Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Cygnet Wallace Hospital, Dundee

Service Provider: Cygnet (OE) Limited

4–5 December 2023

NHS SCOTLAND

Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Advisor on 0141 225 6999 or email his.contactpublicinvolvement@nhs.scot

First published April 2024

www.healthcareimprovementscotland.org

Contents

1 Progress since our last inspection

What the provider had done to meet the requirements we made at our last inspection on 1–2 March 2022

Requirement

The provider must ensure its infection prevention and control policy is in line with Scottish guidance, in particular Healthcare Improvement Scotland's Healthcare Associated Infection (HAI) Standards (2015) and Health Protection Scotland's National Infection Prevention and Control Manual.

Action taken

The infection prevention and control policy had now been updated in line with current infection prevention and control national guidance. **This requirement is met.**

Requirement

The provider must ensure that all emergency equipment is checked regularly.

Action taken

We saw that a process was now in place to ensure all emergency equipment was checked regularly. **This requirement is met.**

What the service had done to meet the recommendations we made at our last inspection on 1–2 March 2022

Recommendation

The service should review how it implements the patient participation policy so that patients and their relatives feel heard.

Action taken

We saw the service now actively engaged with patients and their relatives, where appropriate. Patients and their relatives were involved in decisions about their individual care and the wider service. This included weekly community meetings, patient feedback, individual care planning, patient participation in audits, patient and carer surveys, and families being invited to activity days. Patients we spoke with told us they felt listened to.

Recommendation

The service should comply with national guidance to make sure that the appropriate cleaning products are used for the cleaning of all sanitary fittings, including clinical hand wash sinks.

Action taken

We saw the service was now using the correct chlorine-based cleaning products for sanitary fittings in line with national guidance.

Recommendation

The service should ensure that all surplus supplies are removed from drawers in the treatment room.

Action taken

We found the treatment room was now mostly organised and tidy.

Recommendation

The service should ensure that the front page of the controlled drug register is kept up to date.

Action taken

We found that the front page of the controlled drug book was still not being kept up to date. This recommendation is reported in Domain 4 (Quality improvement) (see recommendation a on page 26).

Recommendation

The service should offer staff the opportunity to attend de-briefs following incidents.

Action taken

From the four incidents we reviewed, we saw that only two included information about staff being given an opportunity to attend debriefs. This recommendation is reported in Domain 4 (Quality improvement) (see recommendation b on page 26).

Recommendation

Staff should be identified for key roles, such as fire warden and immediate life support response for each shift and document this suitably.

Action taken

Staff responsible for roles such as fire warden and life support response were now identified and named in the daily communication book and morning staff handover. This information was available and accessible to all staff working in the service.

Recommendation

The service should ensure that all staff, including agency staff, have access to, and can demonstrate competence in, use of the electronic clinical information system.

Action taken

All staff were given log-in details to enable them to securely access the service's electronic clinical information systems. Agency staff were now also provided with a temporary account during their induction period.

Recommendation

The service should ensure that audit findings are communicated to staff and action plans clearly show when they have been completed.

Action taken

An online quality improvement portal included audit findings and action plans which staff could access.

Recommendation

Observation records should be completed in full, including end-of-shift sign off from the nurse in charge in line with service policy.

Action taken

An audit for completed observations was carried out twice a week. However, from the observations records we reviewed, we found these were still not being consistently and fully completed. This recommendation is reported in Domain 7 (Quality control) (see recommendation d on page 32).

Recommendation

The service should ensure it is clearly indicated how frequently a patient requires physical health monitoring and the reasons for this.

Action taken

While patients had a physical observation record and we saw physical observations were monitored, it was not clearly identified how often a patient required physical health monitoring and the reasons why. This recommendation is reported in Domain 7 (Quality control) (see recommendation c on page 32).

Recommendation

The service should ensure that all confidential patient care records are stored appropriately in line with information governance policy.

Action taken

We found that confidential patient information was now stored securely and in line with the service's information governance policy.

