Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Kings Park Hospital, Stirling

Service Provider: Circle Health Group Limited

23–24 October 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 24–25 October 2023

Recommendation

The service should monitor and evaluate improvements made as a result of patient feedback, to determine whether actions taken have led to the improvement anticipated.

Action taken

The service had implemented 'you said - we did - as a result' board, which detailed outcomes of the improvements suggested that staff and patients could view.

Recommendation

The service should implement a formal process for clinical supervision of trained staff.

Action taken

We saw evidence that reflective learning took place. The provider had a plan in place for staff members to attend formal clinical supervision training at a university.

Recommendation

The service should record that cleaning checklists include cleaning products and processes for clinical hand wash sink that reflect best practice guidance.

Action taken

The service had introduced a process for the cleaning of clinical hand wash sinks in line with current guidance.

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 Kings Park Hospital on Thursday 23 and Friday 24 October 2025. We spoke with a number of staff and patients during the inspection. We received feedback from 23 staff members through an online survey we had asked the service to issue for us during the inspection.

Based in Stirling, Kings Park Hospital is an independent hospital providing non-surgical and surgical treatments.

The inspection team was made up of four inspectors (one of whom was observing).

What we found and inspection grades awarded

For Kings Park 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 continuously monitored. A clear governance structure was in place. The hospital's leadership team was, approachable and 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 continuously 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 helped the service plan and develop staff. The effectiveness of improvements made as a result of patient feedback were evaluated and displayed for staff and patients to see. 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. 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.	✓✓✓ Exceptional

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 no requirements and no recommendations.

We would like to thank all staff at Kings Park 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 continuously 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

Kings Park Hospital is part of Circle Health Group. We saw that the service's vision and values statement informed its strategic plan for 2023–2026. We were told that the provider was in the process of reviewing and updating a new strategic plan to replace the current one.

The provider's purpose was to provide the high quality, safe and compassionate care that its 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 vision was a statement of how it would provide care to patients. The vision and values informed the objectives that had been clearly laid out in the strategic plan, Staff we spoke with understood the organisational values. The strategic plan was comprehensive and set out clear and measurable indicators.

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 way the provider wanted. 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
- optimal value, and
- patient experience.

The hospital strategy also set out the service's key performance indicators for the following year and direction. We saw that the senior management team formally evaluated each objective and identified ongoing actions, which helped to demonstrate a culture of continuous improvement. Monthly reports were produced documenting how well the service was performing against each of the objectives. This report was submitted to the clinical governance group.

The service had a 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 Kings Park 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 service's 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.

The hospital committee and group meetings also reported monthly performance dashboards, discussions and actions taken to make improvements where appropriate. For example, recruiting two new consultants to increase the service's ophthalmology services.

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 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 had completed its most recent internal peer review of Kings Park Hospital in 2023. We saw that the service was performing well when benchmarked against other services, particularly around patient feedback and complaints management. 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
- 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
- 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. 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 those for:

- 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. The speak-up champion role in the hospital was well embedded. Staff told us they were aware of who the speak-up champion was and could contact them at any point.

We spoke with the mental health first aider during our visit. This role was in addition to their substantive role and we were told that it was open to all staff from all departments. Staff were able to apply or be nominated for the role. The purpose of this role was to support staff in their wellbeing and then continue to check in with them or signpost them to further help if required. They introduced small initiatives to get people moving more such as encouraging staff to walk during meetings rather than sit. We were told that they evaluated these initiatives through staff retention figures, staff absenteeism and feedback. We were also told that rather than 'exit interviews' asking why staff leave, they planned to start asking staff at appraisals and one-to-ones the reasons why they stay. This was intended to encourage a more positive approach to staff retention and support staff to feel valued. We were told there was good support for the first aider from management and virtual discussions with other mental health first aiders from other services.

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 we saw good staff interaction.

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
- infection prevention and control (IPC) nurse
- physiotherapy, and
- theatre.

The huddle highlighted any hospital-wide updates and patient numbers for the day. 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 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.

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.

The hospital was in the process of applying for an Autism Accreditation Inclusion Award from the National Autistic Society. We saw feedback of a patient's experience from an autism perspective, which praised staff interactions and that the patient had benefitted from a visit to the hospital before their surgery.

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 had 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 and managers in the 6–12 months before our inspection. We saw evidence of mentorship which allowed them to develop and allowed 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 continuously 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 helped the service plan and develop staff. The effectiveness of improvements made as a result of patient feedback were evaluated and displayed for staff and patients to see. 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 the service was delivered. A dedicated staff member's role included gathering feedback verbally and in written form from patients daily. The service had a dedicated telephone line that patients could call to discuss any aspect of their care. Staff also called patients after their treatment to find out how they were and give an opportunity to raise any issues at the same time.

