Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Ross Hall Hospital, Glasgow

Service Provider: Circle Health Group Limited

13–14 March 2025

NHS SCOTLAND

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1 Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 14 March 2023

Recommendation

The service should securely destroy original Disclosure Scotland PVG records in line with current legislation and implement a system to record PVG scheme identification numbers for all staff.

Action taken

The service no longer kept the original certificates. Relevant information, such as their name, PVG number and expiry date was kept on a separate document for each member of staff.

What the provider had done to meet the requirement we made at our complaint investigation on 12 March 2024

Requirement

The provider must ensure that a record is made in the patient care record which sets out the date and time of any consultation, examination and investigations undertaken and the outcome.

Action taken

We saw that the outcome of the consultation was recorded in the patient care record in the form of a consultant letter. **This requirement is met**.

What the provider had done to meet the recommendation we made at our complaint investigation on 12 March 2024

Recommendation

The service should review the CHG Pathology Policy SOP 07 End to End Process for Management of Pathology Results to ensure results are received, reviewed and recorded in a timely manner by referring clinician.

Action taken

We were told and saw that the CHG Pathology Policy SOP 07 End to End Process for Management of Pathology Results had been updated. We were told that the pathology results could also be accessed electronically in real time. Results were sent in hard copy to the appropriate consultant and were available in the patient care record. Any positive histology results were sent weekly to the director of clinical services in a spreadsheet from the lab provider and this was shared with the appropriate consultants.

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 Ross Hall Hospital on Thursday 13 and Friday 14 March 2025. We spoke with a number of staff, service users, patients and carers during the inspection. We received feedback from 72 staff members through an online survey we had asked the service to issue for us during the inspection.

Based in Glasgow, Ross Hall Hospital is an independent hospital providing non-surgical and surgical treatments.

The inspection team was made up of three inspectors and one clinical advisor.

What we found and inspection grades awarded

For Ross Hall Hospital, the following grades have been applied.

Direction	*How clear is the service's vision and purpose and how supportive is its leadership and culture?*
Summary findings	**Grade awarded**
The hospital had a well-defined and measurable vision and purpose, 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 purpose. Key performance indicators were regularly monitored and reported. Clear benchmarking was in place and continually monitored. A clear governance structure was in place. The hospital's leadership team was visible. Staff were empowered to speak up.	✓✓✓ Exceptional
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patient experience was regularly assessed and used to continually improve how the service was delivered. Appropriate policies and procedures supported staff to deliver safe, compassionate and person-centred care. Comprehensive risk management and quality assurance processes were in place for patient and staff safety. Improvement projects involved all departments. Staff surveys carried out every 2 years helped the service plan and develop staff. The effectiveness of improvements made as a result of patient feedback were evaluated. The quality improvement plan was maintained and updated regularly.	✓✓✓ Exceptional
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. Pharmacy staff reviewed the medicines management in place. 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. Staff must comply with the service's infection prevention and control policy. Medication charts should be rewritten when patients are transferred from critical care to the wards.	✓✓ 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: 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 Circle Health Group Limited to take after our inspection

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

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

This inspection resulted in one requirement and one recommendation.

Results	
Requirement	
1	The provider must ensure compliance with all standard infection prevention and control precautions as detailed in Health Protection Scotland's *National Infection Prevention and Control Manual*, in particular: *(a) clinical waste management, and* *(b) use of personal protective equipment (see page 31).* Timescale – immediate *Regulation 3(d)(i)(iii)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendation	
a	The service should ensure that all medication charts are rewritten when patients are being transferred from critical care to the wards to ensure that information about patients' prescribed medication remains current (see page 31). Health and Social Care Standards: My support, my life. I am fully involved in all decisions about my care and support. Statement 2.14

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

Circle Health 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 Ross Hall Hospital for their assistance during the inspection.

3 What we found during our inspection

Key Focus Area: Direction

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

Our findings

The hospital had a well-defined and measurable vision and purpose, 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 purpose. Key performance indicators were regularly monitored and reported. Clear benchmarking was in place and continually monitored.

