Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Cygnet Wallace Hospital, Dundee
Service Provider: Cygnet (OE) Limited

6-7 May 2026

NHS SCOTLAND

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1 Progress since our last inspection

What the provider had done to meet the requirements we made at our last inspection on 4-5 December 2023

Requirement

The provider must ensure that timeframes for commencement and completion of all building work are included in the building risk assessment and risk register.

Action taken

Timeframes had been added to the service's building risk assessment and risk register for commencing and completion of building works. Building work was completed on the ground floor of the service in December 2024 and the upper level was completed in April 2025. **This requirement is met.**

Requirement

The provider must ensure formal leave plans are in place and signed by the registered medical officer for patients spending time outside of the hospital grounds.

Action taken

All relevant documentation was now in place and included in the patient care records before a patient spent time outside of the hospital. **This requirement is met.**

Requirement

The provider must ensure adequate staffing resources are in place to provide housekeeping cover for weekends and absences.

Action taken

Additional housekeeping staff had now been recruited, including one full-time housekeeper and two part-time housekeepers. This helped to ensure that housekeeping staff were on site every day, including weekends. **This requirement is met.**

Requirement

The provider must ensure that external clinical waste bins are kept locked at all times.

Action taken

This activity had now been added to the service's daily task folder, and the service manager or clinical team lead checked that the outside storage area for clinical waste was locked on their daily walkround of the building. This was then documented on a daily checklist and audited every month. **This requirement is met.**

What the service had done to meet the recommendations we made at our last inspection on 4-5 December 2023

Recommendation

The service should ensure that the front page of the controlled drug book is kept up to date.

Action taken

Controlled drugs are medications that require to be controlled more strictly, such as some types of painkillers. The service was able to demonstrate that the front page of the controlled drug book was up to date for the duration that the book had been in use. The front cover sheet now signposted to the correct page number for recording when any controlled drugs were used. We were told this was monitored by the pharmacist every week.

Recommendation

The service should offer staff the opportunity to attend debriefs following incidents.

Action taken

The service manager and clinical team lead encouraged staff to attend post-incident debriefing sessions. These help to identify and address any physical harm caused, ongoing risks, and any emotional impact on patients and staff. This action formed part of the service's incident reporting system and, if a debrief session did not taken place, then the service investigated the reason why, or why staff had not been invited to attend a session. Individual staff sessions with a clinical psychologist were also now being offered to provide them with another opportunity to debrief following an incident.

Recommendation

The service should ensure patient care records clearly indicate how frequently a patient requires physical health monitoring and the reasons for this.

Action taken

All patient care records we reviewed detailed when vital signs, such as pulse and blood pressure, were to be monitored for each patient, for example daily, weekly or monthly. If there was a change due to the patient being unwell, this monitoring was increased with appropriate information advising of the reason for this. We saw evidence that audits were taking place every month to monitor completion of charts documenting patients' physical health and vital signs.

Recommendation

The service should complete and record observations in full, including end-of-shift sign off from the nurse in charge in line with the service's observation policy.

Action taken

We found that all patient observation records were fully completed with information recorded on various records.

Recommendation

The service should review and re-establish its programme of decoration and refurbishment to ensure that the environment is well maintained.

Action taken

All building and construction work in the service was completed between December 2024 and April 2025. The service was then redecorated with input from patients about the colours and themes used throughout the service.

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 Cygnet Wallace Hospital on Wednesday 6 and Thursday 7 May 2026. We spoke with a number of staff, patients and carers during the inspection. We received feedback from 16 staff members through an online survey we had asked the service to issue for us during the inspection.

Based in Dundee, Cygnet Wallace Hospital is an independent private psychiatric hospital providing specialist care for people with predominantly learning disabilities, mental health needs and autism.

