Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Priory Ayr Clinic, Ayr

Service Provider: The Priory Group Limited

25-26 April 2023

NHS SCOTLAND

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1 Progress since our last inspection

What the provider had done to meet the requirements we made at our last inspection on 3-4 November 2021

Requirement

The provider must upgrade its clinical hand wash basins as part of future planned refurbishment and develop a risk assessment for the current sinks.

Action taken

The service was aware that non-compliant clinical hand wash basins and taps should be replaced during any future planned refurbishment works. For example, we were told the clinical hand wash basin and taps in one of the clinical rooms were to be replaced in May 2023. Although a risk assessment was in place for the continued use of non-compliant clinical hand wash basins across the service, this required more detail. **This requirement is met. However, a new recommendation has been made**. This is reported further in Quality indicator 5.1 (see recommendation c).

Requirement

The provider must ensure that all policies and documentation used in the service refers to Scottish legislation and Healthcare Improvement Scotland as the regulatory body.

Action taken

The service had now updated its policies and documentation to take account of Scottish legislation and guidance. **This requirement is met.**

What the service had done to meet the recommendations we made at our last inspection on 3-4 November 2021

Recommendation

The service should review its staff office accommodation and develop a plan to improve space and ventilation.

Action taken

Mechanical ventilation, bringing in fresh air from outside, had been installed in the pharmacy dispensaries and staff office bases.

Recommendation

The service should ensure physical health monitoring charts are completed consistently across wards.

Action taken

Physical health monitoring charts were now being completed and were kept in the patient care records.

2 A summary of our inspection

The focus of our inspections is to ensure each service is person-centred, safe and well led. Therefore, we only evaluate the service against key quality indicators which apply across all services. However, depending on the scope and nature of the service, we may look at additional quality indicators.

About our inspection

We carried out an unannounced inspection to Priory Ayr Clinic on Tuesday 25 and Wednesday 26 April 2023. We spoke with two patients and a number of staff during the inspection. We received feedback from 28 staff members through an online survey we asked the service to issue for us during the inspection.

The inspection team was made up of three inspectors.

As part of the inspection process, we asked the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality 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.

What we found and inspection grades awarded

For Priory Ayr Clinic, the following grades have been applied to the key quality indicators inspected.

Key quality indicators inspected		
Domain 2 – Impact on people experiencing care, carers and families		
Quality indicator	**Summary findings**	**Grade awarded**
2.1 - People's experience of care and the involvement of carers and families	Patient feedback was gathered to help the service continue to develop and improve. This included patient forum groups and patient surveys. However, methods to collect carer feedback should be further developed. Patients were encouraged to participate in decision making about their care. An annual duty of candour report was published.	✓✓ Good

Key quality indicators inspected (continued)		
Domain 5 – Delivery of safe, effective, compassionate and person-centred care		
Quality indicator	**Summary findings**	**Grade awarded**
5.1 - Safe delivery of care	Systems and processes were in place to make sure patients were cared for in a safe environment. This included good processes for the maintenance of the environment and facilities, and systems to manage incidents and risks. National guidance should be followed for cleaning sanitary fittings and the management of linen.	✓✓ Good
Domain 9 – Quality improvement-focused leadership		
9.4 - Leadership of improvement and change	Staff told us leadership in the service was visible, approachable and supportive. Clear governance structures were in place, with systems and processes to monitor and improve the quality of care delivered. This included a comprehensive quality improvement plan and regular staff meetings.	✓✓ Good

The following additional quality indicators were inspected against during this inspection.

Additional quality indicators inspected (ungraded)	
Domain 3 – Impact on staff	
Quality indicator	**Summary findings**
3.1 – The involvement of staff in the work of the organisation	Good processes were in place to support staff and encourage them to contribute to the service. A weekly newsletter, staff forum groups and staff surveys helped with staff engagement. Staff recognition and wellbeing events helped keep staff motivated.
Domain 5 – Delivery of safe, effective, compassionate and person-centred care	
5.2 - Assessment and management of	The service had a clear and thorough approach to assessing patients and managing their care appropriately. Patient care plans were developed collaboratively

people experiencing care	between staff and patients. A comprehensive and regular audit of patient care records was carried out.
Domain 7 – Workforce management and support	
7.1 - Staff recruitment, training and development	Effective recruitment processes made sure staff were recruited safely. There were incentives for staff to join and then progress through the organisation. Induction and appraisal programmes were in place. Staff compliance rates with the service's mandatory training programme was 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 Framework can also be found on our website at: https://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach/quality_framework.aspx

What action we expect The Priory Group Limited to take after our inspection

This inspection resulted in one requirement and six recommendations. Requirements are linked to compliance with the National Health Services (Scotland) Act 1978 and regulations or orders made under the Act, or a condition of registration. See Appendix 1 for a full list of the requirements and recommendations.

