Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Alpha Hospital Group, Aberdeen

Service Provider: Alpha Hospital Group and Healthcare Ltd

19–20 February 2025

NHS SCOTLAND

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Contents

1 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 Alpha Hospital Group on Wednesday 19 and Thursday 20 February 2025. We spoke with a number of staff and patients during the inspection We received feedback from seven staff members through an online survey we had asked the service to issue for us during the inspection. This was our first inspection to this service.

Based in Aberdeen, Alpha Hospital Group is an independent hospital providing non-surgical and surgical treatments.

The inspection team was made up of two inspectors.

What we found and inspection grades awarded

For Alpha Hospital Group, 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 hospital had a well-defined and measurable vision and aim, with a clear strategy and defined key performance indicators to achieve it. Key principles and values had been identified in line with the vision and aim. Values and principles were displayed in the hospital for staff and patients to see. Key performance indicators were regularly monitored and reported. The leadership team worked well together and was open to ideas for improvement. Staff were empowered to speak up. Operational issues were managed appropriately in a clear governance structure.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
The hospital actively sought patient and staff feedback, using it to continually improve the way the service was delivered. We saw good levels of patient and staff satisfaction. Patient feedback outcomes were shared and staff received regular feedback. Staff were recruited safely. Systems were in place to manage risks. Policies and procedures supported staff to deliver safe, compassionate and person-centred care. Comprehensive risk management and quality assurance processes and a quality improvement plan helped staff to continuously improve service delivery. A formal process for reviewing patient feedback and providing clinical supervision for trained nursing staff should be implemented. A competency framework should be implemented. Audits should follow a structured audit programme.	✓✓ Good

Results	*How well has the service demonstrated that it provides safe, person-centred care?*	
The care environment and patient equipment was clean, equipment was fit for purpose and regularly maintained. Medicines management was good. Staff described the provider as a good employer and the hospital as a good place to work. Patients were very satisfied with their care and treatment. Infrequently used water outlets must be flushed regularly and appropriate records kept. Sinks should be cleaned with cleaning in line with national guidance. Clinical waste bins should secured.		✓ Satisfactory

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

More information about grading can be found on our website at: Guidance for independent healthcare service providers – Healthcare Improvement Scotland

Further information about the Quality Assurance Framework can also be found on our website at: The quality assurance system and framework – Healthcare Improvement Scotland

What action we expect Alpha Hospital Group and Healthcare Ltd 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 one requirement and seven recommendations.

Implementation and delivery	
Requirements	
	None
Recommendations	
a	The service should develop a formal process for reviewing patient feedback (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 develop its own systems and processes and implement clinical supervision of trained staff, including formal recording of it (see page 18). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14
c	The service should implement a competency framework for all staff involved in clinical care (see page 19). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14

Implementation and delivery (continued)	
d	The service should further develop a structured programme of regular audits (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Results	
Requirement	
1	The provider must ensure that all infrequently used water outlets are flushed and appropriate records kept in line with current national guidance (see page 24). Timescale – by 19 May 2025 *Regulation 3(d)(i)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
e	The service should record patients' consent to share information with their next of kin in the event of an emergency in the patient care record (see page 24). Health and Social Care Standards: My support, my life. I am fully involved in all decisions about my care and support. Statement 2.14
f	The service should ensure that appropriate cleaning products are used for the cleaning of all sanitary fittings, including sinks, in line with national guidance (see page 25). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
g	The service should store all waste in a designated, safe, lockable area while awaiting uplift (see page 25). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website:
Find an independent healthcare provider or service – Healthcare Improvement Scotland

Alpha Hospital Group and Healthcare Ltd, the provider, must address the requirement and make the necessary improvements as a matter of priority.

We would like to thank all staff at Alpha Hospital Group for their assistance during the inspection.

2 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 hospital had a well-defined and measurable vision and aim, with a clear strategy and defined key performance indicators to achieve it. Key principles and values had been identified in line with the vision and aim. Values and principles were displayed in the hospital for staff and patients to see. Key performance indicators were regularly monitored and reported.

The leadership team worked well together and was open to ideas for improvement. Staff were empowered to speak up. Operational issues were managed appropriately in a clear governance structure.

Clear vision and purpose

The service's business plan and strategy plan set out how the provider's vision would be achieved. The service aimed to 'become a leading plastic surgery institution' through 'providing advanced, patient-centred plastic surgery and dermatology.' Its vison was to improve patient wellbeing and satisfaction through 'state-of-the-art procedures delivered by top-tier plastic surgeons, doctors and aestheticians'. This aim and vision were displayed in the service and on its website.