Recommendation

The service should ensure that all staff, including temporary and agency staff, receive a suitable induction before working in the hospital and this is clearly documented.

Action taken

A specific induction programme had been introduced for agency staff, which included competency protocols. This information was recorded on staff files. New staff completed an induction booklet and 'shadowed' a permanent member of staff during the on-site orientation period.

Recommendation

The service should ensure that it engages effectively with staff so they are meaningfully involved in developing and improving the service.

Action taken

Regular staff meetings had been introduced as well as 'formulation sessions' to ensure staff were involved in shaping how care was delivered and how the service developed.

Recommendation

The service should ensure that staff of all roles and grades are provided with regular supervision to support them in their roles.

Action taken

A programme of regular supervision sessions was now held with staff and these were documented on an online system.

Recommendation

The service should reintroduce staff meetings with an agenda, minutes, actions recorded and be held at a time which would maximise attendance.

Action taken

Formal staff meetings now took place every month with a set agenda and documented minutes. These included identifying people to take forward any actions. Meetings could be attended either online or in person.

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 Cygnet Wallace Hospital on Monday 4 and Tuesday 5 December 2023. We spoke with several staff and two patients during the inspection. We received feedback from four members of staff through an online survey we had asked the service to issue for us during the inspection.

Based in Dundee, Cygnet Wallace Hospital is an independent private psychiatric hospital providing specialist care for people with predominantly learning disabilities, mental health needs and autism.

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For Cygnet Wallace 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 mission statement and defined aims and objectives. Key performance indicators allowed the service to measure its performance and to ensure continuous improvement was embedded in the delivery of care. The service had a skilled and diverse staffing complement to meet the complex needs of patients. There were clear lines of reporting and for escalating concerns.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
The service had established good links with the local community, accessing various local activities and facilities. Patients were encouraged and supported with all aspects of their care, and with being involved in helping to continually improve the service. Care was patient centred and tailored to meet their individual needs. A duty of candour report was published annually. Risk assessments and audits were in place for all environmental and clinical activities. A comprehensive audit programme was in place. The complaints policy and processes were up to date and accessible to patients. Timeframes for commencement and completion of all building work must be included in the building risk assessment and risk register. The front page of the controlled drug book should be kept up to date. Staff should be offered the opportunity to attend debriefs following incidents.	✓✓ Good
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
Safer recruitment processes were followed. The majority of staff described the provider as a good employer. Patients spoke positively about their experiences, and said they felt supported by staff. Patient care records demonstrated a holistic approach to care with patients' needs regularly assessed. The environment appeared clean but was in need of redecoration. The service's programme of decoration should	✓ Satisfactory

be re-established to ensure the environment is suitably maintained. Clinical waste storage must be improved. Adequate housekeeping staffing resources must be in place to ensure the environment is kept to a good standard. Formal leave plans must be in place for patients spending time outside of the hospital grounds. Physical health monitoring charts should be fully completed.	

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 Cygnet (OE) 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 four requirements and five recommendations.

Implementation and delivery	
Requirement	
1	The provider must ensure that timeframes for commencement and completion of all building work are included in the building risk assessment and risk register (see page 28). Timescale – by 4 July 2024 *Regulation 10(2)(b)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
a	The service should ensure that the front page of the controlled drug book is kept up to date (see page 26). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19 This was previously identified as a recommendation in the March 2022 inspection report for Cygnet Wallace Hospital.
b	The service should offer staff the opportunity to attend debriefs following incidents (see page 26). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19 This was previously identified as a recommendation in the March 2022 inspection report for Cygnet Wallace Hospital.