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For Cygnet Wallace 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 service had a well-defined and measurable vision, aims and objectives with a clear strategy identified to help achieve these. Key performance indicators and organisational values had also been identified. Benchmarking and continuous monitoring was in place across the provider's services, including progress against the key performance indicators. Effective governance structures included clear lines of reporting and for escalating concerns. The service's senior management team was visible, and staff were empowered to speak up. Annual staff surveys helped the service to plan staff development. The staff group was well established, skilled and diverse, and able to facilitate and meet the complex needs of patients.	✓✓✓ Exceptional
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patients were encouraged to be actively involved in everyday activities in the service, including community engagement, and were supported to contribute to their care plans. Staff tailored their approach to ensure that each patient's communication needs were met. Patient experience was regularly assessed and used to continually improve how the service was delivered. The effectiveness of any improvements made was evaluated and shared with patients. The service had established good links with the local community, accessing various local activities and facilities. Appropriate policies and procedures supported staff to deliver safe, compassionate and person-centred care. Comprehensive risk management and quality assurance processes helped to ensure patient and staff safety, including a detailed audit programme and regularly updating the service improvement plan. A duty of candour report was published annually. The complaints policy and processes were up to date and were widely accessible.	✓✓✓ Exceptional

Results	*How well has the service demonstrated that it provides safe, person-centred care?*
Summary findings	**Grade awarded**
The hospital had recently been fully refurbished. The care environment and patient equipment was clean, equipment was fit for purpose and regularly maintained. Medicines management was good. Safer recruitment processes were followed. Staff described the provider as a good employer and the service as a good place to work. Patients spoke positively about their experiences, and said they felt supported by staff. Relatives also told us that they felt supported and that staff were approachable and caring. Patient care records demonstrated a holistic approach to care with patients' needs regularly assessed.	✓✓✓ 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 Cygnet (OE) 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 Cygnet Wallace 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 service had a well-defined and measurable vision, aims and objectives with a clear strategy identified to help achieve these. Key performance indicators and organisational values had also been identified. Benchmarking and continuous monitoring was in place across the provider's services, including progress against the key performance indicators.

Effective governance structures included clear lines of reporting and for escalating concerns. The service's senior management team was visible, and staff were empowered to speak up. Annual staff surveys helped the service to plan staff development. The staff group was well established, skilled and diverse, and able to facilitate and meet the complex needs of patients.

Clear vision and purpose

The service is part of the Cygnet (OE) Limited group offering a wide range of health and social care services for young people and adults with mental health needs, acquired brain injuries, eating disorders, autism and learning disabilities in the UK.

The service's aims and objectives of 'providing a specialist service focused on recovery, independence and positive outcomes for patients' were part of the provider's overall vision. This vision included 'providing high quality, sustainable specialist services that ensure patients feel safe and supported, staff are proud of and stakeholders trust'. The aims, objectives and vision were featured in the provider's overall strategic plan.

The provider's values of integrity, trust, empowerment, respect and care were embedded into the service's everyday working ethos. These were displayed throughout the service and were also featured on the staff intranet.

The strategic plan (2022–2027) detailed the provider's strategic aims and its key performance indicators for each year within the 5-year period. The strategic plan and annual impact report were comprehensive and set out clear and measurable indicators. The provider's key strategic key performance indicators included:

- putting patients first
- delivering service excellence
- valuing and developing staff, and
- innovation for the future.

We saw that the service's senior management team and the provider's senior leadership team regularly evaluated performance against the indicators. The provider monitored these key performance indicators through Northeast England and Scotland regional operational governance group meetings held every 3 months. We also saw performance against the key performance indicators detailed in a monitoring report produced for the Dundee Health and Social Care Partnership. Line managers and the service manager, with input from the organisational development team, also set local key performance indicators to be monitored as part of service delivery. These included:

- staffing levels
- staff training and development
- supervision and appraisal processes
- medication management
- safeguarding (public protection), and
- serious incidents.

This information was highlighted in the provider's annual impact report. The report displayed results using various methods, including infographic techniques, to show how performance was measured and how this would drive improvement in the service. This information was discussed at senior management team meetings, was shared at staff meetings and was also available on the staff intranet.