Key performance indicators (KPIs) helped to make sure the provider's vision was measurable. The business plan and strategy were reviewed regularly at leadership forums and used to inform the next strategy. KPIs were continually monitored in a variety of ways, including monthly reviews at the senior staff meeting, as well as through data analysis from:

- assurance tools
- business intelligence systems monitoring workforce, audits, safety alerts, risk and incident reporting and complaints, and
- the service's clinical governance framework.

We saw evidence of regular monitoring, recording and reporting through appropriate governance structures.

The hospital's strategy plan set out KPIs linked to the strategic objectives and included issues, such as:

- 'Agreed Strategy and Priorities for Alpha Hospital.'
- 'Challenge Identification for Alpha Hospital's Day Case Unit.'
- 'Resource Inventory for Alpha Hospital's Day Case Unit.'
- 'Understanding of Context, Alpha Hospital's Capabilities, and Major Challenges.'
- 'Understanding of the Local and Target Population Profile, Needs, and Inequalities.'

We saw that the service recorded progress against KPIs and reported this through the governance structure.

The strategy plan was reviewed and discussed regularly at leadership forums and team meetings. A comprehensive 6-month review of the plan had been carried out. We saw that the service was making good progress in achieving its KPIs from minutes of meetings we reviewed and staff we spoke with. Values and principles were displayed in the hospital for staff and patients to see. Staff we spoke with were aware of the service's vision, purpose and values.

- No requirements.
- No recommendations.

Leadership and culture

The hospital's staffing resource was made up of:

- a healthcare support worker
- facilities staff
- medical staff, including consultant surgeons and anesthetists
- reception and administrative staff, and
- registered nurses.

The hospital had an effective leadership structure in place through its senior management team, which was made up of the:

- consultant surgeon, who was also one of the company directors
- hospital manager, who was also one of the company directors
- operations manager, and
- theatre manager.

Regular senior management team meetings were held and minutes showed that information and strategic plan updates were shared at these meetings. Actions and updates on previously agreed actions were recorded. Service improvements were also discussed at the different management and governance meetings.

The hospital had a comprehensive and inclusive programme of department and staff meetings, including those for:

- clinical governance,
- health and safety
- infection prevention and control
- managing patient care
- medicines management, and
- monitoring compliance with professional standards and legislation.

Staff we spoke with were clear in their roles and how they could impact change in the hospital. They reported that they felt the senior management team listened to and valued them.

The service proactively managed its staffing compliment based on a patient-dependency model to help make sure that an appropriate skill-mix and safe staffing was always provided.

We attended a daily huddle in the theatre department, which included the theatre staff and other appropriate staff. The huddle discussed:

- management of the equipment used
- staffing levels
- theatre lists and an overview of theatre cases
- whether it was safe to carry out the day's business.

On the day we attended the huddle, no adverse incidents had been reported.

A ‘freedom to speak up’ system had been introduced, where staff could use a QR code to raise any concerns anonymously. Staff we spoke with were clear about how they could raise any concerns they had. Staff told us they did not have any concerns to raise. Staff we spoke with also told us that they could speak to any member of the senior leadership team and they felt supported and encouraged in their role.

Staff were kept up to date through:

- email
- safety briefs, and
- ward staff meetings every 2 months.

We were told that the service had started to include bank staff in staff meetings so they could raise anything to be discussed.

The leadership team worked well together and was open to ideas for improvement. The team engaged well in the inspection process and shared all information we asked for. Staff told us they felt empowered to speak up and felt safe to do so.

What needs to improve

The service had a whistleblowing policy and a process in place for staff to report any concerns anonymously through a QR code. While the service did not have a formal, designated ‘speak up guardian’ for staff, a nominated informal speak up champion was in place. We discussed this with the service during the inspection and we will follow this up at future inspections.

- 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 hospital actively sought patient and staff feedback, using it to continually improve the way the service was delivered. We saw good levels of patient and staff satisfaction. Patient feedback outcomes were shared and staff received regular feedback. Staff were recruited safely. Systems were in place to manage risks. Policies and procedures supported staff to deliver safe, compassionate and person-centred care. Comprehensive risk management and quality assurance processes and a quality improvement plan helped staff to continuously improve service delivery.

A formal process for reviewing patient feedback and providing clinical supervision for trained nursing staff should be implemented. A competency framework should be implemented. Audits should follow a structured audit programme.