Results	
Requirements	
2	The provider must ensure formal leave plans are in place and signed by the registered medical officer for patients spending time outside of the hospital grounds (see page 32). Timescale – by 4 July 2024 *Regulation 3(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
3	The provider must ensure adequate staffing resources are in place to provide housekeeping cover for weekends and absences (see page 32). Timescale – by 4 July 2024 *Regulation 12(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
4	The provider must ensure that external clinical waste bins are kept locked at all times (see page 32). Timescale – immediate *Regulation 3(d)(iii)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
c	The service should ensure patient care records clearly indicate how frequently a patient requires physical health monitoring and the reasons for this (see page 32). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing care and support. Statement 4.11 This was previously identified as a recommendation in the March 2022 inspection report for Cygnet Wallace Hospital.

Results (continued)	
Recommendations	
d	The service should complete and record observations in full, including end-of-shift sign off from the nurse in charge in line with the service's observation policy (see page 32). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing care and support. Statement 4.19 This was previously identified as a recommendation in the March 2022 inspection report for Cygnet Wallace Hospital.
e	The service should review and re-establish its programme of decoration and refurbishment to ensure that the environment is well maintained (see page 32). Health and Social Care Standards: My support, my life. I experience a high quality environment if the organisation provides the premises. Statement 5.22

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

Cygnet (OE) Limited, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at Cygnet Wallace 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 mission statement and defined aims and objectives. Key performance indicators allowed the service to measure its performance and to ensure continuous improvement was embedded in the delivery of care. The service had a skilled and diverse staffing complement to meet the complex needs of patients. There were clear lines of reporting and for escalating concerns.

Clear vision and purpose

The provider is a national organisation offering a wide range of health and social care services for young people and adults with mental health needs, acquired brain injuries, eating disorders, autism and learning disabilities in the UK.

The service is provided by Cygnet (OE) Limited, which has a group of similar services across the UK. Due to the nature of the service, patients can be admitted from anywhere in Scotland, and are either funded for treatment through NHS boards or local authorities. As the service is based in Dundee, its performance is monitored by both the provider and Dundee Health and Social Care Partnership, which comprises NHS Tayside and Dundee City Council.

The service also worked closely and collaboratively with a variety of local authorities and other stakeholders to ensure patients from any area were fully supported to help maintain family links.

The service's 5-year strategic plan (2022–2027) included a clearly defined purpose, vision and mission statements with aims and objectives. These were available throughout the service in an easy read format for patients to understand. The service's values were also displayed in several areas for staff, patients and visitors to view.

The strategic plan identified the key strategic priorities as key performance indicators which would allow the service to measure its performance and ensure continuous improvement was embedded in the delivery of care. These included:

- putting service users first
- delivering service excellence
- valuing and developing staff, and
- innovation for the future.

The service measured the key performance indicators using patient and carer testimonials, case studies affecting people who use the service, the services available at local level, culture (focusing on customer satisfaction), service user satisfaction, staff testimonials and freedom to speak up, learning and development, and quality of service using regulatory ratings. This information was highlighted in the provider's annual impact report using various methods, including infographic techniques to advise how this was measured and how it would drive improvement in the service. This was also discussed at senior management meetings, and was shared with staff through staff meetings and was also available on the staff intranet.

- No requirements.
- No recommendations.

Leadership and culture

The service had a diverse workforce of staff to reflect the complex needs, support and specialist interventions required of its patients. This included:

- consultant psychiatrists
- specialist speech and language therapists
- psychologist
- registered nurses
- occupational therapists, and
- support workers.

We attended one of the daily morning meetings which staff members from the multidisciplinary team attended. The meeting discussed:

- patients' presentations over the last 24-hour period
- staffing levels
- arranged training
- planned appointments or activities for patients
- incident reviews
- patients' daily risk assessments, and
- staff with designated roles for the day, for example fire warden and life support response.

Maintenance staff members also attended this meeting before any discussions about patient care took place. They advised staff on any maintenance work being carried out on that day and provided updates on any work that was ongoing.

The service had effective governance processes in place which demonstrated a supportive leadership culture with clearly defined roles and lines of accountability. Effective communication took place through clinical and line management structures to highlight any areas of concern, when required. The service manager and/or assistant service manager were routinely on site, as well as the operations director. This helped to promote visibility of senior managers to staff. The consultant psychiatrist was also the medical director for the provider's services across Scotland. This helped to keep the service up to date with the latest information from other services across the wider provider organisation.