A programme of site visits carried out by the provider's operations manager helped to monitor progress against the key performance indicators. This included site assurance visits and peer review visits with the service's senior management team. The visits included audits of the service, as well as reviewing the service's audit programme. This helped to support the service to follow policy and regulatory requirements.

The service measured its local key performance indicators using methods such as:

- patient and carer testimonials
- case studies affecting people who use the service
- the services available at local level
- culture (focusing on stakeholder satisfaction, such as local authorities)
- patient satisfaction
- staff testimonials and freedom to speak up
- learning and development, and
- the quality of service using regulatory ratings.

- No requirements.
- No recommendations.

Leadership and culture

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

- administrative, facilities and housekeeping staff
- healthcare support workers
- medical staff
- specialist occupational, and speech and language therapists
- psychologists, and
- registered nurses.

We noted that the service manager had been in post for a number of years and that some staff had either been promoted or were currently progressing into management team positions.

A board of directors was responsible for setting strategies and making sure the provider had the necessary financial, staffing and physical resources in place to meet its strategic aims. They were also responsible for monitoring performance and overseeing risk management. Responsibility for day-to-day oversight had been delegated to the regional operational governance group. Non-executive board members also held the board to account at yearly general meetings.

The annual impact report outlined how the service was performing, as well as how its performance compared with other services within the provider wider organisation.. As well as the annual impact report, the service's performance was also monitored by Dundee Health and Social Care Partnership, which includes NHS Tayside and Dundee City Council. The service continued to produce a monitoring report every 6 months for the Partnership as well as the provider. This focused on areas such as:

- patients (patient numbers, patient placements)
- staffing (recruitment, safe staffing levels and training)
- governance and quality assurance (audits, accidents and incidents, complaints, policy reviews), and
- future developments planned for the next 6 months.

The service had very good processes in place which demonstrated a supportive leadership culture with clearly defined roles and lines of accountability. Effective communication took place through clinical and line management structures to highlight any areas of concern, when required. The operations manager frequently carried out both announced and unannounced visits to the service. This helped to promote visibility of senior managers to staff. The consultant psychiatrist was also the medical director for the provider's services across Scotland. This helped to keep the service up to date with the latest information from other services across the wider provider organisation.

A 'freedom to speak up' system was well established where staff could speak with a nominated freedom to speak up 'guardian' or 'champion' in confidence if they had any concerns. Their contact details were displayed on a noticeboard in the staff rooms along with a QR code to make it easy for staff to raise concerns or queries. Details of monthly 'drop in' freedom to speak up sessions were also displayed for staff to attend. The speak-up guardians also met regularly with the provider's dedicated staff representative and the service's senior management team.

The service also held monthly human resource sessions, where staff from the provider's human resources team would visit the service and invite staff to speak with them on a voluntary basis.

A member of the housekeeping staff had been identified as the service's mental health first aider. They were available for general mental health wellbeing and support for staff. They attended mental health first aider meetings organised by the provider every 3 months as part of their role and supported an annual visit from the head of service. Staff could also access up to six psychology sessions free of charge through an employee assistance programme, as well as free financial and mortgage advice.

The hospital administrator was also the women's networking ambassador advocating women's rights in the workplace, with a focus on menopause. They attended provider meetings every month and were able to highlight areas of concern or issues in the workplace. They then fed relevant information back to the service through team meetings.

Staff we spoke with told us that they found leaders at all levels to be visible and approachable. During the inspection, we saw that senior staff knew the names of individual staff members as they walked round the site and we noted that staff interacted well with them.

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

- the staff intranet
- local staff meetings, including daily 'flash' meetings
- online monthly newsletters, and
- open forums, including an open invitation to speak with the chief executive.

