Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Scottish Epilepsy Centre, Glasgow

Service Provider: Quarriers

30-31 August 2023

NHS SCOTLAND

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Contents

1 Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 8 May 2019

Recommendation

The service should amend its patient information pack to include more information about advocacy services.

Action taken

The patient information pack had now been amended and included information about advocacy services that patients or carers could request to be involved in their care pathway.

Recommendation

The service should complete risk assessments for all appropriate work tasks. These risk assessments, and the risk register, should be regularly reviewed.

Action taken

Although the service had a range of risk assessments in place, these were out of date. A new requirement has been made and is reported in Domain 5 (Planning for quality) (see requirement 3 on page 22).

We noted the service's clinical risk register had also not been reviewed or updated since 2019. This recommendation is reported in Domain 5 (Planning for quality) (see recommendation c on page 22).

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 the Scottish Epilepsy Centre on Wednesday 30 and Thursday 31 August 2023. We spoke with a number of staff and patients during the inspection. We received feedback from 14 staff members through an online survey we had asked the service to issue for us during the inspection.

Based in Glasgow, the Scottish Epilepsy Centre is an independent hospital providing residential assessment, monitoring and treatment of adults with epilepsy.

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For the Scottish Epilepsy Centre, the following grades have been applied.

Direction	*How clear is the service's vision and purpose and how supportive is its leadership and culture?*
Summary findings	**Grade awarded**
The service had a clear vision and purpose, with a comprehensive strategy and defined objectives with measurable key performance indicators for continuous improvement. There was a visible and supportive leadership, and staff felt valued and supported. Governance arrangements were in place, which were accessible and understood by staff.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patient experiences and feedback were regularly sought to allow for ongoing improvement into how care was delivered. A quality improvement plan and staff training also helped to improve how the service was delivered. A comprehensive audit programme and policies and procedures set out the way the service was delivered and supported staff to deliver safe and person-centred care. Safer recruitment processes were in place. A duty of candour report was published every year. Feedback from patient participation meetings should be acted on or reasons why this is not possible should be fed back to patients. A risk assessment must be developed and appropriate procedures put in place for the disposal of waste. Risk assessments and the risk register must be regularly reviewed. Staff must have regular appraisals.	✓ Satisfactory
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The environment was clean an in a good state of repair. Staff spoke positively about working in the service and patients were very satisfied with their care and treatment. Multidisciplinary meetings should be recorded in the patient care record.	✓✓ Good

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

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

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

What action we expect Quarriers 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 four recommendations.

Implementation and delivery	
Requirements	
1	The provider must develop a risk assessment and ensure appropriate procedures are in place for the safe disposal of clinical waste, in line with national guidance (see page 20). Timescale – immediate *Regulation 3(d)(i)(iii)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

Implementation and delivery (continued)	
Requirements	
2	The provider must ensure that all staff receive a regular documented performance review to give staff the opportunity to discuss progress in their role or raise any concerns (see page 20). Timescale – by 22 January 2024 *Regulation 12(c)(i)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
3	The provider must review and update all risk assessments on a regular basis to demonstrate a proactive approach in identifying and managing risk (see page 22). Timescale – immediate *Regulation 13(2)(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
a	The service should ensure actions arising from the patient participation meetings are acted on or reasons why this is not possible fed back to patients (see page 15). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.8
b	The service should update the patient information folder and give consideration to presenting the information in alternative formats to benefit all patients (see page 15). Health and Social Care Standards: My support, my life. I am fully involved in all decisions about my care and support. Statement 2.9
c	The service should ensure that the clinical risk register is regularly reviewed and updated (see page 22). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11

Results	
Requirement	
4	The provider must risk assess the availability of hand wash basins and sinks in the domestic services room and dirty utility room against current guidance, and a risk-based refurbishment plan should be developed to reduce any risks identified to minimise the spread of infection (see page 25). Timescale – immediate *Regulation 3(d)(i)(ii)(iii)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendation	
d	The service should ensure that a record of multidisciplinary meetings are documented in the patient care record (see page 25). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.17

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

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

We would like to thank all staff at the Scottish Epilepsy Centre for their assistance during the inspection.