A clear governance structure was in place. The hospital's leadership team was, approachable and visible. Staff were empowered to speak up.

Clear vision and purpose

Ross Hall Hospital is part of Circle Health Group Limited, the provider. The provider's purpose was to provide the high quality, safe and compassionate care their patients need and expect.

The provider had the following principles:

- 'We believe that patients come first.'
- 'We believe in our people.'
- 'We believe that 'good enough' never is.'
- 'We believe in being open-minded and innovative.'

The provider also stated its values:

- 'We value people who are selfless and compassionate.'
- 'We value people who are collaborative and committed.'
- 'We value people who are agile and brave.'
- 'We value people who are tenacious and creative.'

The purpose, principles and values were detailed in the Circle Health Group Limited 'Circle Operating System' (COS), used in the service. The COS described the methodology and tools to set up and run healthcare facilities in 'The Circle

Way'. Through COS, Circle Health Group Limited aimed to remain a high-performing, agile organisation with a dedication to continuous improvement, innovation and invention.

The provider had a corporate strategy and each hospital set its own local hospital strategy, which could include local performance growth opportunities.

The strategic objectives for the service were:

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

The service had a Ross Hall Hospital business plan and clinical strategy in place, which outlined the site-specific plans for a 12-month period. The document included:

- actions for the forthcoming year
- emerging priorities, and
- planned improvements.

A variety of committees and groups regularly reviewed the strategy and plans.

The executive director showed us the new key priorities document for Ross Hall Hospital, which would be shared with all staff for their feedback. We were told that department specific plans were developed based on the hospital-level document.

The provider set corporate key performance indicators (KPIs) for its services to meet. The provider monitored these KPIs through local performance and finance meetings and we saw them detailed in the Ross Hall Hospital business plan. Line managers and heads of department also set local KPIs as part of the appraisal process. KPIs were measured and discussed at the corporate operational site review meetings, held every 3 months with regional directors and area directors of corporate performance.

We also saw that the hospital committee and group meetings reported monthly performance dashboards, discussions and actions taken to make improvements where appropriate. For example, initiatives had been introduced to reduce the number of falls in some clinical areas after a slight increase had been reported in a month.

We saw evidence that KPIs reported in these dashboards benchmarked the service against the provider's other hospitals. This allowed the service to regularly monitor its performance in the hospital and compare it with other hospitals.

We were also told that a programme of site visits helped monitor KPIs, such as site assurance visits and peer reviews with heads of departments and senior management teams. The visits used a 'find and fix' methodology to support services to follow policy and regulatory requirements.

The provider completed its most recent internal peer review of Ross Hall Hospital in February 2023. We saw the report and the service's action plan from the review. From minutes of meetings, we saw that the service was completing the provider's quality and standards review tool to prepare for the next planned internal peer review visit.

- No requirements.
- No recommendations.

Leadership and culture

The service had a highly skilled staffing resource made, which included a mix of clinical and non-clinical staff, for example:

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

The hospital's senior management team was made up of:

- the director of clinical services
- the director of operations and business development, and
- the executive director.

The senior management team supported the clinical and non-clinical teams and heads of departments.

The provider's 'Circle Safer Staffing' model defined the staffing required for all clinical areas, including the number of positions to be filled. We were told that hospital managers could use their professional judgement to alter the staffing if they could evidence safe, effective practice. The service told us it had good recruitment and retention levels and that a number of its student nurses applied to work in the service after they qualified, as they had a good experience while in training. The service operated its own staff bank, which meant it did not need to use agency staff.

The provider's governance and reporting framework clearly detailed the governance and reporting structure for the provider and each hospital. For each group or committee, this included:

- membership
- reporting schedule
- standing agenda items, and
- terms of reference.

Hospital-level committees or groups included:

- clinical governance
- health and safety
- infection prevention
- medical advisory, and
- medicines management.

We saw evidence that operational issues were also discussed at committee structures or groups and managed appropriately. Staff we spoke with told us about information shared with them from a variety of groups and committees, such as quality improvement initiatives.