Members of the senior management team, including the medical director and current specialist doctors and other senior hospital staff, attended the daily flash meeting, as well as staff from:

- facilities/maintenance
- allied health professional group
- wards, and
- the medical student during their placement at the hospital.

This meeting highlighted any service-wide updates and current patient numbers. Wards' daily updates included all patients' conditions, capabilities, excursions, planned visitors, finances, identified needs, current mood and any incidents which may have taken place overnight. In addition to staff updating patient care records at the point of care, a senior doctor collated patient information from this meeting to share with the provider and relevant stakeholders.

Staff we spoke with were clear about their roles and responsibilities and how to raise concerns if they had any. They told us they felt well supported by members of the senior management team.

We saw agendas and minutes of the regional operational governance group meetings. These included updates from the provider, regulator ratings, bed occupancy, staffing levels, performance, governance and departmental updates. Additional sessions in these meetings gave the option for regional management peer support and supervision. This helped to engage staff and promote discussion around each service's successes and challenges. This helped to build relationships across the wider provider organisation. Outcomes from these meetings were reported to local senior management team meetings and staff team meetings.

We saw clear lines of escalation from local to corporate meetings, including action plans. We also saw evidence of audit findings discussed in senior meetings, including action plans and evidence of progress. The senior management team was responsible for the service's local key performance indicators being met. Information on progress against the provider's key performance indicators was made available from monthly clinical governance meetings and was presented at regional operational governance meetings. Key staff from the service attended the regional meetings to provide feedback and identify any unresolved issues. This helped with shared learning across the services.

A 'needs' led model for safe staffing was used by the service. This was a core group of staff on duty supplemented by extra staff to cover patient observations and increased patient need. Staff rotas were prepared 4-6 weeks in advance. The rotas we saw for the previous 3 months showed that all staff absences were covered. We were told that, if an absence occurred, full-time members of staff would be contacted in the first instance, followed by bank staff and then agency staff.

We saw evidence of workforce staffing levels and training needs and requirements being regularly reviewed. This information was added to the service's workforce management plan, and was also reviewed in the monthly clinical governance meetings.

A comprehensive all-staff survey was carried out by the provider every year. We saw that results from the most recent survey showed a high level of satisfaction, and that staff were content at work and morale was high. Minutes of monthly staff meetings and daily team briefs demonstrated that staff could express their views freely. Staff we spoke with also confirmed this.

- 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

Patients were encouraged to be actively involved in everyday activities in the service, including community engagement, and were supported to contribute to their care plans. Staff tailored their approach to ensure that each patient's communication needs were met. Patient experience was regularly assessed and used to continually improve how the service was delivered. The effectiveness of any improvements made was evaluated and shared with patients. The service had established good links with the local community, accessing various local activities and facilities. Appropriate policies and procedures supported staff to deliver safe, compassionate and person-centred care. Comprehensive risk management and quality assurance processes helped to ensure patient and staff safety, including a detailed audit programme and regularly updating the service improvement plan. A duty of candour report was published annually. The complaints policy and processes were up to date and were widely accessible.

Co-design, co-production *(patients, staff and stakeholder engagement)*
An information pack about the hospital was available on the service's website in standard and easy-to-read format. This provided information to patients and their carers about what to expect before and during admission, including:

- staff working in the service
- the environment
- activities available, and
- support they could expect from staff.

We were told patients and carers had the opportunity to visit the service, where appropriate, before their admission. This helped them become familiar with the service and the environment before their admission.

Information leaflets were available in the foyer which gave information on the services provided.

All patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 and were referred to the service by NHS boards throughout Scotland. Appropriate legal consent and treatment documentation was in place for all patients. Consent and capacity to consent was assessed in line with relevant legislation and best practice. An up-to-date admission, transfer and discharge policy helped to ensure that correct processes were followed throughout the patient's admission.

The service provided a safe, therapeutic and structured environment, supported by experienced clinical leaders and a compassionate team. The experienced multidisciplinary team worked collaboratively to create personalised care pathways that supported each patient.