The provider published an annual impact report describing each service's current position and its focus for the next 5 years for all services which included to:

- continue to maintain and enhance high quality person-centred care
- further expand the provision of mental health and social care services
- use data to drive improvement
- recognise staff are the most important asset, and
- demonstrate how the workforce is valued.

The service produced a monitoring report every 6 months for Dundee Health and Social Care Partnership and the provider. This focused on areas such as:

- patients (patient numbers, patient placements)
- staffing (recruitment, agency staff levels and training)
- governance and quality assurance (audits, accidents and incidents, complaints, policy reviews), and
- future developments planned for the next 6 months.

We saw agendas and minutes of monthly clinical governance meetings from October and November 2023. These included discussions such as staffing matters, including recruitment, and training and education, as well as patient/carer experience, patient progress and care plans, statutory compliance and regulation, accidents and incidents, and post-incident debriefs.

Local clinical governance meetings were attended by the regional manager. They had increased the number of face-to-face meetings with service managers across the provider's organisation since taking up post in the last year. This helped to engage staff and promote discussion around each service's successes and challenges. This helped to build relationships across the organisation. Outcomes from regional meetings fed into the operations directors' meetings and, in turn, into the managing directors' meetings.

We saw clear lines of escalation from local to corporate meetings, including action plans. We saw evidence of audit findings discussed in senior meetings. This included action plans and evidence of progress. The senior management team was responsible for the key priorities being met. Information on progress of the key performance indicators was made available from monthly clinical governance meetings and was presented at regional governance meetings which were held every 3 months. Key staff from the service attended the regional meetings to provide feedback and identify any unresolved issues. This helped with shared learning.

We saw evidence of workforce staffing levels and trainings needs and requirements being regularly reviewed. The information was documented in the 3-6 monthly meetings with the service's in-house training team, and was then added to the workforce management plan. This information was also reviewed in clinical governance meetings. A recent staff survey had shown that staff were satisfied and content at work and morale was high.

The service recognised its staff in a variety of ways. This included:

- a staff recognition scheme where staff could nominate other members of staff for going above and beyond their role
- a thank you board on the staff intranet, and
- a suggestion box in the staff room giving staff the opportunity to leave comments and suggestions.

Two members of staff had recently been nominated for the Cygnet Staff Awards where they had reached the final stage of the competition. One of the medical consultants was awarded 'Medical Educator of the Year' in 2023. Staff achievements were celebrated with details displayed in staff areas of the service.

- 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 service had established good links with the local community, accessing various local activities and facilities. Patients were encouraged and supported with all aspects of their care, and with being involved in helping to continually improve the service. Care was patient centred and tailored to meet their individual needs. A duty of candour report was published annually. Risk assessments and audits were in place for all environmental and clinical activities. A comprehensive audit programme was in place. The complaints policy and processes were up to date and accessible to patients.

Timeframes for commencement and completion of all building work must be included in the building risk assessment and risk register. The front page of the controlled drug book should be kept up to date. Staff should be offered the opportunity to attend debriefs following incidents.

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

An information pack about the hospital was available on the service's website in standard and easy-to-read format. This provided information to patients and their carers about what to expect during admission, including:

- staff working in the service
- activities available, and
- support they could expect from staff.

We were told patients and carers had the opportunity to visit the service, where appropriate, before their admission to hospital. This helped patients become familiar with the service and the environment before their admission.

All patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 and referred to the service by NHS boards throughout Scotland. Appropriate legal consent and treatment documentation was in place for all patients. Consent and capacity to consent was assessed in line with relevant legislation and best practice. An up-to-date admission, transfer and discharge policy helped to ensure that correct processes were followed throughout the patient's admission.