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

The Priory Group Limited, the provider, must address the requirement and make the necessary improvements as a matter of priority.

We would like to thank all staff at Priory Ayr Clinic for their assistance during the inspection.

3 What we found during our inspection

Outcomes and impact

This section is where we report on how well the service meets people's needs.

Domain 2 – Impact on people experiencing care, carers and families

High performing healthcare organisations deliver services that meet the needs and expectations of the people who use them.

Our findings

Quality indicator 2.1 - People's experience of care and the involvement of carers and families

Patient feedback was gathered to help the service continue to develop and improve. This included patient forum groups and patient surveys. However, methods to collect carer feedback should be further developed. Patients were encouraged to participate in decision making about their care. An annual duty of candour report was published.

All patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. Patients were encouraged to complete an 'advance statement' document to express how they wished to be treated and preferences for their care, values and beliefs. We saw patients had the opportunity to nominate a named person to support and represent them with decisions about their care. Patients were also provided with an information booklet detailing their admission to hospital and their legal rights, including consent to treatment while detained in hospital, and support information such as the Mental Welfare Commission for Scotland and patient advocacy services.

The hospital displayed a range of information throughout the wards about advocacy services, the Mental Welfare Commission and accessing legal support. We saw patients were offered an opportunity to attend sessions about making or reviewing their advance statements.

We saw evidence of patient involvement, including one-to-one meetings with different staff members of the multidisciplinary team, care plan reviews and individual care reviews. Patients' relatives, named persons and advocacy representatives were also invited to attend multidisciplinary care plan meetings with health and social services, and mental health tribunals. Patients spoke positively about their involvement in their own care and felt staff were supportive.

The service users and carer policy supported the engagement work staff carried out with patients and their families to encourage them, as far as possible, to be involved in discussions and decisions about their own care and treatment. From patient care records we reviewed, we saw evidence of staff regularly updating family members on patients' progress or changes to their treatment plan, where appropriate. We saw that relatives were involved in decisions about patients' leave from hospital and staff would often support patients to travel home for an extended period of time.

We saw comprehensive involvement from patients about all aspects of their care, including individual care planning and the wider service. Patients had the opportunity to give feedback through patient questionnaires and patient forum meetings. During the inspection, we attended a patient forum meeting. Patients were encouraged to discuss any concerns about the ward or offer suggestions for activities or improvements. For example, patients had requested more easy to read information to be available on the ward and increased flexibility to access the enclosed garden. Patients were also updated with information from the senior management about new initiatives planned such as smoking cessation. These meetings were also used to celebrate any patient or staff achievements. Meetings were minuted and could be easily accessed by staff and patients. The service also had suggestion boxes in each ward and patients were encouraged to use these to leave anonymous comments or suggestions.

We saw evidence of change and improvements as a result of patient participation, for example:

- a 6-week rolling menu was now in place, which changed every 3 months for seasonal availability of products and patient requests, and
- increased access to the enclosed garden areas.

A 'safewards' programme encouraged staff and patients to work together to promote a safe and calm environment. These interventions were visible throughout the wards such as the 'getting to know you' folders where staff and patients shared hobbies and interests with each other, tools for relaxation and self-help, and ward group activities.

We saw a range of activities and therapies were available to support and maintain patients' health and wellbeing. Each ward had a timetable of activities for the week ahead and patients were also provided with an individual timetable. This included recreational activities, occupational skills and therapy programmes. For example, swimming groups, dog walking, gardening, life skills and structured psychology sessions were all available.

Duty of candour is where healthcare organisations have a professional responsibility to be honest with people when something goes wrong. Staff had access to a duty of candour policy on the service's staff intranet and told us they understood their duty of candour responsibilities. We were told the service had not had any instances requiring it to implement duty of candour principles. We saw copies available of the service's annual duty of candour report, and were told this was due to be published on the service's website.