The service also worked closely and collaboratively with a variety of local authorities and other stakeholders to ensure patients admitted from any area in Scotland were fully supported to help maintain family links. This took place through regular meetings with the designated local authorities and NHSScotland boards. They submitted requests for patients to be reviewed by the service manager and clinical lead about patients' suitability for admission to the hospital. The hospital met with local authorities every 6 months to provide information on patients, and a progress report was also provided for each individual patient. Relevant stakeholders were also kept informed on a daily basis about patients' physical and psychological conditions.

We saw that the service provided a holistic approach to healthcare in line with the provider's values and purpose. The service provided 'open days' for local residents, families and carers of prospective patients showcasing the current facilities as well as plans for further and future developments.

A participation policy was in place, and we saw that the service engaged and gathered feedback from patients and carers in a variety of ways. Overall responsibility for overseeing participation lay with the allied health professionals. This consisted of specialist speech and language therapists, occupational therapists and psychology staff.

They explained and showed us how they involved patients in everyday activities in the service, encouraged community engagement and how they supported patients in contributing to their care plans. They also showed us how they measured patients' engagement with activities and how they were constantly looking at ways to improve.

On a day-to-day basis, each patient was supported and encouraged to participate in the activities provided by the service. These included pampering sessions, general socialising, personal shopping, and free time or activities in the garden. The service had improved and increased the outside spaces of the hospital since our last inspection. This included introducing space for patients to grow flowers and vegetables, an outside dining area for patients and staff, and a games area and a lounge area for patients to relax. Every morning, patients were encouraged to meet and discuss the proposed activities for the day. Patients could then decide whether they wanted to proceed with the planned activities or if they needed to be changed.

At the time of the inspection, we saw that the activities team was discussing the forthcoming Scottish elections with patients, explaining how elections worked and what it meant for each patient. This was done in a manner which did not favour or influence a specific political party. Arrangements were made for patients to attend the local polling station if they wished to do so.

We were told that the activities team was focusing on community involvement for each patient. The long-term plan was to help patients make an easier transition when they were discharged from the hospital setting back into the community. To enable them to do this, a programme was in place that included road safety, public transport, shopping and volunteering.

The service 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. Patients were supported to give feedback in a variety of ways, including verbal, written or pictorial methods. The service also had a variety of push buttons to assist patients to leave feedback about all aspects of the service. This included but was not limited to smiling and sad faces.

Feedback was analysed every month, and results were shared at staff meetings. We saw results from the previous 2 months showed high levels of patient satisfaction, with some suggestions about food and activities.

The provider benchmarked (compared) patient satisfaction outcomes across its group of services, and this was reviewed at leadership meetings at both service and provider level. The outcomes of this benchmarking fed into the service improvement plan.

We saw that all patients were reviewed by the multidisciplinary team every month, or sooner if the patient's condition changed. Patients were also reviewed every 6 months under the 'care programme approach'. This involved multidisciplinary care plan meetings with health and social care professionals

involved in the patient's care. We saw close working relationships with community services and local authorities, such as community learning disabilities teams and care managers.

A family and carer involvement policy was in place. Staff provided support to patients and their families to encourage them, as far as possible, to be involved in discussions and decisions about their own care and treatment. For example, we saw evidence of patients being supported and encouraged to attend meetings about their care. We saw patients were well supported by the specialist speech and language therapist and occupational therapist with goal setting and expressing their achievements to help develop their own easy-to-read care plans.

All patients had their own communication sheet that they had developed, where appropriate, with assistance from the specialist speech and language, and occupational therapists. This was used to assist staff members in communicating with patients by understanding their individual communication needs, using language and communications tools that were suitable to their needs.

Specific rooms and facilities were dedicated to activities designed to help patients upon discharge into the community, such as helping patients with food preparation and laundry.