All patients were reviewed by the multidisciplinary team every month, or if the patient's condition changed and had to be reviewed sooner. Patients were also reviewed every 6 months under the 'care programme approach'. This involved multidisciplinary care plan meetings with health and social care professionals involved in the patient's care. We saw close working relationships with community services and local authorities, such as community learning disabilities teams and care managers.

A family and carer involvement policy was in place. Staff provided support to patients and their families to encourage them, as far as possible, to be involved in discussions and decisions about their own care and treatment. For example, we saw evidence of patients being supported and encouraged to attend meetings about their care. We saw patients were supported by the specialist speech and language therapist with goal setting and expressing their achievements to help develop their own easy-to-read care plans.

Patients were encouraged and supported with all aspects of their care and in helping to continually improve the service. For example, patients were supported to chair and minute the weekly community meeting attended by staff and patients. During this meeting, patients were encouraged to discuss any concerns about the service and to offer suggestions for activities or improvements. We saw minutes of these meetings were displayed in easy read format and could be easily accessed on the patient noticeboard. Examples of improvements included:

- new food menus suggested by patients, and
- a range of patient activities and outings.

We saw evidence of patients supporting the specialist speech and language therapist to carry out an inclusive communications audit every 6 months. This helped to make sure that information and communications displayed throughout the service were inclusive and accessible to patients.

We saw an example of a patient providing autism training to staff. This helped staff to understand autism from a patient's perspective, including what they found helpful and unhelpful from staff supporting them.

All patients had a communication sheet that was developed by the patient, where appropriate, with assistance from the specialist speech and language therapist. This was used to assist staff members in communicating with patients by understanding their individual communication needs, using language and communications tools that were suitable to their needs.

Information boards were displayed throughout the service and in easy read format. For example, 'who will help me' information identified each staff member and their role in the service, what activities were on and menus for the day.

We saw a range of activities and therapies were available to support and maintain patients' health and wellbeing. Patients were encouraged and supported to attend local amenities such as the local gym. We saw that each patient had been assessed to ensure activities were suitable to meet their needs.

We saw staff had developed an easy-to-read poster informing patients about our inspection. This helped patients to understand the purpose of our inspection and why we were there.

The service actively engaged with patients' carers and relatives. We saw family members were kept up to date and involved about decisions relating to care, where appropriate. We also saw family members and carers were invited to social events held by the service, for example a funday and barbecue.

Patients we spoke with said staff treated them with kindness and respect, and worked to maintain their independence where possible. This included support to attend and participate in activities outwith the service both independently and with staff support.

We were told the service had recently been inspected by the Mental Welfare Commission for Scotland and had started to prepare an action plan based on the inspection findings. These mainly related to the repair and restoration of the current physical environment.

What needs to improve

The service had recently sent out a family and carer survey. We will follow this up at the next inspection.

- 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.

The registered manager understood the notification process to Healthcare Improvement Scotland, and we saw incidents and events were appropriately reported to us within the specified timeframes.

Governance structures and comprehensive policies and procedures helped support the delivery of safe, person-centered care. Policies were reviewed regularly or in response to changes in legislation, national guidance and best practice. To support version control and accessibility, policies were available electronically on the staff intranet. We saw policies for:

- medication management
- restraint and violence reduction
- safeguarding (public protection)
- infection control
- health and safety, and
- medical emergencies.

The service also had a range of organisational and local policies and procedures, which were reviewed by the policy review group every month. These were available on the staff intranet. The local policies reflected Scottish legislation.

Staff we spoke with had a good awareness of the service's safeguarding policy and understood their responsibilities and how to implement it, if needed.

Processes were in place to help keep patients and staff safe. Patient risk assessments were reviewed every day. This helped to review patients' clinical presentation, changes in behavior and identify any potential risks. We saw any changes identified were shared with the multidisciplinary team and support staff to ensure that patients were safely cared for.

Patient care records were stored electronically on a secure password-protected database and in paper format stored securely in a locked filing cabinet. The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights) to make sure confidential patient information was safely stored.