The Circle Operating System stated that all staff had a voice and could actively contribute to how things get done. It encouraged staff to share knowledge and lessons learnt with the wider organisation, allowing for learning and adaptation. It described how decision-making was devolved and inclusive to give all staff ownership and accountability. We saw that leaders promoted a culture of staff empowered to make decisions for patients, knowing their contribution was valued and with pride in the outcomes achieved.
The provider had a 'Speak Up Champion' role in each hospital and we were told that this was advertised and interviewed for among existing staff in each

hospital. We saw speak-up-champion posters displayed in the hospital with details of who the speak up champion was and how to contact them. We were told that the champion role in Ross Hall Hospital had been well received. Staff told us they were aware of who the speak up champion was.

Staff we spoke with told us they found leaders at all levels to be visible and approachable. We saw that senior staff knew the names of staff as they walked round the site and the staff interacted with senior staff. We were told that lunch meetings were well attended and held every 2 weeks for staff to have lunch with the executive director and discuss any concerns.

The service communicated with its staff in a variety of ways, including:

- intranet information
- local staff meetings
- meetings and huddles
- newsletters, and
- open forums.

Members of the senior management team and a variety of other senior staff for the hospital attended a daily huddle, including staff from:

- catering
- estates
- nursing
- pharmacy, and
- physiotherapy.

The huddle highlighted any hospital-wide updates and patient numbers for the day. The wards also held a daily safety brief, which highlighted patient safety issues, such as patients with allergies, diabetes or those at risk of falls.

Staff had opportunities to meet to debrief after any incident or error that occurred. We were told and saw examples of incidents, such as medication errors where staff were encouraged to reflect on and identify improvements in the processes and how to prevent any similar incidents. We also saw evidence of 'stop the line,' where staff could speak out safely about practice if they had concerns, which could mean the process was stopped while it was reviewed. We were told of a member of staff querying a swab count in theatre. They had raised their concerns, the process was stopped, and the swab count was re-done. The Circle Operating System also allowed staff time to meet, reflect on

patient experience and learn from it. Staff we spoke with during our inspection were enthusiastic about the Circle Operating System.

Staff that we spoke with told us the service supported them in introducing new initiatives. We were told and saw evidence that the paediatric team had achieved the Autism Accreditation Inclusion Award from the National Autistic Society. We saw that the certificate of accreditation was displayed in the ward.

We also saw that the following improvements had been introduced:

- Picture format of interventions, such as taking blood pressure, weight and having a blood test. Patients were sent these out in advance so that parents could be involved.
- 'Then and now' pictures boards, so that autistic patients knew what to do before being discharged. These included 'time to sleep overnight', 'have you eaten and drunk something' and 'have you gone to the toilet'.
- Picture cards to express 'how you are feeling today.'
- A mock video for children of a patient journey from admission to the ward, to theatre, into recovery and back to the ward.
- Autistic paediatric patients could visit the ward in advance of their surgery and the nurse who helped to show them round would be on duty on the day of their admission.

Autism champions had completed extra training through the provider's online training platform and the national autistic society. These staff members organised drop-in sessions to educate other members of staff in the hospital.

We were told that staff were supported to develop in the service and staff we spoke with at a variety of levels told us how the organisation had supported their learning and development. This has allowed the staff to progress in their career and develop the business. For example, we saw that the service had appointed some new heads of department in the 12–18 months before our inspection. They had been appointed after other managers had mentored them over the years to allow them to develop and allow for succession planning in the service.

- No requirements.
- No recommendations.

Key Focus Area: Implementation and delivery

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

Our findings

Patient experience was regularly assessed and used to continually improve how the service was delivered. Appropriate policies and procedures supported staff to deliver safe, compassionate and person-centred care. Comprehensive risk management and quality assurance processes were in place for patient and staff safety. Improvement projects involved all departments. Staff surveys carried out every 2 years helped the service plan and develop staff. The effectiveness of improvements made as a result of patient feedback were evaluated. The quality improvement plan was maintained and updated regularly.