Patients were encouraged and supported with all aspects of their care and in helping to continually improve the service. For example, patients were supported to chair and minute the weekly community meeting attended by staff and patients. During this meeting, patients were encouraged to discuss any concerns about the service and to offer suggestions for activities or improvements. We saw minutes of these meetings displayed in easy read format and could be easily accessed on the patient noticeboard. Examples of improvements included new food menus suggested by patients, and a range of patient activities and outings.

As a result of patient participation and feedback, significant changes had been made to improve the hospital's external environment, for example increasing the space for outside use. We saw that the service had made good use of this increased outside space. Garden games had been introduced, including 'Giant Jenga' and 'Connect 4', as well as gardening activities and organised barbecues.

These changes were reviewed and monitored by the service's senior management team, and discussed at team and patient meetings.

We saw evidence of patients supporting the specialist speech and language, and occupational therapists to carry out an inclusive communications audit every 6 months. This helped to make sure that information and communications displayed throughout the service were inclusive and accessible to patients.

We saw that the service's quality improvement programme described how patients could be encouraged to communicate their feelings and views. For example, we saw easy to read posters displayed showing patients how they could ask for help if they were unhappy or distressed.

As a result of auditing and evaluating how well patients engaged with the weekly community meetings, the activities team had introduced two additional community meetings. For example, one was designed to give patients with higher support needs more time and assistance to help make their views, needs and opinions clearer. We saw that the minutes of the meetings showed that these patients were able to contribute to things that were important to them. This included outside activities such as going for a walk or swimming. Indoor activities included playing pool or karaoke, as well as meal preferences and the timetable for doing their laundry. We saw that 'You said, we did' patient feedback information was also contained in the minutes.

The provider recognised and rewarded its staff in a variety of ways. This included recognising staffs' length of service achievements for 5, 10 and 20 years with cash enhancements. A 'characters of care awards scheme' was also in place, where staff could nominate colleagues for demonstrating the provider's values, with a central team reviewing the nominations. Members of management teams could also nominate staff for organisational awards.

- 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 service was delivered and supported staff to deliver safe, compassionate, person-centred care. This included:

- safeguarding (public protection)
- risk assessment
- whistleblowing (detailing how staff could raise concerns about patient safety and/or practice in the service)
- managing medical emergencies and resuscitation
- health and safety, and
- medicines management.

The service's infection prevention and control policies and procedures were in line with national infection prevention and control guidance and standards. These described the precautions in place to prevent patient and staff from being harmed by avoidable infections. These precautions included hand hygiene practice, the use of personal protective equipment (such as disposable aprons, gloves and face masks), and the management of sharps and clinical waste. Cleaning schedules were completed for all clinical areas. Clinical staff participated in walkrounds and formal infection prevention and control audits. Online infection prevention and control training modules were completed by all staff.

An onsite maintenance manager supported all routine maintenance and repairs. Contracts were in place with external contractors for any maintenance and repair work that the onsite team could not deal with, such as specialist equipment and machinery. Comprehensive policies and procedures were in place to manage the facilities. These also included more specialist risk assessments and operational plans for managing key building risks, such as legionella (a water-based infection), gas and ventilation. We saw that the maintenance manager's action plan included all completed works and expected needs for the future. For example, we saw that some current work included fixing potholes in the car park. The maintenance manager attended the daily flash meeting and was given the opportunity to discuss any ongoing or upcoming facilities work.

The service had a detailed medicines management policy and protocols in place to make sure medicines were managed safely and effectively. Medicines were stored in locked cupboards and medicine fridges. The fridge temperatures were monitored daily to make sure medicines were stored at the appropriate temperature.

Emergency medicines were easily accessible. We saw emergency equipment bags were checked every day and were kept in accessible locations. Staff we spoke with were familiar with the location of the emergency equipment. We saw that a controlled drug check was regularly carried out with the checks documented in the controlled drug book.

Incidents were recorded and managed through an electronic incident management system. We tracked three incidents that had taken place and saw that they had been reported and managed in a timely manner, including actions taken and learning shared with staff through governance and team meetings.