Information leaflets were available for patients throughout the hospital. We saw information boards with evidence of how the service used patient feedback to make changes and how the changes were evaluated. The evaluation assessed whether the changes were an improvement and sustainable.

We saw that patients could leave feedback on the service website, which the hospital then responded to directly. Feedback was analysed monthly. Results were shared at staff meetings and displayed clearly on noticeboards in 'you said - we did - as a result format where staff, visitors and patients could see them.

We looked at a wide selection of surveys the service carried out, including those for cleanliness of the environment and patient dignity, which showed consistently high levels of patient satisfaction at all stages of their journey.

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.

Information leaflets were readily available for patients in the hospital and available in different formats and languages. Information boards were comprehensive and information was 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 '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, carried out in 2025 showed a high level of satisfaction, which was consistent with the previous survey and this had been acknowledged across the provider's organisation. The results were due to be shared with staff at monthly staff meetings.

Staff we spoke with in the wards also confirmed that meetings were held regularly. Minutes were displayed and stored in ward folders Staff receive emails and monthly newsletters to keep them updated with any operational changes.

We spoke with the recycling champion in theatre department who told us of some recycling initiatives in the hospital. We saw staff throughout the hospital participated in recycling and minimising waste, through education and providing access to recycling units. This had helped embed a culture of awareness of the importance of the environment in order to promote sustainability.

We saw that the hospital recognised the importance of supporting charities. Staff regularly took part in a variety of fund-raising activities, such as sponsored walks, runs and other organised events to help support different charities.

- 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:

- 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, as well as 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 engineer 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 x-ray equipment.

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 lead participated in audits, training and coaching 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.

We looked at six paper-based patient care records. 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:

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

We saw good compliance with patient risk assessments, including:

- falls
- nutrition
- 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 in case patients had any concerns or questions. Patients told us they 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 contact details. A clear process was in place for managing complaints.

We reviewed three current complaints in the service. These response 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 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 duty of 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.

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 (for example, experiencing major haemorrhage or sepsis) 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 practising 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 included recruiting staff in 2023 from overseas. We saw evidence that these members of staff were well supported and felt part of the team.

We reviewed five files of employed staff and five files of individuals granted practising 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 practising privileges. We saw evidence that reflective learning took place for clinical staff and the provider had a plan in place for staff members to attend formal clinical supervision training at a university.

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 had the opportunity to discuss any additional training or education needs and any concerns. 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 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 lead 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). 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.

We were also told of a dignity initiative which was in the early stages of being implemented. The service held focus groups with staff and patients about how the dignity of patients and staff could be improved. A dignity champion had been introduced in the theatre department and the service planned to introduce:

- better footwear
- disposable underwear for patients undergoing a colonoscopy
- improved information at the pre-assessment clinic to make it easier for patients to bring dressing gowns and slippers with them on admission to hospital, and
- multi-faith gowns.

Another meeting was planned in 6 months' time to evaluate the planned improvements with staff and patients.

- 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. 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.

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.

All environment in the hospital was in good condition, tidy, well maintained and clean. All equipment seen was in good condition and clean. The housekeepers followed a cleaning schedule and 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 hospital.

Sharps were managed 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.

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 completed laser 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 and we saw that the environment was fit for purpose.

We saw evidence of sustainability and that the service was reducing it carbon footprint using recycling and green initiatives, these included:

- electric vehicle charging points
- recycling bins in theatre and ward staff areas
- reducing the use of paper disposable paper rolls on treatment couches unless clinically indicated, and
- using reusable sharps bins from a waste provider.

We also saw that the service was discussing how it could recycle the blue drapes that the surgical packs came in with the provider.

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

- 'The feedback we receive from patients shows that all teams work cooperatively to deliver a positive outcome throughout their journey.'
- 'Firstly, very patient focused but seems to pride itself on being a happy place to visit or work.'
- 'The service is very good at providing quality, safe and compassionate care to our patients and listening to patient feedback.'
- 'Nothing! This is a[n] amazing place to work and I love my job.'

The catering team cooked food on-site and any specific requests from patients were accommodated. The catering team baked a variety of snacks, such as scones and biscuits daily. Feedback from patients that we spoke with was positive about the menu choices, as well as the range of food and snacks available.

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

- ‘Everyone has introduced themselves to me and explained what will happen next.’
- ‘Lovely place with very helpful and accommodating staff.’

Patients that we spoke with also told us that they felt actively listened to, that they had an active voice and that any ideas for improvement or any concerns would be taken on board and acted on.

- No requirements.
- No recommendations.

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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