The complaints policy contained clear information on how to make a complaint and was available on the service's website. Information about how to make a complaint was also displayed throughout the service. A complaints tracker was used to monitor and review the progress of complaints. We saw that complaints and concerns was a standing agenda item for staff meetings and senior management meetings. We reviewed a recent complaint the service had received and saw this was managed appropriately.

What needs to improve

The service's complaints policy, complaints leaflet and online complaints booklet made it clear that patients could contact Healthcare Improvement Scotland at any stage of the complaints process. However, Healthcare Improvement Scotland's contact details were incorrect (recommendation a).

We were told the service regularly received informal feedback from carers verbally and by email. The service also continued to receive a small number of responses from formal carer feedback questionnaires that were posted to carers. We discussed the benefit of considering different methods of collecting feedback and engagement with carers to help further improve the service (recommendation b).

Patients we spoke with told us they were regularly supported by staff to attend activities both on the ward and outings to the local community, including the beach and local shops. However, during our last inspection, both staff and patients told us that patient care, such as activities, was affected when staffing numbers were low. We saw the service had introduced a daily huddle for senior management and ward managers. During this meeting, staffing numbers and skill mix, and patient activity, including patients having planned time off the ward, was discussed. We saw staff were redeployed to wards to ensure patients were cared for safely and patient activities were not impacted, where possible. However, from our survey, we saw staff still consistently felt that staffing numbers and skill mix could be improved. We will follow this up at the next inspection.

- No requirements.

Recommendation a

- The service should update the complaints policy and any information in relation to complaints to include the correct contact details for Healthcare Improvement Scotland.

Recommendation b

- The service should continue to develop carer engagement and consider using different methods to obtain feedback.

Domain 3 – Impact on staff

High performing healthcare organisations value their people and create a culture and an environment that supports them to deliver high quality care.

Our findings

Quality indicator 3.1 - The involvement of staff in the work of the organisation

Good processes were in place to support staff and encourage them to contribute to the service. A weekly newsletter, staff forum groups and staff surveys helped with staff engagement. Staff recognition and wellbeing events helped keep staff motivated.

We saw good processes in place to support staff and allow them to engage with the service. An online staff survey was completed every year and results were shared with staff. Staff had formal one-to-one meetings with their line manager every month. All staff had yearly appraisals and personal development plans.

As a result of the most recent staff survey, we saw an action plan had been developed by senior management prioritising three areas for action:

- leadership
- safe working environment and wellbeing, and
- improving staff perceptions.

We saw that positive changes had been made as a result of the staff survey, for example two additional ward managers had been appointed in the step-down wards (wards where patients are transferred to in preparation for discharge) and an additional director of clinical services had been appointed. Staff we spoke with felt this provided leadership across the wards and more engagement from senior management across the sites.

A group forum called ‘Have your say’ was held remotely across the Priory sites every month. Discussions were held about each site and department, promoting staff wellbeing and social events. A nominated representative from each ward attended and shared any concerns from colleagues and provided updates. We saw a calendar of scheduled staff wellbeing and social events such as a music festival, bank holiday barbeque and employee appreciation day. A staff recognition scheme awarded staff achievements and staff could nominate each other for this. Minutes of these meetings were circulated to all staff.

Staff were sent a weekly newsletter from the provider which shared the latest updates, lessons learned from incident reviews, staff training and good news from across the organisation.

We spoke with three staff members who had recently been employed as ward managers. They spoke positively about feeling supported by staff and senior management. They felt listened to and were encouraged to give feedback about how the service could continue to improve.

From our survey, 78% of staff who responded felt they were able to influence how things were done in the organisation, and 90% of staff said they would recommend the organisation as a good place to work. Comments included:

- ‘I feel the clinic is a great learning environment and gives people good opportunities.’
- ‘I have been welcomed into my role and feel listened to, respected and taken seriously.’
- ‘Open door policy, senior management team are all approachable.’

- No requirements.
- No recommendations.

Service delivery

This section is where we report on how safe the service is.

Domain 5 – Delivery of safe, effective, compassionate and person-centred care

High performing healthcare organisations are focused on safety and learning to take forward improvements, and put in place appropriate controls to manage risks. They provide care that is respectful and responsive to people's individual needs, preferences and values delivered through appropriate clinical and operational planning, processes and procedures.