3 What we found during our inspection

Key Focus Area: Direction

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

Our findings

The service had a clear vision and purpose, with a comprehensive strategy and defined objectives with measurable key performance indicators for continuous improvement. There was a visible and supportive leadership, and staff felt valued and supported. Governance arrangements were in place, which were accessible and understood by staff.

Clear vision and purpose

The service had a vison and values statement, and we saw how these values informed the service's strategic plan for 2022-2025. The Scottish Epilepsy Centre is part of the Quarriers charity, and the mission and values are stated on its website. The vision was a statement of what services would be provided to patients with epilepsy. The values were clearly stated and easily understood by staff. The vision and values informed the objectives that had been clearly laid out in the strategic plan. These were separated into four main categories:

- clinical excellence
- staff
- partnership and innovation, and
- development and sustainability.

Each category had specific, measurable objectives with an expected date of when these were to be achieved. The service had defined what percentage of achievement would be judged as a success for each objective. Each objective was formally evaluated and any ongoing actions identified. This helped to demonstrate a culture of continuous improvement.

Reports were produced every 3 months, which documented how well the service was performing against each of the objectives. This report was submitted to the clinical governance group, and a copy was also emailed to staff.

- No requirements.
- No recommendations.

Leadership and culture

The service had a clear leadership structure with well-defined roles. Staff in the service included a diverse range of healthcare professionals to reflect the complex needs and monitoring required of its patients. A staff board in the reception area displayed pictures of staff members and their area of responsibility for patients and their carers to view.

The provider had recently relocated its head office and moved into the service. This meant the service manager had direct and ready access to the chief executive officer, including formal Board meetings and unscheduled catch-ups as required.

Regular meetings were held with the staff as a team. The timing of these meetings was regularly moved to ensure as many staff as possible could attend. We noted minutes from these meetings identified areas for action and who was responsible.

A staff engagement folder was available online where staff could access information such as minutes of meetings, presentation slides from training days, survey results and discussions. A chat function had recently been added and we were told this would be evaluated to gather feedback on how useful it was for staff.

Staff told us they felt valued and supported, and felt able to speak up. For example, following a staff suggestion, new garden furniture had been purchased for patients and carers.

A leadership and improvement network helped support the service's governance framework and leadership structure. A number of improvement subgroups helped to support continuous improvement across the whole service. These subgroups included:

- risk management
- medication improvement
- information governance, and
- food and nutrition.

Each subgroup was led by a senior member of staff with input from all staff members. We noted that minutes from these meetings were reported in the 3-monthly service report and shared with staff.

What needs to improve

We noted that some of the subgroups from the leadership and improvement network did not meet as planned during this year. We were told this was due to low staffing numbers. We saw the service had acknowledged and reported this in its 3-monthly service report with plans to hold these meetings within the next 3 months. We will follow this up at the next inspection.

- No requirements.
- No recommendations.

Key Focus Area: Implementation and delivery

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

Our findings

Patient experiences and feedback were regularly sought to allow for ongoing improvement into how care was delivered. A quality improvement plan and staff training also helped to improve how the service was delivered. A comprehensive audit programme and policies and procedures set out the way the service was delivered and supported staff to deliver safe and person-centred care. Safer recruitment processes were in place. A duty of candour report was published every year.

Feedback from patient participation meetings should be acted on or reasons why this is not possible should be fed back to patients. A risk assessment must be developed and appropriate procedures put in place for the disposal of waste. Risk assessments and the risk register must be regularly reviewed. Staff must have regular appraisals.

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

The participation policy was clearly available on the service's website in standard and easy-to-read format. This described how patients would be involved in decisions about their care and treatment as well as how they could provide feedback. We saw monthly formal patient participation meetings took place. These resulted in an action plan of activities and suggestions from patients that would help improve their stay. Suggestion boxes were also available for patients and the opportunity to feedback to their designated nurse.

With patients' consent, families and carers were involved with the clinical team in understanding the patient's health challenges before they were admitted. They were then meaningfully involved in planning care and assistance after discharge.

The service regularly carried out a discharge survey with all patients. The most recent results from January-March 2023 were reported in the 3-monthly service report and included on the agenda for team meetings and the patient participation group. We were told the service used this information to identify areas where it could further improve the patient experience.