While in the service, patients were temporarily registered with a local GP practice and a community pharmacy supplied their medication. We saw comprehensive medicine management processes were in place for ordering, prescribing and administering medication. This ensured safe medicine management in the service. A pharmacy audit was carried out every 2 weeks and a monitoring system was in place with the pharmacy supplier for raising any issues. These were sent directly to clinical staff to review and take any necessary actions.

The provider operated a model of care which helped patients, families and other stakeholders understand their journey of care. This process was audited locally to ensure the service was adhering to this model. Results from this audit were shared with, and monitored by, the provider.

Incident and accidents were recorded using an electronic incident reporting system. These were also reported to the provider's clinical governance group who had access to the system. They could track and input further queries directly to the service's senior management. The information recorded included:

- a description of the incident and immediate actions taken
- the action plan for improvement, and
- any areas of good practice.

From minutes we reviewed, we saw evidence of incidents being discussed at staff meetings.

The complaints policy set out timeframes and expectations for how complaints would be managed. Information on making complaints to Healthcare Improvement Scotland was available on the service's website.

Duty of candour is where healthcare organisations have a professional responsibility to be honest with patients when something goes wrong. The service had a duty of candour policy, and an annual report was available on the provider's website. Staff also had training on duty of candour principles as part of their training schedule.

Policies were in place for recruitment, induction and staff development. Staff files contained a checklist to help make sure that recruitment processes and pre-employment checks had been carried out. The provider's human resources department supported the service with the recruitment process. Systems were in place to ensure all staff had up-to-date Protecting Vulnerable Groups (PVG) background checks. These checks were reviewed on a weekly basis.

We saw clear policies and checklists to ensure all aspects of induction were covered for new staff. All staff members completed a 2-week induction programme which involved face-to-face training, e-learning and webinars. New staff shadowed a more experienced member of staff to gain practical experience before commencing their role. General induction topics included:

- safeguarding
- data protection
- infection prevention and control, and
- learning disabilities, including autism.

Staff were given additional time in work to attend training sessions and complete online learning modules as part of their mandatory training. Additional training opportunities were available for staff and funding applications could be made to access external courses if approved by senior management.

Staff performance and personal development was monitored through supervision and yearly appraisals. We saw appraisals were linked to the provider's values. Staff were asked to reflect how they met the provider's values, and to set objectives and personal development goals for the year ahead. The appraisals we saw had been comprehensively completed.

We noted more than 70 training opportunities were made available for staff during the previous 6 months.

What needs to improve

Controlled drugs are medications that require to be controlled more strictly, such as some types of painkillers. We noted that stock levels and entries about the administration of controlled medication in the controlled drug book were accurately recorded. However, the front cover sheet which should signpost to the correct page number for recording any controlled drugs used was not kept up to date. This had been identified as an issue during the previous inspection in March 2022 (recommendation a).

From the service's incident reporting system, we reviewed four incidents involving patients who had required support and physical intervention from staff. From these incidents, we noted the post-incident 'debrief' form was not always completed. Post incident debriefs help the service to identify and address any physical harm caused, ongoing risks and emotional impact on patients and staff. This provides an opportunity for staff to give their perspective of the event and understand what happened. This had been identified as an issue during the previous inspection in March 2022 (recommendation b).

- No requirements.

Recommendation a

- The service should ensure that the front page of the controlled drug book is kept up to date.

Recommendation b

- The service should offer staff the opportunity to attend debriefs following incidents.

Planning for quality

We saw evidence of programmes of audits taking place every month for clinical and non-clinical areas to help ensure patient care and treatment were consistent and safe. Action plans were produced detailing timescales which were signed off by senior management. All staff were involved in the audit process with results made available on the staff intranet. Audits included:

- infection prevention and control
- nutrition and hydration, and
- patient care records.

The provider's quality assurance manager regularly visited the service to carry out independent audits and monitor progress with a view to highlighting any recommendations for improvement.