Our findings

Quality indicator 5.1 - Safe delivery of care

Systems and processes were in place to make sure patients were cared for in a safe environment. This included good processes for the maintenance of the environment and facilities, and systems to manage incidents and risks. National guidance should be followed for cleaning sanitary fittings and the management of linen.

The environment appeared well maintained. An estates reporting system was in place for staff and patients to report any maintenance issues. We saw that any jobs that could not be repaired by the service's maintenance staff were assigned to external contractors, with oversight by the service's maintenance management. We saw records of appropriate safety checks on equipment and facilities such as water supply, heating and fire safety systems. These were all on a planned programme of visits organised by an estates management company.

Equipment and patient areas appeared clean, and cleaning schedules for all rooms and areas were completed to show that cleaning had taken place.

We saw that an annual infection prevention and control report was produced and that all infection prevention and control processes had been aligned to Healthcare Improvement Scotland's *Healthcare Associated Infection Standards* (2015). This guidance has now been superseded by Healthcare Improvement Scotland's *Infection Prevention and Control Standards* (2022). We were told the service planned to review and update its infection prevention and control processes to the new standards.

Infection prevention and control training was part of the staff induction programme, as well as ongoing mandatory learning that staff must complete. We noted good staff compliance with completing this training. A good supply of

personal protective equipment was available throughout the service for use by both staff and visitors. This included face masks, disposable gloves and aprons. This was appropriately stored at reception and close to where care was delivered. The service continued to follow national guidance on the wearing of face masks.

The service's quality and compliance administrator managed the local audit programme which included audits for:

- safeguarding (public protection)
- infection prevention and control
- care management, and
- restrictive interventions (nursing interventions to manage patient risk).

A monthly quality walkround audit, which included staff and patients, looked at areas such as fire safety, and the cleanliness and condition of the environment. Audits of both non-clinical and clinical areas took place every 3 months. The audits were split into nursing, estates and housekeeping staffing groups' responsibilities. The provider's healthcare compliance officer visited every 6 months to complete a full inspection of the service and review its performance aligned with Healthcare Improvement Scotland's inspection methodology. The results and action plans of all audits were discussed during clinical governance meetings.

We saw that the service held both an operational and a clinical risk register. These detailed ongoing risks as well as evidence of actions taken to mitigate or reduce the risks. The risk registers were a standing agenda item at the clinical governance meetings and the risk and improvement meetings. During these meetings, existing risks on the risk register were discussed and newly identified risks could be added.

We tracked incidents recorded on the service's incident reporting system and saw:

- a full description of the incident and immediate actions taken
- an incident review and investigation
- areas of good practice
- an action plan for improvement, and
- sharing lessons learned with staff.

We saw evidence that a recent clinical incident had been discussed at various meetings, including the patient safety meeting, divisional meeting, staff meeting and hospital huddle. This showed transparency and oversight from the appropriate parts of the organisation. The incident was also shared with other Priory services as an opportunity for learning. An overview of the incident had been shared in the all staff 'healthcare divisional cascade' the same month the incident had occurred. This had included what had happened and shared a point of learning about patient assessments. The director had also commended the staff involved for their quick action which had averted a more serious outcome. This showed a culture of learning and improvement. We also saw evidence of the actions being put into practice at ward level.

The service had an adult support and protection policy and staff had received training.

Whistleblowing is when a staff member can raise a confidential concern if they became aware of any instances of harm or wrongdoing putting patient safety at risk. A whistleblowing policy was in place, as well as details on the staff intranet for how staff could report a concern.

The service was aware that, as a registered independent healthcare service, it had a duty to report certain matters to Healthcare Improvement Scotland, as detailed in our notifications guidance.

Policies were in place to ensure the safe management of medicines, including the safe receiving, storing, prescribing and disposal of medicines. These were available on the service's intranet for staff to access. Before staff members were able to administer medicines, an online medication administration module had to be completed, which included a competency test. The pharmacy used by the service also provided training sessions for staff and all staff had access to the pharmacy's online learning system.

The service had an identified clinical lead responsible for the safe, effective and secure use of medicines. There was also an appointed controlled drugs accountable officer and Home Office license in place, as this is required for prescribing and holding controlled drugs. These are medications that require to be controlled more strictly, such as some types of painkillers.

There was appropriate and secure storage of medicines and appropriate checks in place.