An all staff survey was carried out every year with the last one in November 2022. We saw the overall satisfaction rate was high.

Staff received information and a newsletter, 'The Bulletin', was emailed every 2 weeks. Information was also available on the internal staff intranet. A staff recognition policy detailed various ways that good practice could be promoted and shared. These included:

- an article in The Bulletin
- documented and formalised in supervision minutes
- team meeting minutes
- letter from chief executive office to the staff member, and
- nomination for an external award.

Staff employee benefits included a cycle to work scheme, health benefits package, and discounts on selected health and fitness facilities, as well as access to saving schemes and wellbeing support.

As the provider is a charity, it regularly engages and works with a range of stakeholders. This included corporate support for resources requiring substantial funding, to previous patients and their families undertaking small fundraising events.

The service also had a contract with NHS boards to provide care for patients with epilepsy across Scotland. It had a close working relationship and shared staff with the Queen Elizabeth University Hospital, Glasgow. There were also strong links with social work and community care providers. The innovative care and treatment being provided in the service benefitted all staff across their different working environments as they received training in:

- epilepsy as a condition
- effective monitoring to help identify patients who would be suitable for surgery, and
- the use of new drug therapies to manage the condition.

We noted the service compared its food and meals satisfaction results against local NHS providers, with favourable results.

What needs to improve

We were told actions identified from the patient participation meetings were not currently being taken forward due to staffing pressures. The service was planning to address this in the coming weeks. It had recognised that not taking forward suggestions by patients was missing an opportunity to engage them and give them the ability to affect changes in the service (recommendation a).

A patient information folder included information on all aspects of the service, including rules to keep everyone safe, laundry services, advocacy services and diagnostic tests that would take place. Some information was in the form of photographs to help better explain medical tests. However, some sections of the patient information folder had not been reviewed and updated for several years. We were also told there was no alternative source of information provided for patients who could not engage with a written format, such as some patients with learning disabilities. It was noted this is approximately one third of all admissions (recommendation b).

- No requirements.

Recommendation a

- The service should ensure actions arising from the patient participation meetings are acted on or reasons why this is not possible fed back to patients.

Recommendation b

- The service should update the patient information folder and give consideration to presenting the information in alternative formats to benefit all patients.

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.

Governance structures and comprehensive organisational and local policies helped support the delivery of safe, person-centered care. The provider's organisational policies were reviewed and updated by the quality and assurance department and were available on the staff intranet. We saw policies and procedures in place for:

- infection control
- safeguarding (public protection)

- duty of candour, and
- information management.

The service also had a range of local policies and procedures specific to the care and treatments it provided, for example a video observation and video telemetry policy. Telemetry is video recording patients while they wear an electroencephalogram (EEG) monitor to measure electrical activity in the brain. We saw policies were regularly reviewed or in response to changes in legislation or best practice guidance.

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. The service also had a dedicated page on its website for safeguarding, including the contact details for the safeguarding officer.

Incidents and accidents were recorded and managed using an electronic incident management system. These were reviewed by senior members of the clinical team and reported to the provider's clinical governance group. We tracked three incidents 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.

Incidents were reported in the 3-monthly service report with details of what actions were taken. We saw evidence of incidents being discussed at staff meetings and saw staff were provided with a lessons learned bulletin every 3 months. The service was aware of the notification process to Healthcare Improvement Scotland, and we saw incidents and accidents were appropriately reported to us within the specified timeframes.

We saw the service had introduced an improvement reporting system. This allowed staff to report any errors and identify general improvements required. For example, medication checks were carried out four times each day and any errors identified, such as a patient not being administered their medication on time, would be reported. We spoke with nursing and senior members of staff who told us this system had been beneficial in quickly identifying and addressing errors. Information was also collated and documented in the 3-monthly service report.

The service had a detailed corporate complaints policy. This explained the different stages of a complaint and stated that Healthcare Improvement Scotland could be contacted by the complainant at any time during the process. We noted the service had not received a complaint in the 4 years since the last inspection.

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.