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

The hospital actively sought feedback from patients about their experience of treatment and care and used this information to continually improve the way its service was delivered. The service had a current patient experience and engagement strategy in place, with a review date in 2026. This document set out details of local patient engagement and engagement projects, as well as initiatives to address the service's strategic priorities and further support patients and colleagues, including the following:

- Introducing a patient safety partner (patient, carer or lay person) into the clinical governance committee and engage them in quality improvement projects.
- Further developing patient participation groups for all specialties.
- Discussing compassionate care with teams to provide assurances that a culture of excellence in compassionate care is visible and evident.

The service's up-to-date patient experience and engagement policy described how feedback would be gathered, analysed and used to inform improvement activities. We saw this had been embedded into the daily activities of patient care in the service. For example, different questionnaires were available for patients attending as outpatients or inpatients, to complete at different times during their experience, including after admission and discharge. Patients were also regularly asked to give their feedback on other parts of the service, such as:

- catering
- pharmacy
- theatre staff, and
- whether they had enough time with the consultant.

Paediatric patients were asked for their feedback. A paediatric feedback form was given to parents to complete with their child. Questions included:

- the two best things about their visit
- the worst two things about their visit, and
- their ideas to make the hospital better, as well as any other comments.

The senior paediatric nurse reviewed feedback daily and weekly and we saw that action plans were developed following feedback. Improvements made as result of feedback included:

- a designated children's menu
- a welcome pack for children, which included colouring-in pictures with pencils and a cuddly toy
- designated quiet spaces in each department, and
- refurbishment of the reception area, with improved signage and the employment of a greeter to meet patients and visitors.

We saw evidence of focus groups carried out in the service. This is where service users meet as a group to talk about their experience of the service, whether positive or not. The service was then able to share the positives with staff and learn and improve where necessary. These included:

- a bariatric focus group
- a urology focus group, and
- an oncology focus group.

We were told and saw that the service was setting up a general surgery focus and a vestibular focus group.

The provider had processes in place to make sure that all patient experiences were captured in its quality processes. The service employed an appropriately trained healthcare assistant as a 'patient voice champion.' They actively spoke

with patients during their stay to gain real time feedback on their experience and find out any queries or concerns. Patients could talk about their experience with the patient voice champion face-to-face before discharge, or over the phone after discharge. We saw that these experiences were discussed at regular staff meetings using 'the patient hour.' The patient hour was used to reflect on and develop learning outcomes from the feedback gathered. This included the teams involved, the service and the provider. The patient hour was also a standing item on the different clinical governance committees in the service and the process was well documented.

We saw evidence that the service was appointing a patient representative to attend the service's clinical governance committee.

Critical care staff maintained a patient diary to aid patients during their post-operative recovery and any re-visit back to the hospital. We saw evidence that one patient and their family had found this particularly helpful.

Information leaflets were readily available for patients in the hospital and available in different formats. Information boards with comprehensive and inclusive information were also displayed in an accessible format. Patients could leave feedback on the hospital's website, which the hospital then responded to directly. Results of monthly feedback analysis were shared at staff meetings. We saw good levels of patient satisfaction, especially in patient care and individual staff members.

A 'you said, we did' board in the hospital detailed examples of improvements made as a result of feedback. For example, after a patient complained the hospital changed the provision of care in the department to improve the delivery of care. The improvement activity had been shared with the patient in a meeting and the changes had been evaluated to make sure they met the patients' needs. The complainant had given the hospital excellent written feedback about the handling and subsequent outcome of the complaint.

The hospital recognised its staff in a variety of ways, including:

- cards acknowledging positive feedback from patients
- staff birthday celebrations, and
- the leadership team giving staff pizza and ice cream.