The service was registered with the Medicines and Healthcare products Regulatory Agency (MHRA) to receive notifications of alerts, recalls and safety information on medicines and medical devices. MHRA alerts were printed and

kept in a folder to show they had been actioned such as communication about the alerts between staff and the pharmacist.

The pharmacist regularly visited the three Priory Ayr sites and carried out safety checks and monthly audits on medicines management. The pharmacist documented any queries and actions for relevant clinical staff to review and action following these checks and audits. We saw evidence of relevant staff responding to and acting on the pharmacist's findings. We also saw evidence of audit reports being shared at management and clinical governance meetings.

What needs to improve

Sanitary fittings, including clinical hand wash basins, were not being decontaminated (cleaned) with an appropriate chlorine-releasing disinfectant and detergent product and method as detailed in Health Protection Scotland's *National Infection Prevention and Control Manual*. The service's housekeeping policy stated that a 'suitable bathroom cleaning solution' and 'suitable toilet cleaner' should be used. The service's decontamination of medical devices and other equipment policy stated that toilets and commodes should be cleaned with 'hot water and detergent' (requirement 1).

A risk assessment had been carried out for the continued use of the non-compliant clinical hand wash basins and taps. However, it did not include all measures to control the risk such as cleaning and flushing. We also saw that measures to control the risks were not always being followed, such as items being stored on surrounding surfaces which could result in splash contamination and a plug being used (recommendation c).

Flushing of identified less frequently used water outlets was taking place to prevent the growth of waterborne bacteria. However, there was no formal process to regularly update the list of these outlets held by the estates team. This may cause some less frequently used outlets to not be flushed as required, such as when rooms change use or when access is limited due to storage obstructing the basin (recommendation d).

Patient clothing from Priory Ayr Clinic and Lochlea was washed in the onsite laundry rooms while other linen, such as bedding, was sent to an external laundry. All linen from the Gatehouse was washed in onsite professional washing machines and tumble driers, including any linen contaminated with blood or body fluids. The laundry policy stated that linen must be washed at temperatures as detailed in national guidance. However, the equipment had not been regularly calibrated to ensure that it could still achieve the required thermal disinfection temperature and times. We also saw that reusable mop heads were being laundered in the same equipment (recommendation e).

All domestic services rooms in the Priory Ayr Clinic and Lochlea were cluttered with multiple cleaning products and equipment. This prevented effective cleaning of these rooms. Access to clinical hand wash basins was also obstructed. There was no dedicated domestic services room in the Gatehouse. A general store room was used to store cleaning equipment and products. Domestic services rooms should have sufficient storage space and have the following facilities:

- large sink with draining board to allow non-disposable cleaning equipment to be thoroughly cleaned after use
- stainless steel sluice (slop) hopper
- low level bucket sink, and
- separate hand washing facilities (recommendation f).

Requirement 1 – Timescale: immediate

- The provider must ensure that appropriate cleaning products and processes are used to decontaminate the environment in line with national guidance. Housekeeping and decontamination policies must be updated accordingly.

Recommendation c

- The service should further develop its risk assessment for the continued use of non-compliant clinical hand wash basins and ensure that control measures are followed.

Recommendation d

- The service should formalise its process for updating its list of less frequently used outlets to ensure all identified outlets are routinely flushed.

Recommendation e

- The service should ensure washing machines in the Gatehouse used to wash shared linen are calibrated to make sure they can achieve thermal disinfection temperatures or make alternative arrangements for washing linen.

Recommendation f

- The service should declutter and clean its domestic services rooms and ensure there are appropriate facilities in the Gatehouse.

Our findings

Quality indicator 5.2 - Assessment and management of people experiencing care

The service had a clear and thorough approach to assessing patients and managing their care appropriately. Patient care plans were developed collaboratively between staff and patients. A comprehensive and regular audit of patient care records was carried out.

We saw clear and thorough processes in place to assess patients' suitability for being admitted to the service. Senior members of the multidisciplinary team carried out a pre-admission assessment. We were told patients' care would be discussed, and care and treatment plans, including risk plans, would be considered at pre-admission.

On admission, patients were assessed by a doctor and a nurse from the admitting ward. We saw that the assessment process considered patients' physical, psychological and emotional needs. We saw a checklist of admission tasks included orientation to the ward and introducing patients to named and associate nursing staff. We saw evidence of information sharing from the referring hospital, including risk and psychological reports. This was also incorporated into the patient's keeping safe care plan and reviewed monthly or if any incidents occurred.