Patients were referred to the service through the NHS or through their local authorities. There was an up-to-date admission, transfer and discharge policy, and we saw comprehensive admission and discharge checklists were completed. This helped to ensure that the correct processes were followed throughout the patient's admission.

We saw detailed, daily handover systems for nursing staff. This information was also included in the weekly multidisciplinary team meeting to provide an update on patients' weekly progress.

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. This included reconciliation of patient's medication with their own GP to ensure the service had an accurate list of patient's medication before their admission.

The service was responsive to patients' needs with certain medications. For example, if a patient took their medication at a certain time at home, staff would highlight this on a whiteboard in the dispensary so this would not be omitted in error if it was outside set medication times. Medications for discharge were also highlighted to prevent any delays with ordering.

We saw clear guidelines which were easily accessible to staff and students for:

- drug therapy
- seizure management
- common side effects of anti-epilepsy medication, and
- information on the reduction of one drug and introduction of another.

There were also standard operating procedures for the ordering of medication, controlled drugs (medications that require to be controlled more strictly, such as some types of painkillers) and stock control with details on who was responsible for these.

The service's infection prevention and control policies and procedures were in line with national guidance. All linen and patients' laundry was laundered in onsite professional washing machines and tumble dryers. We saw the correct washing temperatures were used, in line with national guidance.

The development manager was responsible for the day-to-day maintenance management of the service, and a maintenance programme was in place. A reporting system was in place for staff to report any maintenance issues. We saw that any maintenance work that could not be carried out by the provider's maintenance staff was assigned to external contractors. We saw records of appropriate safety checks on equipment and facilities such as water flushing and fire safety systems. We saw meetings took place every 3 months with maintenance contractors to update the service on maintenance work carried out and to plan any future work required.

Maintenance contracts were in place for fire safety equipment and the fire detection system. We saw daily fire safety checks were carried out and evidence of staff training in fire safety.

The service used hard copy patient care records, which were stored securely in the nurses' office. The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights).

The service's recruitment policy was in line with safer staffing guidance. We saw evidence of the background checks that were done both by the provider's human resources department and at the service by the hospital manager. We saw clear policies and checklists to ensure all aspects of induction were covered for new staff. This included supervision to allow staff to identify any needs and learning opportunities they required, as well as allowing for feedback to new staff about their progress. Awareness of the service's aims and objectives was also a key aspect of induction. A list of mandatory and role-specific training was included with follow-up actions if identified.

The training manager told us they delivered onsite training to staff at various times and days to allow staff to easily attend and remain up to date. Staff also had role-specific and mandatory training modules allocated to them through the staff intranet. We saw evidence that the hospital manager and learning and development manager monitored and ensured compliance with these modules.

We noted two members of nursing staff were about to complete a non-medical prescribing course they had undertaken with support from the service. Staff were also able to access specialist epilepsy training.

We noted various training and development days were available, and staff told us they had good opportunities for training and education. For example, we noted that the senior neurophysiologist was offering EEG training for nursing staff. Several members of staff were involved in external training programmes.

Group supervision sessions took place with staff from another independent inpatient service. This allowed for challenges and good practice to be shared with other healthcare professionals.

The service used a pool of their own 'relief' staff as well as agency staff to cover short-term sickness absence or increased clinical activity, as required.

What needs to improve

The service no longer used a macerator for the safe disposal of human waste, used bedpans and urine bottles. We were told staff now used absorbent granules for the containment of urine, and other human waste was disposed of in biohazard clinical waste. Disposable bedpans and urine bottles were disposed of in clinical waste bins. This practice does not follow current guidelines for infection prevention and control. There was also no risk assessment in place to ensure any risks associated with the spread of infection using this waste disposal method were minimised (requirement 1).

Staff appraisals were not up to date. We were told this was due to staffing pressures on management. We noted this had already been escalated to the clinical governance group who was looking at ways to address this (requirement 2).

We noted that any concerns or complaints raised about the service were not being managed at a local level in the service. We raised this with the senior team who then immediately met with the chief executive officer. We were assured that the corporate policy would be addressed in the coming weeks to allow local resolution of complaints. We will follow this up at the next inspection.

