- the majority of staff felt they could influence how things were done in the hospital
- the majority of staff staff felt their line manager took their concerns seriously, and
- the majority of staff staff 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:

- 'I believe the entire hospital team strive to provide a first rate service to our patients.'
- 'Works cohesively as team for the best outcome of their staff and their patients alike.'
- 'We ensure we put our patients first and go above and beyond to meet their expectations.'
- 'Delivers excellent patient care.'
- 'Makes time to listen to your concerns.'

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

- 'Always treated dignity and respect- they could not do more for me- absolutely fantastic.'
- 'All the nurses have introduced themselves when meeting me.'
- 'Environment cleanliness has been excellent.'
- 'Attended Pre-op and the staff couldn't have been nicer.'
- 'Everything was explained thoroughly, through from the pre-op to the aftercare after surgery.'
- 'Could not have been treated better- ask for something and it's done.'

What needs to improve

We found that in theatres, the cleaning checklists did not record that clinical hand wash sinks were being cleaned in line with national guidance (recommendation c).

During our inspection, we observed that a trolley stacked with linen did not have a cover in place. We observed patients touching it when they passed it. We raised this with management who took immediate action to store this trolley and we are aware that a new cover linen trolley has been ordered. We will follow this up at future inspections.

- No requirements.

Recommendation c

- The service should record that cleaning checklists include cleaning products and processes for clinical hand wash sink that reflect best practice 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

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