We reviewed five patient care records across three wards. We found a range of assessments, care plans, legal paperwork, risk assessments and progress notes, as well as correspondence with relatives and other involved agencies such as the Scottish Government. All records were fully completed, easy to read and filed in the same order to make finding information easy. Patient care plans were divided into four areas: keeping safe, keeping connected, keeping well and keeping healthy. We saw evidence of care plans identifying patients' personal goals and the goals of the multidisciplinary team. The patient care plans we reviewed showed that patients had signed and agreed their plan of care or, if they had refused, this was also documented.

We saw documented reviews were taking place of the patient care plans in a regular timely manner. We saw evidence of family involvement where appropriate, and evidence of a named person and advance statement being prepared. If the patient did not wish either a named person and/or advance statement, this was documented and reviewed with the patient regularly.

We saw evidence of multidisciplinary discharge planning and involvement of other agencies to support this. We saw all patients being reviewed with suitable discharge plans discussed alongside family and/or named persons. We saw detailed discharge planning involving external agencies, community support and supervision.

All patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 and required 'suspension of detention' paperwork to be completed to allow them to leave the hospital. We saw clear and up-to-date information on the suspension of detention for all patients in the patient care records for planned and unplanned leave from the hospital. We saw ongoing risk assessments and reviews of this at the multidisciplinary team meetings with observation and escorting requirements individual to each patient.

We saw comprehensive audits of patient care records were carried out which included:

- legal paperwork
- consent to treatment
- case notes
- care plans, and
- one-to-one meetings with a named/associate nurse.

Ward managers were emailed every week with a report from this audit which identified any areas for improvement.

- No requirements.
- No recommendations.

Domain 7 – Workforce management and support

High performing healthcare organisations have a proactive approach to workforce planning and management, and value their people supporting them to deliver safe and high quality care.

Our findings

Quality indicator 7.1 - Staff recruitment, training and development

Effective recruitment processes made sure staff were recruited safely. There were incentives for staff to join and then progress through the organisation. Induction and appraisal programmes were in place. Staff compliance rates with the service's mandatory training programme was good.

We reviewed four staff files and found all were well organised with evidence of appropriate recruitment having taken place. Recruitment checks followed the safer staffing guidance, and we saw policies related to recruitment and selection as well as standard operating procedures for recruitment. This included an easy read flow chart that could be used alongside the policy and highlighted the key processes that were to be followed.

The provider's central human resources (HR) department supported the service's HR staff with the recruiting process. After employment, systems were in place for ongoing safety checks such as a risk-based Disclosure Scotland background check, and fitness to practice check for healthcare practitioners.

We saw evidence of induction and training through policies and standard operating procedures. This included timescales for completion of mandatory training and clear escalation protocols if this was breached. Mandatory training was to be completed within the first week of employment and covered various topics such as infection prevention and control, fire safety, and moving and handling.

A dedicated training portal offered opportunities for extensive e-learning, using online teams or face-to-face training. Monthly reports and a spreadsheet showed that compliance rates were high.

We saw internal posts being circulated to existing staff to allow them to apply for promotion. We saw opportunities for staff who wished to undertake a registered nurse degree to receive financial support and time off to study.

From the responses to our staff survey and from our discussions with staff, the use of agency and staffing skill mix remained an issue. We saw evidence of recruitment drives to attract new staff to enhance the skill mix available and reduce the dependency on agency staff. We noted that staffing skill mix was discussed on a daily basis by senior management and redeployment of staff within the units if this was required.

In the staff files we reviewed, we saw appraisals and mid-year reviews took place, as well as evidence of clinical supervision. Compliance rates with this was high, and was monitored and audited.

- No requirements.
- No recommendations.

Vision and leadership

This section is where we report on how well the service is led.

Domain 9 – Quality improvement-focused leadership

High performing healthcare organisations are focused on quality improvement. The leaders and managers in the organisation drive the delivery of high quality, safe, person-centred care by supporting and promoting an open and fair culture of continuous learning and improvement.

Our findings

Quality indicator 9.4 - Leadership of improvement and change

Staff told us leadership in the service was visible, approachable and supportive. Clear governance structures were in place, with systems and processes to monitor and improve the quality of care delivered. This included a comprehensive quality improvement plan and regular staff meetings.