A 'long service award' was also given to staff that had worked in the hospital for 5 years or more. Recipients were given a certificate of recognition, a voucher to spend and had their photo displayed. Further awards were given with every

extra 5 years of service. A benefits programme was in place for staff, which included private healthcare, access to savings schemes and wellbeing support. A staff survey called 'Be Heard' was carried out every 2 years, which asked a comprehensive set of questions. Results from the most recent survey showed a high level of satisfaction, which had improved from previous year's survey, and this had been acknowledged across the provider's organisation. Results were shared with staff at monthly staff meetings. The staff we spoke with in the wards also confirmed that meetings were held regularly. Minutes were displayed and stored in ward folders after the next meeting. Staff receive emails and monthly newsletters to keep them updated with any operational changes. At the time of our inspection, the next survey was due to be sent out.

The hospital recognised the importance of supporting charities. We saw an ongoing collection for a local food bank staff and were donating Easter eggs for a local children's charity.

- No requirements.
- No recommendations.

Quality improvement

We saw that the service clearly displayed its Healthcare Improvement Scotland registration certificate and was providing care in line with its agreed conditions of registration.

Comprehensive policies and procedures set out the way the hospital supported staff to deliver safe, compassionate, person-centred care. For example, we saw policies and procedures in place for:

- clinical supervision
- complaints management
- consent
- duty of candour
- health and safety
- infection prevention and control
- medicines management, and
- safeguarding.

A process was in place for writing all policies, submitting them to appropriate corporate groups and approving them through the medical advisory committee. Policies and procedures were updated regularly or in response to changes in legislation, national and international guidance and best practice. To support

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

The operations manager looked after the day-to-day management of the building and its specialist equipment. An on-site engineering and maintenance team, including medical physics carried out all routine maintenance and repairs. Contracts were in place with external contractors for maintenance and repairs that the on-site team could not deal with, such as specialist decontamination equipment and x-ray machines. Comprehensive policies and procedures in place to manage the facilities included schedules for managing routine issues, such as:

- electrical safety
- fire safety
- gas boiler safety
- ionising radiation safety
- medical gases, and
- water safety

It also included more specialist risk assessments and operational plans for managing key building risks, such as legionella and ventilation.

Incidents were recorded and managed through an electronic incident management system. Each one was reviewed and reported through governance groups. The outcomes of the discussions from these meetings were fed back through regular staff meetings.

The hospital's infection prevention and control policies and procedures were in line with Health Protection Scotland's *National Infection Prevention and Control Manual*. Procedures were in place to help prevent and control infection. Cleaning schedules were in place for all clinical areas. An infection control nurse participated in visual audits, formal audits and training opportunities on-site.

The hospital had a detailed medicines management policy in place. All departments we visited had standard operating procedures (SOPs) and patient group directives (PGDs) in place for safety and compliance, including controlled drugs. The service's PGDs were developed from national NHS Scotland templates. The lead pharmacist had also developed PGDs for local competencies in line with national guidelines.

We looked at four paper-based patient care records. Some patients had been referred to the service by their GP and some had self-referred. All consultations included details of the treatment risks and benefits discussed with patients. We

saw evidence that treatment options had been discussed. All patient care records we reviewed included:

- aftercare and follow-up
- consent to treatment and sharing of information
- medical history, with details of any health conditions, and
- patient risk assessments.

We saw good compliance with patient risk assessments, including falls, nutrition and pressure care and venous thromboembolism (VTE).

Staff told us that patients were given written aftercare instructions when they were discharged and information about any recommended follow-up. Hospital contact details were provided on discharge included in this information in case patients had any concerns or questions. Patients we spoke with told us their consultant had visited them during their stay and were clear about what to expect and who to contact after discharge.

The hospital and the provider were 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.

The leadership team was aware of its duty to report certain matters to Healthcare Improvement Scotland as detailed in our notification guidance.

We saw the hospital's complaints procedure displayed prominently in the hospital and published on the provider's website. It included the timescale for addressing the complaint, the process of investigation and Healthcare Improvement Scotland (HIS) contact details. A clear process was in place for managing complaints

We reviewed three current complaints in the service. 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. We were told that a weekly meeting with the hospital director discussed the progress of all complaints and identified any emerging themes.