Co-design, co-production *(patients, staff and stakeholder engagement)*
Patient feedback was gathered before, during and after consultations and treatments using a variety of methods, including the use of QR codes included in all patient correspondence. Other methods of gathering patient feedback included:

- online applications
- patient testimonials on the service's website
- social media, and
- verbally.

This information was used to improve the way the service was delivered. For example, the service had purchased a clinic in an Aberdeenshire town which reduced the need for patients to travel to Aberdeen for consultations and post-op care.

We saw that patients had follow-up calls following treatment to find out how they felt and to provide an opportunity to raise any issues at the same time.

Patient feedback was analysed regularly. These results and improvement actions were shared at staff meetings and the service's internal online information system. This information was also included in a 3-monthly patient newsletter. We looked at a selection of surveys the service had carried out, which showed good levels of patient satisfaction.

Staff meetings were held every 6 months. A staff survey was shared before the staff meeting, which asked a comprehensive set of questions. Results from the most recent survey were discussed at the staff meeting and any changes made to the service were shared. Minutes of these meetings demonstrated that staff could express their views freely and staff we spoke with agreed. Improvements we saw included the use of a QR code where staff could report any suggestions, complaints or concerns anonymously to the operations manager.

Staff received emails and information on patient feedback, complaints and any operational changes. Staff told us they received information and training on new initiatives and policy updates.

When staff worked late, the service would order in food from a local takeaway.

What needs to improve

While patient feedback was analysed regularly in line with the service's participation policy, the service did not have a formal process in place for reviewing patient feedback (recommendation a).

- No requirements.

Recommendation a

- The service should develop a formal process for reviewing patient feedback.

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.

Appropriate policies and procedures set out the way the service was delivered and supported staff to deliver safe, compassionate, person-centred care. A process was in place for writing all policies and approving them through the clinical governance group and medical advisory committee. Policies and procedures were updated regularly or in response to changes in legislation, national and international guidance and best practice. To support effective

version control and accessibility, policies were available electronically on the service's staff intranet.

The service's infection prevention and control policies and procedures were in line with Health Protection Scotland's *National Infection Prevention and Control Manual*. We saw that electronic cleaning schedules were in place for all areas and departments.

A detailed medicines management policy was in place, which included the use of controlled drugs.

The service was aware of the notification process to Healthcare Improvement Scotland. During our inspection, we saw that the service had submitted all incidents that should have been notified to Healthcare Improvement Scotland.

All staff completed a 6-month probation period when they started working in the service, which included a 'check in' with their line manager at 4, 8 and 12 weeks. As well as completing a general induction programme, staff also completed a role-specific induction programme where appropriate.

Staff completed mandatory and role-specific online learning modules. Mandatory training included safeguarding of people and duty of candour. The theatre manager and service manager used an online platform to monitor compliance with mandatory training completion. Staff told us they received enough training to carry out their role. We saw evidence in staff files and training reports of completed mandatory training, including for medical staff with practicing privileges (staff not employed directly by the provider but given permission to work in the service).

Staff completed an annual appraisal where aims, objectives and goals were identified and discussed. A process was in place to review progress made against the identified aims and objectives in the 6 months after they had been set. Staff had an opportunity at this stage to feedback any issues or change the original aims, objectives and goals. The appraisals we saw were comprehensively completed. Staff we spoke with told us their appraisals helped them feel valued and encouraged their career goals.

A clear process was in place for managing complaints. Information about how to make a complaint was visible in the hospital and on the website. We were told that when someone made a complaint, they:

- received an acknowledgement letter with a full description of the complaint
- then received a follow-up letter when the complaint had been fully investigated, with the outcome of the investigation, and
- were offered a face-to-face with a member of the senior management team.

We saw these letters were comprehensive and answered the complaints in full, with the actions taken. An electronic system was used to monitor the progress of complaints. Complaints were discussed at the leadership team meetings and governance meetings.

A duty of candour procedure was in place (where healthcare organisations have a professional responsibility to be honest with patients when things go wrong). Staff we spoke with fully understood their duty of candour responsibilities and had received training in it. The service had published a yearly duty of candour report. We saw evidence that the service had followed its own procedure when dealing with these incidents and shared learning with staff and consultants.

The provider and service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights). We saw that patient care records were stored securely.

Staff told us that patients were given written aftercare instructions and information about any recommended follow-up when discharged. We saw evidence of this recorded in the patient care record. The service's contact details were provided on discharge in case patients had any concerns or queries. Patients we spoke with told us they were clear about what to expect after discharge.