Comprehensive leadership structures were in place with clear roles and responsibilities. Of the staff who responded to our survey, 96% stated there was positive leadership in the organisation. Comments from our survey included:

- 'The leadership team are very supportive.'
- 'I feel there is positive leadership skills on the ward, we are always supported by our ward manager and given the opportunity to improve our leadership skills.'
- 'The hospital director and director of clinical services are always positive.'

We found well-defined governance systems and processes that focused on continually improving the service. This included regular senior management meetings, staff meetings, risk management and a significant programme of rolling audits feeding directly into the service's quality improvement plan.

The clinical governance committee met every month. The agenda for this was aligned with Healthcare Improvement Scotland's Quality of Care Approach. We were told this had helped the service to focus on Scottish legislation and guidance. Standing agenda ideas focused on:

- patient and carer experience
- complaints
- delivery of safe care

- incidents
- staffing
- organisational outcomes, and
- quality improvement.

Senior staff attended both regional and divisional provider meetings to share information on patient safety, learning from incidents, improvement projects and benchmarking with other services within the organisation. This information was shared with staff on the staff intranet and through a weekly newsletter. This ensured staff were updated with the latest guidance and any changes in the organisation.

A detailed quality improvement plan highlighted areas of improvement identified in our last inspection, and other areas such as outcomes from audits, health and safety, and cleanliness. We saw improvements had been made, for example new furnishings for wards, a training room for staff, and assigning staff to complete physical health monitoring and compliance checks as part of monthly ward walkrounds.

The psychology department was involved in a current research project for the dynamic appraisal of situational aggression risk assessment which had been introduced to the service 6 years ago by the head of psychology. We were told a similar service had adopted this approach following data collected and a positive impact reported by the service.

Senior staff regularly attended a range of clinical forums including forensic and personality disorder networks. This allowed the service to be kept up to date with best practice initiatives, sharing of clinical expertise and promoting governance.

The serviced had introduced an initiative to support and encourage patients to manage negative emotions and increase coping skills. Staff spoke positively about this initiative and told us this had led to other services considering this approach.

During the inspection, we attended a safewards meeting with the director of clinical services and ward staff. Staff discussed interventions used in their wards, and shared ideas and learning.

We were told of plans for each ward to have their own quality improvement plan. We were told this will ensure all staff have a role in quality improvement across the service. We will follow this up at the next inspection.

- No requirements.
- No recommendations.

Appendix 1 – Requirements and recommendations

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 at the discretion of Healthcare Improvement Scotland.
- **Recommendation:** A recommendation is a statement that sets out actions the service should take to improve or develop the quality of the service but where failure to do so will not directly result in enforcement.

Domain 2 – Impact on people experiencing care, carers and families	
Requirements	
None	
Recommendations	
a	The service should update the complaints policy and any information in relation to complaints to include the correct contact details for Healthcare Improvement Scotland (see page 12). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.20
b	The service should continue to develop carer engagement and consider using different methods to obtain feedback (see page 12). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Domain 5 – Delivery of safe, effective, compassionate and person-centred care	
Requirement	
1	The provider must ensure that appropriate cleaning products and processes are used to decontaminate the environment in line with national guidance. Housekeeping and decontamination policies must be updated accordingly (see page 18). Timescale – immediate *Regulation 3(d)(i)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
c	The service should further develop its risk assessment for the continued use of non-compliant clinical hand wash basins and ensure that control measures are followed (see page 18). Health and Social Care Standards: My support, my life. I experience a high quality environment if the organisation provides the premises. Statement 5.24
d	The service should formalise its process for updating its list of less frequently used outlets to ensure all identified outlets are routinely flushed (see page 18). Health and Social Care Standards: My support, my life. I experience a high quality environment if the organisation provides the premises. Statement 5.24
e	The service should ensure washing machines in the Gatehouse used to wash shared linen are calibrated to make sure they can achieve thermal disinfection temperatures or make alternative arrangements for washing linen (see page 18). Health and Social Care Standards: My support, my life. I experience a high quality environment if the organisation provides the premises. Statement 5.24
f	The service should declutter and clean its domestic services rooms and ensure there are appropriate facilities in the Gatehouse (see page 18). Health and Social Care Standards: My support, my life. I experience a high quality environment if the organisation provides the premises. Statement 5.24

Appendix 2 – About our inspections

Our quality of care approach and the quality framework allows us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this approach 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: www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.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

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