The service's risk management system incorporated operational, local, activity specific and patient specific risk management. A risk matrix helped to ensure that staff were able to consistently prioritise any risks they identified to ensure appropriate actions would be taken within specified timescales.

The service's risk management policy covered all areas of risk, including risks specific to the service, as well as risks identified by the provider that covered all services. These included:

- health and safety
- environment
- information technology and data protection, and
- medication.

An up-to-date fire risk assessment was in place. We also saw specialist risk assessments for managing key building risks such as legionella (a water-based infection). These risks were regularly reviewed and approved at both regional operational team meetings and local operational team governance meetings. We saw that risk-themed reports were shared with staff that included lessons learned from any accidents or incidents.

We also saw a building risk assessment and risk register which included identified risks and action to reduce those risks. This included:

- ongoing remedial work on the drainage being carried out in the ground floor unit
- development of rooms on the ground floor to increase space for patient activities and staff training, and
- damage to a wall between patients' rooms which had compromised the integrity of the wall and required work to stabilise.

We also saw up-to-date checks for:

- electrical safety
- fire safety
- lift maintenance, and
- water management.

At the time of our inspection, the service had access to additional space on the ground floor of the building. This included an activity room for patients and a staff training room. We were told about some challenges when using this space in relation to the provision of staff to support the safe use of this room with patients.

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.

The service proactively managed its staffing complement to help make sure that an appropriate skill mix and safe number of staffing was provided. Staffing rotas were prepared 4-6 weeks in advance, and we were told the service used a permanent pool of bank staff and agency nurses to help cover staffing gaps to maintain safe and effective staffing levels.

What needs to improve

The building risk assessment and risk register did not include defined timeframes for actions to be taken forward. All risks in relation to building and maintenance issues were listed as 'ongoing' (requirement 1).

We were told that further development of the ground floor was planned. This would increase bed numbers and provide additional space for staff and patients. However, we were told there was no timeframe or fixed plan for these improvements at this time. We will follow this up at future inspections.

Requirement 1 – Timescale: by 4 July 2024

- The provider must ensure that timeframes for commencement and completion of all building work are included in the building risk assessment and risk register.

- 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

Safer recruitment processes were followed. The majority of staff described the provider as a good employer. Patients spoke positively about their experiences, and said they felt supported by staff. Patient care records demonstrated a holistic approach to care with patients' needs regularly assessed.

The environment appeared clean but was in need of redecoration. The service's programme of decoration should be re-established to ensure the environment is suitably maintained. Clinical waste storage must be improved. Adequate housekeeping staffing resources must be in place to ensure the environment is kept to a good standard. Formal leave plans must be in place for patients spending time outside of the hospital grounds. Physical health monitoring charts should be fully completed.

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.

A process was in place for maintenance staff to carry out any minor repairs and a planned maintenance programme was completed by an on-site maintenance staff member. A daily health and safety checklist was completed and the onsite maintenance staff member attended the daily morning meetings where any current issues were identified. We saw evidence of minor repairs being reported and fixed promptly.

We saw completed and up-to-date clinical and housekeeping cleaning schedules, including for the newly repurposed ground floor area.

We saw evidence of a good standard of clinical care with good awareness of risk and how to manage it. Staff we spoke with showed care and compassion as well

as a high level of specialist knowledge. They demonstrated a good understanding of their role and told us they enjoyed working in the service.

We reviewed five patient care records and found all contained appropriate information. This included detailed clinical assessments of the patient's clinical presentation that addressed their mental and physical health, emotional and social wellbeing. We saw patient risk assessments were updated every day and any changes identified were shared with staff. Each patient care record had a range of care plans in place to help support staff to provide person-centered care.

From the patient care records we reviewed, we saw evidence of staff updating family members on patients' health and wellbeing or changes to their treatment plan, where appropriate.

We reviewed seven staff files and found all contained the required background checks to show staff had been safely recruited. This included:

- professional registration checks and qualifications where appropriate
- Protecting Vulnerable Groups (PVG) status, and
- references.