The medicines fridges were checked regularly, including its contents and daily temperatures. Staff we spoke with knew the process for reporting faults. We saw that the emergency equipment trolley was checked daily and kept in accessible locations. Staff we spoke with were familiar with the location of the emergency equipment.

We saw that the service had a deteriorating patient protocol, which included a:

- malignant hypothermia procedure
- national early warning score chart (NEWS 2), and
- major haemorrhage protocol.

The service's recruitment policies described how staff would be appointed. We reviewed five files of employed staff and five files of individuals granted practicing privileges. All 10 files were well organised. We saw evidence of clear job descriptions and that appropriate recruitment checks had been carried out, including:

- professional register checks and qualifications where appropriate
- Protecting Vulnerable Groups (PVG) status of the applicant (this was repeated every 3 years), and
- references.

Appropriate pre-employment checks were carried out for employed staff. All staff had completed an induction, which included an introduction to key members of staff in the service and mandatory training. All new staff we spoke with had completed an induction programme. We were told that new staff were allocated a mentor and the length of the mentorship depended on the skills, knowledge and experience of the new member of staff.

What needs to improve

While yearly appraisals carried out, the service did not have a policy and process in place for clinical supervision. We saw no evidence of clinical supervision taking place at the time of our inspection (recommendation b).

The service had a staff induction process in place. However, we saw no evidence of a competency framework for all staff involved in clinical care (recommendation c).

- No requirements.

Recommendation b

- The service should develop its own systems and processes and implement clinical supervision of trained staff, including formal recording of it.

Recommendation c

- The service should implement a competency framework for all staff involved in clinical care.

Planning for quality

Accidents and incidents were recorded and managed through an electronic incident management system. Each one was reviewed and reported through the clinical governance framework. Learning was fed back to staff through:

- e-mails
- one-to-one meetings
- theatre huddles, and
- team meetings.

The service's risk management process included corporate and clinic risk registers, auditing and reporting systems. These detailed the actions taken to mitigate or reduce risk. The service carried out a variety of risk assessments to help identify and manage risk. These included risk assessments for:

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

An equipment asset register had been established to track when each item of equipment was due to be serviced or maintained. We saw evidence that all equipment servicing and maintenance was up to date. Examples included:

- clinical and medical equipment
- fire equipment
- gas boilers,
- medical gases, and
- the fixed electrical installation.

Processes were in place to manage the service's water safety, including a legionella risk assessment and monthly visits from a specialist water safety

management company. This company carried out water sampling, checked the temperature of water outlets and performed routine maintenance.

The service carried out audits, which helped make sure it delivered consistent safe care and treatment for patients and identified any areas for improvement. Action plans were produced to make sure any actions were addressed.

Audits carried out included those for:

- clinical outcomes
- controlled drugs
- health and safety
- infection prevention and control
- lasers
- medication, and
- patient care records.

What needs to improve

While regular audits were carried out, we saw no evidence of a formal audit programme in place (recommendation d).

- No requirements.

Recommendation d

- The service should further develop a structured programme of regular audits.

Key Focus Area: Results

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

Our findings

The care environment and patient equipment was clean, equipment was fit for purpose and regularly maintained. Medicines management was good. Staff described the provider as a good employer and the hospital as a good place to work. Patients were very satisfied with their care and treatment.

Infrequently used water outlets must be flushed regularly and appropriate records kept. Sinks should be cleaned with cleaning in line with national guidance. Clinical waste bins should secured.

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.

We saw that care was delivered in a clean hospital environment and theatre suite with equipment that was fit for purpose and regularly maintained. The consulting or treatment rooms and minor surgery rooms were in good condition, tidy and clean. Electronic cleaning schedules were in place which were well completed. Appropriate cleaning products were used to clean general equipment and the environment, including a locked cupboard for materials under COSHH. Clinical waste was managed in line with national guidance and clean linen was stored correctly.

The equipment we saw was clean and well maintained. Patients we spoke with told us that they felt safe and that the cleaning measures in place to reduce the risk of infection in the service were reassuring. All patients stated the clinic was clean and tidy. Comments included:

- ‘Very clean.’
- ‘No complaints.’

We looked at five patient care records and saw they all included the patients' name, address and next of kin. Patient care records also included:

- details of their assessment and consultation
- documentation of the discussion about the treatment plan, including the risks and benefits of each treatment offered
- patient consent to treatment and to share information with their GP or other relevant healthcare professional where appropriate, and
- post-treatment aftercare discussions with patients before their discharge from the service.