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

The service's complaints procedure was displayed prominently in the hospital and published on the provider's website, including in an easy read and pictorial format. The procedure included the timescale for addressing complaints, how complaints would be investigated and Healthcare Improvement Scotland's contact details. A clear process was in place for managing complaints.

We reviewed a complaint the service was currently acting on, and noted that this was the first complaint the service had received in over a year. The correspondence letter was comprehensive, answered the complaint in full and detailed the actions taken. An electronic system was used to monitor the progress of complaints. We were told that the progress of all complaints was discussed at a weekly meeting with the regional manager with any emerging themes identified.

We saw evidence that lessons learned following this complaint were discussed at staff and management meetings. We saw evidence of changes made in relation to how families are communicated with after the complaint had been made. The service also 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 something goes wrong). Staff we spoke with fully understood their duty of candour responsibilities and had received appropriate training. The service had experienced no candour events over the past 12 months. A duty of candour report was published annually, and we saw this was available on the provider's website.

The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights) to make sure confidential patient information was safely stored.

The service's recruitment policy described how staff would be appointed. All staff had permanent contracts in place. Appropriate pre-employment checks were carried out for all staff employed in the service. Staff files contained a checklist to help make sure that appropriate recruitment checks had been carried out.

A training needs analysis was carried out every year, and a generic mandatory training programme was in place. Staff completed this training as well as role-specific online learning modules. Mandatory training included safeguarding of people and duty of candour. Line managers monitored compliance with completion through the staff intranet. The service's in-house training department met every 3-6 months to review additional training needs and workforce planning. This was monitored both by the service and the provider, and was benchmarked against the provider's other services.

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.

The service facilitated NHS learning disability and mental health student nurse placements as part of the national student nurse curriculum from the University of Dundee and Abertay University. Registered nurses in the service had completed relevant NHS practice supervisor and practice assessor modules to facilitate these student placements.

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 update their aims, objectives and goals if needed. The appraisals we saw had been comprehensively completed and staff we spoke with told us their appraisals helped them to feel valued and encouraged their career goals. Clinical supervision for staff took place every month and managerial supervision for senior staff took place every 3 months. This helped to provide consistent practice across the staff groups, and provided staff with opportunities for reflection and development.

- No requirements.
- No recommendations.

Planning for quality

The service carried out a variety of risk assessments to help identify and manage risks to staff, including:

- manual handling
- lone working, and
- infection prevention and control.

The service's risk management system was comprehensive and included corporate and clinic risk registers. These detailed the actions that would be taken to mitigate risk and reduce harm to patients and staff. Ongoing key business risks were recorded and monitored regularly. These included:

- financial sustainability
- outbreak of infection
- drug and medicine supply
- medical equipment
- staff recruitment and retention, and
- security.

Systems were in place to alert managers to review dates for risk assessments, and the provider's risk management team also reviewed the risks.

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.

We saw that accidents and incidents were recorded and managed through an electronic incident management system. We were told these were reviewed and reported through the clinical governance framework and any learning was fed back to staff through:

- the daily flash meeting
- one-to-one meetings
- team meetings, and
- emails.

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

- clinical and medical equipment
- fire equipment
- gas boilers
- medical gases, and
- electrical installations.

A detailed audit programme helped to make sure the service delivered consistent safe care and treatment for patients and identified any areas for improvement. All staff we spoke with participated in audits and were aware of when these were completed. Action plans were produced to make sure any actions needed were progressed, for example providing the use of 'talking mats' to support patients to communicate and contribute to their care plans.

Audits carried out included those for:

- health and safety
- infection prevention and control
- patient care records, and
- pharmacy clinic.