We saw evidence that complaints were well managed, and lessons learned were discussed at staff and management meetings. We saw evidence of changes made in the hospital after complaints had been made. The hospital was subscribed to the Independent Sector Complaints Adjudication Service (ISCAS),

an independent adjudication service for complaints about the private healthcare sector.

A duty of candour procedure was in place (where healthcare organisations have a professional responsibility to be honest with patients when things go wrong). Staff we spoke with fully understood their duty of candour responsibilities and had received training in it. The hospital had experienced candour events over the past 12 months, which were reflected in its yearly duty of candour published report. We saw evidence that the hospital had followed its own procedure when dealing with these incidents and shared learning with staff and consultants.

We saw emergency equipment was checked regularly, and the trolleys were kept in accessible locations. Staff we spoke with were familiar with the location of the trolleys.

The medicines and blood product fridges were checked regularly, including the contents and daily temperatures. The staff we spoke with knew the process for reporting faults. We saw emergency equipment trolleys were checked daily and kept in accessible locations. Staff we spoke with were familiar with the location of the emergency equipment. We saw that specific staff were identified at the start of a shift during the daily huddle to respond to medical emergencies, such as a deteriorating patient with major haemorrhage and in the event of a fire.

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, which included a:

- major haemorrhage protocol
- malignant hypothermia procedure
- national early warning score chart (NEWS 2), and
- ‘sepsis 6’ protocol.

The hospital’s recruitment policies described how staff would be appointed. Appropriate pre-employment checks were carried out for employed staff and healthcare professionals appointed under practicing privileges (staff not employed directly by the provider but given permission to work in the hospital). Staff files contained a checklist to help make sure that appropriate recruitment checks had been carried out.

The hospital used a safe staffing tool to proactively manage its staffing compliment and make sure that an appropriate skill mix and safe number of staffing was always provided. The hospital was actively trying to recruit to vacancies and to recruit more than the minimum number of staff needed as a contingency, to provide some flexibility. We were told and saw that the hospital used minimal agency and bank staff and only when clinically required to cover staffing gaps to maintain safe and effective staffing levels. The hospital's innovative and forward-thinking approach also included recruiting staff from overseas who had obtained their nursing qualification in their home country. The hospital had supported these staff to settle in the area and arranged further advanced training in order to qualify to be registered on the Nursing and Midwifery Council (NMC) professional register.

We reviewed five files of employed staff and five files of individuals granted practicing privileges. All 10 files were well organised, and we saw evidence that appropriate recruitment checks had been carried out, including:

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

We saw evidence that all employed staff had completed an induction, which included an introduction to key members of staff in the hospital, mandatory training and role-specific training. We were told that a mentor was allocated to new staff and the length of the mentorship depended on the skills, knowledge and experience of the new staff member.

We saw that a training needs analysis was carried out every year. Mandatory training and non-role specific training programmes were in place. Staff completed mandatory and role-specific online learning modules. Mandatory training included safeguarding of people and duty of candour. Senior Charge Nurses, Senior Nurses and the Senior Management Team used an online platform to monitor compliance with mandatory training completion.

Staff told us they received enough training to carry out their role. We saw evidence in staff files and training reports of completed mandatory training, including for medical staff with practicing privileges (staff not employed directly by the provider but given permission to work in the service). We saw evidence in staff files and training reports of completed mandatory training, including medical staff with practicing privileges.

We saw evidence that the service offered regular clinical supervision for trained staff provided by clinical trainers. We saw evidence of written clinical supervision sessions.

Staff completed an annual appraisal where aims, objectives and goals were identified and discussed. Progress against the identified aims and objectives was reviewed after 6 months and staff could share any issues or re-negotiate and amend the original details at that stage. The appraisals we saw had been completed comprehensively and staff we spoke with told us their appraisals helped them feel valued and encouraged their career goals.

- No requirements.
- No recommendations.