The service was actively trying to recruit a clinical nurse manager, but had been unsuccessful on several occasions. Other ways were now being considered to attract the required type of candidate into this post and the service had spoken with the provider's marketing department for advice and suggestions. We will follow up progress with this at the next inspection.

Requirement 1 – Timescale: immediate

- The provider must develop a risk assessment and ensure appropriate procedures are in place for the safe disposal of clinical waste, in line with national guidance.

Requirement 2 – Timescale: by 22 January 2024

- The provider must ensure that all staff receive a regular documented performance review to give staff the opportunity to discuss progress in their role or raise any concerns.

- No recommendations.

Planning for quality

The service's risk management process included corporate and clinic risk registers. These detailed actions taken to mitigate or reduce risk. The service carried out a number of risk assessments to help identify and manage risk. These included:

- recruitment and retention
- financial sustainability
- technology failure
- data protection
- medication mismanagement, and
- outbreak of infection due to failure of infection control systems and processes.

An up-to-date fire risk assessment was in place. We also saw more specialist risk assessments for managing key building risks such as legionella (a water-based infection).

A comprehensive programme of audits helped to ensure the service delivered consistent safe care and treatment for patients. We saw action plans were produced with responsibilities highlighted where appropriate. Results were emailed to staff and were available on the staff intranet. These were also reported in the 3-monthly service report which was sent to the provider's clinical governance group. Audits included:

- infection prevention and control
- domestic cleaning, and
- patient care records and care plans.

Daily and monthly medication audits also took place. Findings from these audits were discussed at the medicines management group and emailed to all staff. Audit results were also available on the intranet for staff to view.

Two nursing staff were designated to lead the infection prevention and control audit. This audit was carried out every month with a focus on two different key areas each time, such as the safe management of equipment and the safe management of the care environment. We noted good outcomes from these audits. We saw the results were discussed at the risk management group and displayed on the noticeboard in the patient dining area. We were told a senior nurse was currently undertaking relevant additional training in the Scottish Infection Prevention and Control Education Pathway. This enables staff to continuously improve their infection prevention and control knowledge and skills, and enhance their practice skills. This will help to ensure the service is kept up to date with any changes to best practice and guidance.

The development manager carried out a monthly environmental walkround, focusing on the cleanliness and condition of the environment. Two senior nurses were identified as health and safety representatives for the service and were responsible for carrying out a health and safety audit every 6 months. We saw the results from these audits were discussed at the risk management group with staff responsible for carrying out actions identified.

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

The quality improvement plan took account of the service's objectives, and included both short-term goals and longer-term projects. For example, a short-term goal was to ensure staff had access to a wider professional network to increase their clinical knowledge and support career development. An example of a longer-term project was the major technical upgrade of the unique patient monitoring system that allowed patients to freely move around while being continuously monitored.

What needs to improve

A documented process was in place which stated that risk assessments were to be reviewed or updated each year. However, we noted that a number of risk assessments were out of date. This included a range of health and safety risk assessments, as well as patient-specific risk assessments such as management of seizures and observing patients on the video observation system (requirement 3).

The service's clinical risk register had not been reviewed or updated since 2019. We were told the service was currently referring to the provider's corporate risk register. However, we noted that this did not cover the service's specific clinical risks (recommendation c).

Requirement 3 – Timescale: immediate

- The provider must review and update all risk assessments on a regular basis to demonstrate a proactive approach in identifying and managing risk.

Recommendation c

- The service should ensure that the clinical risk register is regularly reviewed and updated.

Key Focus Area: Results

Domain 6: Relationships	Domain 7: Quality control
How well has the service demonstrated that it provides safe, person-centred care?	

Our findings

The environment was clean an in a good state of repair. Staff spoke positively about working in the service and patients were very satisfied with their care and treatment. Multidisciplinary meetings should be recorded in the patient care record.

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 satisfactory self-evaluation.

The environment and patient equipment was clean and well maintained. We saw cleaning schedules for all rooms and areas were completed to show that cleaning had taken place. Adequate supplies of cleaning products and equipment were available. There was a good supply of personal protective equipment such as gloves, masks and aprons. Single-use equipment was used to prevent cross-infection.

We reviewed eight staff files and found all contained the required information and appropriate 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.