The staff files also included information on each staff member's induction, supervision and appraisals.

We saw a process was in place to ensure ongoing reviews of professional registrations and regular PVG checks were carried out, as required.

As part of our inspection, we asked the service to circulate an anonymous staff survey. From our survey, 60% of the staff who responded said they would recommend the organisation as a good place to work. However, only 40% felt they were able to influence how things were done in the organisation. Comments included:

- 'Great team, organisational culture is very good, can raise any issues, and they want to hear about it, never act like they would rather you kept quiet.'
- 'Amazing leadership.'
- 'Some concerns that staff raise don't get resolved right away and sometimes are forgotten about.'
- 'Efforts of improving our environment is often considered by multidisciplinary team (MDT) yet overruled by management, therefore staff get discouraged.'

What needs to improve

All patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 and required 'suspension of detention' paperwork or a local leave plan to be completed to allow them to leave the hospital. From the patient care records we reviewed, we found no suspension of detention certificates, or a local leave plan signed by the registered medical officer, to authorise patients spending time outside of the hospital grounds (requirement 2).

The service currently had no housekeeping staff working at the weekend and only long-term planned absence was generally covered with temporary housekeeping staff. Appropriate resources must be available to ensure housekeeping staff cover is available during any planned or unplanned absence (requirement 3).

Although waste appeared to be managed well, the outdoor storage area for clinical waste was not locked at the time of inspection (requirement 4).

Each patient had a physical observations record which contained information about physical health monitoring and what physical examinations had been carried out, for example electrocardiogram (ECG) or blood tests. However, it was not clear whether patients received additional physical health monitoring such as pulse and blood pressure and the reasons for this. This had been identified as an issue during the previous inspection in March 2022 (recommendation c).

Patients were placed on nursing observations dependent on any risk identified and the level of support required to ensure their safety and wellbeing. From the observation records we reviewed, we found these were not being consistently completed or signed by the nurse in charge to confirm they had reviewed them at the end of their shift, as detailed in the service's observation policy. This had been identified as an issue during the previous inspection in March 2022. The hospital manager told us a recent audit had been implemented to improve compliance (recommendation d).

The environment was tired and in need of redecoration with some floors and walls damaged. We were told that the rolling programme of redecoration had been paused while the service awaited the outcome of hospital relocation. We were told that no redecoration work had taken place in 2023 and there was no timeframe to restart this at present. This meant that effective cleaning of the environment, particularly damaged areas, was challenging (recommendation e).

We were told of the impact of both staff absence and increased clinical activity on the ability to complete cleaning schedules. Staff told us of ad hoc cleaning taking place due to challenges in accessing patients' rooms without causing them undue distress. We suggested housekeeping staff should be part of the daily morning meeting to allow greater planning of domestic activity throughout the day. Following our inspection, the service confirmed that this had been implemented. We will follow this up at the next inspection.

Requirement 2 – Timescale: by 4 July 2024

- The provider must ensure formal leave plans are in place and signed by the registered medical officer for patients spending time outside of the hospital grounds.

Requirement 3 – Timescale: by 4 July 2024

- The provider must ensure adequate staffing resources are in place to provide housekeeping cover for weekends and absences.

Requirement 4 – Timescale: immediate

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

Recommendation c

- The service should ensure patient care records clearly indicate how frequently a patient requires physical health monitoring and the reasons for this.

Recommendation d

- The service should complete and record observations in full, including end-of-shift sign off from the nurse in charge in line with the service's observation policy.

Recommendation e

- The service should review and re-establish its programme of decoration and refurbishment to ensure that the environment is well maintained.

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

Edinburgh Office	Glasgow Office
Gyle Square	Delta House
1 South Gyle Crescent	50 West Nile Street
Edinburgh	Glasgow
EH12 9EB	G1 2NP
0131 623 4300	0141 225 6999

www.healthcareimprovementscotland.org