We saw evidence of policies and procedures for emergency situations and for transferring patients to an acute NHS facility if required. Processes and procedures were also in place to identify patients with deteriorating conditions using the updated national early warning scoring (NEWS 2) system.

We saw evidence of good standards of medicines management. This included completed records of stock checks and medicines reconciliation (the process of identifying an accurate list of the patient's current medicines and comparing it with what they are actually using). We saw that controlled drugs were stored securely. Controlled-drugs keys were kept separately from medication cupboard keys and were signed out. We saw that medication used for sedation was stored in a locked cupboard with a book that recorded the stock level.

The hospital's Home Office certificate for stocking and prescribing controlled drugs was valid and in-date.

Take-home medication for patients was ordered in advance of their discharge and the pharmacist had oversight of this and reviewed all prescriptions before dispensing any medication.

The service had a certified laser protection advisor, with a signed contract detailing dates of their contract with the hospital. All staff operating lasers had updated their core of knowledge training and equipment training. This was kept on file and available to view on the day of our inspection. The laser protection supervisor worked closely and alongside the laser protection advisor to develop the local rules for all laser equipment being used. Local rules to be followed for the safe use of lasers were in place with a review date every 2 years and had been recently reviewed.

To help assess the safety culture in the clinic, we followed a patient's journey from admission through theatre, recovery room and then being discharged.

Before the patient arrived in theatre, we observed a pre-safety brief which made sure all staff in theatre were aware of the patient's details, journey and the procedure planned. We saw that staff followed World Health Organization guidelines, such as taking a ‘surgical pause’ before starting surgery to check they had the correct patient and equipment. We also observed staff following safe procedures for managing swabs and instruments in line with guidelines, including those for tracking and tracing instruments used.

A suitable member of staff accompanied patients to and from the theatre department. Staff took time to talk and listen to the patient at each point in the journey, with various staff introducing themselves and explaining what was happening. The patient was closely monitored while anaesthetised during the operation and then in the recovery room. Patients’ privacy and dignity was maintained at all times. We saw effective multidisciplinary working with informative staff handovers and communication at all stages in the patient journey.

Staff told us they felt the approachable leadership team valued and supported them well. Minutes of staff meetings and the staff survey showed that staff could express their views freely. From our own observations of staff interactions, we saw a compassionate and co-ordinated approach to patient care and hospital delivery, with effective oversight from a supportive leadership team.

As part of our inspection, we asked the hospital to circulate an anonymous staff survey which asked five ‘yes or no’ questions. The results for these questions showed the following:

- All staff felt there was positive leadership at the highest level of the organisation.
- All staff felt there was positive culture at work.
- All staff felt they could influence how things were done in the hospital.
- All staff felt their line manager took their concerns seriously.
- All staff would recommend the hospital as a good place to work.

The final question of the survey asked for an overall view about what staff felt the hospital did really well and what could be improved. Comments were mostly positive and included:

- 'We provide a high level of care to all patients.'
- 'Patient care and customer service is excellent.'
- 'Customer service.'
- 'Excellent patient care and outcomes.'
- 'The patient care service from consultation through to after care post op is impeccable. All patients are so happy and so appreciative of how well they're cared for.'

What needs to improve

As part of the service water management system, we saw that a process was in place for the flushing of water outlets and recording when this was done. However, on reviewing the documentation we found that these water outlets were not being flushed in line with current guidance (requirement 1).

Patient care records did not demonstrate that the service recorded that patient's consent to share information with their next of kin in the event of an emergency (recommendation e).

The service's clinical handwash basins were not cleaned with the appropriate cleaning solution, in line with current guidance (recommendation f).

While we found that all storage bins used to store clinical waste bags were kept locked, they were not secured to the wall (recommendation g).

Requirement 1 – Timescale: immediate

- The provider must ensure that all infrequently used water outlets are flushed and appropriate records kept in line with current national guidance.

Recommendation e

- The service should record patients' consent to share information with their next of kin in the event of an emergency in the patient care record.

Recommendation f

- The service should ensure that appropriate cleaning products are used for the cleaning of all sanitary fittings, including sinks, in line with national guidance.

Recommendation g

- The service should store all waste in a designated, safe, lockable area while awaiting uplift.

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: [The quality assurance system and framework – Healthcare Improvement Scotland]

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

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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