Planning for quality

The hospital's risk management system was comprehensive and included corporate and clinic risk registers. These documents detailed the actions that would be taken to mitigate risk and reduce harm. The hospital had recorded ongoing key business risks that it monitored regularly. These included:

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

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
- staff huddles, and
- team meetings.

Each department had its own risk register, which was reviewed regularly and included clinical and non-clinical risks. Managers were alerted to review dates and the provider's central team also reviewed the risks. A maintenance programme was in place for all equipment and areas in the hospital, which the engineering site manager managed. This included maintenance of medical and compressed gases, fire and electricity and legionella risk assessments.

The hospital also received ‘flash alerts’ from the provider’s other services. The flash alerts detailed information and advice from incidents or identified risks, as well as steps to take to reduce or remove risk.

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

The provider’s ‘Circle Operating System’ included processes to help staff consider the quality of treatment and care being provided at all times.

The hospital had a detailed audit programme which helped make sure staff delivered consistent safe care and treatment for patients and identified any areas for improvement. The staff we spoke with participated in audits and were aware of when these were completed. Each senior nurse carried out audits in a different ward to the one they worked in. Action plans were produced to make sure any actions needed were taken forward. The infection prevention and control nurse for the service carried out extensive audits in all departments and supported areas with any actions arising as a result.

The comprehensive audit programme included audits carried out for:

- complaints and compliments
- infection prevention and control, including mattresses
- health and safety
- medication management, and
- patient care records.

The hospital had several clinical accreditations, including from the Association for Perioperative Practice (AfPP), as well as having deep vein thrombosis (DVT) prophylaxis exemplar status. We also saw evidence that the hospital was working towards obtaining ‘Joint Advisory Group’ (JAG) accreditation for gastrointestinal endoscopy.

Part of the hospital's corporate improvement plan detailed the following, which we saw had been implemented:

- Accountable handover, where the handover of each patient between shifts was carried out in front of the patient with their consent.
- Intentional rounding, where nurses conducted regular checks with patients to proactively address fundamental care needs and improve patient experience.
- Improved documentation of fluid balance charts to make sure that patients received enough fluid and reduced the occurrence of kidney injury.

We also saw the service's local improvement plan. This evidenced local quality improvement initiatives, including the following:

- A surgical safety champion was introduced in the theatre department to promote safety and reduce incidents.
- 'Call Before you Fall'. This initiative encouraged patients to press the buzzer before attempting to get up from sitting or out of bed.
- 'Prep stop block'. This was an initiative when injections were used for pain relief, such as nerve blocks or steroid injections. Before the injection, the practitioner stopped to confirm the patient's identity, the area to be injected and that the equipment was correct (including the medication, colour-coded syringe and needle). The treatment was only carried out after this information was confirmed, to improve patient safety.
- The introduction of a 'patient experience champion', to gather real time feedback from patients.

We saw evidence from audits that the number of patients falling in the hospital and incidents resulting in patient harm had been reduced as a result of these improvement projects.

- No requirements.
- No recommendations.

Key Focus Area: Results

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

Our findings

The care environment and patient equipment was clean, equipment was fit for purpose and regularly maintained. Pharmacy staff reviewed the medicines management in place. 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. Staff must comply with the service's infection prevention and control policy. Medication charts should be rewritten when patients are transferred from critical care to the wards.

Every year, we ask the service to submit an annual return. This gives us essential information about the service such as composition, activities, incidents and accidents, and staffing details. The service submitted an annual return, as requested. As part of the inspection process, we ask the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Assurance Framework and ask the service to tell us what it does well, what improvements could be made and how it intends to make those improvements. The service submitted a comprehensive self-evaluation.

The ward environment was in good condition, tidy, well maintained and clean. The majority of equipment seen was in good condition and clean. The housekeepers followed a cleaning schedule; the supervisor attended the wards daily and was supportive. Ward staff completed a checklist to record that the wards were clean.

We saw appropriate personal protective equipment (PPE) and alcohol-based hand rub located throughout the ward.