We also saw evidence of annual checks on staff to ensure their registration remained valid.

Results from our staff survey showed positive feedback in relation to leadership and culture, and that the service was a good place to work.

- ‘All staff strive to provide the highest standards of care and assessment. There is a uniform approach to this disseminated from management and embraced by the team.’
- ‘Positive work culture is evident in both in and out patient departments of the service. I feel the service works cohesively utilizing an MDT approach to provide positive service to patients. Positive culture and teamwork is visible to patients, students and staff as evidenced in feedback such as satisfaction surveys.’
- ‘… provides a person-centred service providing compassion, dignity and respect to all patients within all geographical regions. No barriers to allow all patients a safe and smooth patient pathway for specialised diagnosis and treatment. Patient safety is paramount and working as a team to deliver a high standard of service is the clear vision and purpose of staff within the centre.’
- ‘Patient care. Person centered, inclusive. Beneficially outcomes for patients and families.’

All staff we spoke with showed care and compassion as well as a high level of specialist knowledge. Staff also spoke of the opportunities they had to develop their skills and knowledge. During the inspection, staff also spoke of opportunities for open and reflective practice in the service which allowed for improved patient care.

We reviewed five patient care records and found all contained comprehensive information and were fully completed. This included detailed clinical assessments on the day of the patient’s admission to the service that addressed the patient’s self-care needs, seizure and medical history, and current medication. Each patient care record had a range of care plans in place to help support and manage the patient’s seizures. We saw a daily seizure risk assessment was completed for all patients. We saw patients were asked to consent to share information with other healthcare professionals and their GP. They were also asked for consent for their information to be used for research, audit and training purposes.

We spoke with two patients during the inspection. Both spoke highly of the care they were receiving. They told us:

- ‘There is nothing that could be improved.’
- ‘The staff are so caring.’
- ‘Everything clearly communicated.’
- ‘Always there and always supportive.’

What needs to improve

No hand washing facilities or a sink with draining board were available in the domestic services room to allow non-disposable cleaning equipment to be thoroughly cleaned after use. One sink was used to clean clinical equipment in the dirty utility room. There was no additional sink for urine disposal or separate hand washing facilities to ensure staff could safely decontaminate (clean) their hands. We saw this had been identified and discussed at a recent risk management meeting. We discussed this with the development manager and they told us this would be considered in future refurbishment plans (requirement 4).

Patients were reviewed every week by the multidisciplinary team and we saw that nursing staff documented in the patient care record any outcomes from the meetings, such as any changes to treatment, including medication and discussions with the patient. However, we saw no record of the multidisciplinary team meeting having taken place in the patient care record. For example, what staff were in attendance, what discussions took place about changes to treatment and responsibilities of staff for any decisions made (recommendation d).

Requirement 4 – Timescale: immediate

- The provider must risk assess the availability of hand wash basins and sinks in the domestic services room and dirty utility room against current guidance, and a risk-based refurbishment plan should be developed to reduce any risks identified to minimise the spread of infection.

Recommendation d

- The service should ensure that a record of multidisciplinary meetings are documented in the patient care record.

Appendix 1 – About our inspections

Our quality assurance system and the quality assurance framework allow us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this system to check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. Inspections may be announced or unannounced.

We follow a number of stages to inspect independent healthcare services.

Before inspections

Independent healthcare services submit an annual return and self-evaluation to us.

We review this information and produce a service risk assessment to determine the risk level of the service. This helps us to decide the focus and frequency of inspection.

Before

During inspections

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.

During

After inspections

We publish reports for services and people experiencing care, carers and families based on what we find during inspections. Independent healthcare services use our reports to make improvements and find out what other services are doing well. Our reports are available on our website at: **www.healthcareimprovementscotland.org**

We require independent healthcare services to develop and then update an improvement action plan to address the requirements and recommendations we make.

We check progress against the improvement action plan.

After

More information about our approach can be found on our website: https://www.healthcareimprovementscotland.org/scrutiny/the_quality_assurance_system.aspx

Complaints

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Telephone: 0131 623 4300

Email: his.ihcregulation@nhs.scot

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
or email his.contactpublicinvolvement@nhs.scot

Healthcare Improvement Scotland

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