Sharps were manged appropriately, and clean linen was stored correctly.
We saw appropriate cleaning solutions were available and used, including chlorine-based products for sanitary fixtures and fittings. All cleaning materials and equipment were stored in a locked area in the ward.

Patients we spoke with stated the hospital was clean and tidy. Comments included

- ‘Place is spotless.’
- ‘Clean and tidy.’
- ‘Very clean.’

We reviewed four patient records and saw they included the patients’:

- assessment and consultation
- GP details and patient consent to treatment and to share information with their GP or other relevant healthcare professional where appropriate
- name, address and identifier number
- next of kin, including consent to share information, and
- referral pathways to access other healthcare professionals, such as physiotherapy if required.

The majority of patient risk assessments were completed in patient care records we reviewed, along with the pre-operative health questionnaire. We saw the consultant and patients had signed and dated consent forms for different procedures carried out, with risks and benefits discussed.

The consultation letter was present in all patient care records we reviewed.

The provider had introduced an electronic consent form which clearly showed the two-stage consent process. Consent forms we reviewed were fully and accurately completed. The patients and consultant surgeons had also signed the consent forms on the day of surgery.

We saw evidence that treatment plans, options and aftercare had been discussed with patients before their discharge from the service.

During our inspection, we followed a patient’s journey from the ward through theatre, recovery room and then to the ward. 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.

Emergency equipment in the wards which was checked and documented daily.

Posters were displayed at the outpatient clinic, which highlighted to patients they could have a chaperone if required. This was also in the patient information booklet in all patient bedrooms.

We saw evidence of 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).

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

Take-home medication for patients was ordered in advance of their discharge from the hospital's pharmacy department.

Staff told us they felt the approachable leadership team valued and supported them well. From our 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:

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

- ‘Really shows we care for the patient and that the patients’ needs always come first. Teams from different areas collaborate very well together.’
- ‘Provides a safe holistic service to client’s needs. Puts clients at the centre of the service. Provides an up-to-date modern service with new upcoming technologies i.e. robotic surgery.’
- ‘Supportive environment, expert knowledge, teamwork, kind towards both staff and patients, Listened to, good communication.’

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

- ‘Everyone has introduced themselves and explained what will happen.’
- ‘Lovely place with very helpful staff.’
- ‘I wouldn’t go anywhere else.’

What needs to improve

The majority of staff we observed were following the service’s own infection prevention and control manual which is in line with the *National Infection Prevention and Control Manual.* However, we did observe some instances where staff were not following the service’s own infection prevention and control manual. These included:

- the large storage bins used to store clinical waste bags were not locked while awaiting uplift, and
- housekeepers not wearing aprons when cleaning vacant rooms (requirement 1).

We saw two patients that had been transferred from the critical care unit to one of the wards. One patient care record had a ward medication chart with blank patient care notes. However, we found that the medication chart from the critical care unit was still used in the ward to prescribe and record medication. It is best practice for all medication to be transcribed to a new ward medication chart when a patient is transferred from one area of care to another (recommendation a).

The ‘to take out’ (TTO) medication discharge prescription sheet did not include a space for pharmacy staff to record their clinical check before dispensing. It also

lacked space to record any allergies in line with Royal Pharmaceutical Society (RPS) guidance. However, we saw a new TTO medication discharge prescription sheet which included space for these. We will follow this up at the future inspections.

Some admission documentation was blank in the surgical pathway for staff booklet. Staff told us that while all documents should be completed if a patient was admitted the day of surgery, duplication in the document meant that this was not always completed. Senior management told us that the patient documentation was under review and the service planned to introduce a new critical pathway booklet. We will follow this up at future inspections.

Requirement 1 – Timescale: immediate

- The provider must ensure compliance with all standard infection prevention and control precautions as detailed in Health Protection Scotland's *National Infection Prevention and Control Manual*, in particular:

  (a) clinical waste management, and
  (b) use of personal protective equipment

Recommendation a

- The service should ensure that all medication charts are rewritten when transferred from critical care to the wards to ensure that information about patients' prescribed medication remains current.

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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