The activities team demonstrated how they evaluated each patient activity in order to improve how it was provided, and how they strived to make the activities worthwhile, authentic and avoid tokenism or a tick box exercise. They told us that they saw communication as the major contributory factor. All patients had different levels of communication skills and the team saw it as their purpose to capture these views, for example by providing pictorial mats. These allowed each patient to tell staff about how they were feeling, what they liked and what they were worried about. The activities team also showed us how they formally evaluated interventions with two patient outcome tools in use. One was a Cygnet-wide tool which measured the patient's experience of being in hospital and highlighted any additional needs they might have. We were told that this tool was being trialled in the service, and may then be rolled out for use across other services in the wider provider organisation. The other tool was an occupational therapy tool which measured patient outcomes in daily living activities such as personal hygiene, dressing, managing food preparation and financial management skills.

Quality improvement is a structured approach to evaluating performance, identifying areas for improvement and taking corrective actions. The service improvement plan was reviewed annually by the service's senior management team. The plan detailed improvements and actions that arose locally from the service, for example from the local key performance indicators. This included providing time during work hours for additional staff training and development to meet and support the increase in patient needs and requirements. It also detailed improvements and actions carried out as a result of inspections carried out by Healthcare Improvement Scotland and the Mental Welfare Commission. These included structural changes and updates to the hospital building and patient environment with consideration and collaboration of their current patient group.

The provider's quality assurance manager regularly visited the service to carry out independent audits and monitor progress with a view to highlighting any recommendations for improvement, for example providing staff with quality improvement training and subsequently employing quality improvement advisors who review, process and register quality improvement projects throughout the organisation. The quality improvement projects were added to the service improvement plan and were reviewed through the provider's local and regional governance structures.

- 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 hospital had recently been fully refurbished. The care environment and patient equipment was clean, equipment was fit for purpose and regularly maintained. Medicines management was good. Safer recruitment processes were followed. Staff described the provider as a good employer and the service as a good place to work. Patients spoke positively about their experiences, and said they felt supported by staff. Relatives also told us that they felt supported and that staff were approachable and caring. Patient care records demonstrated a holistic approach to care with patients' needs regularly assessed.

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.

We observed many examples of staff interacting positively with patients and other staff in a friendly and compassionate way with effective oversight from a supportive senior management team.

The service had recently undergone a complete refurbishment. We saw that care was delivered in a clean environment and patients' own rooms were designed to be a safe homely setting. Patient equipment was fit for purpose and regularly maintained. The shared dinning and lounge areas were in good condition, tidy and clean. We saw that housekeeping staff completed cleaning checklists. Patients we spoke with commented that the service and equipment was clean. We also saw evidence that linen was washed at the correct temperatures, with clean linen stored correctly.

We saw that clinical hand wash sinks were cleaned regularly in line with national infection prevention and control guidance. Appropriate cleaning products were used to clean general equipment and the environment, and any Control of Substances Hazardous to Health (COSHH) products were stored correctly in a

locked area. Clinical waste, including sharps, was managed in line with national guidance. We saw that all large clinical waste bins were locked and stored securely.

Appropriate personal protective equipment and alcohol-based hand rub were readily available throughout the service.

We saw evidence of good standards of medicines management. This included completed records of stock checks and medicines reconciliation (ensuring that a patient's medication list is as up to date as possible).

Controlled drugs were stored securely with the keys kept separately from medication cupboard keys. Staff had to sign out access to these keys.

Patient care records were a mix of paper and electronic. The paper records comprised mainly of historic assessments and the legal documents associated with being detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. We reviewed the detention, consent and suspension of detention certificates and found these were all completed and up to date.

We reviewed five patient care records and found them to be comprehensive. All records contained detailed clinical assessments of the patient's clinical presentation that addressed their mental and physical health, as well as their emotional and social wellbeing. We saw that each patient's risk assessments and care plans were updated every day during the daily flash meeting. Any changes or any challenges identified were shared with staff during the meeting. Each patient care record had a range of care plans and risk assessments in place to help support staff to provide person-centred care. From the patient care records we reviewed, we saw evidence of staff updating family members on patients' health and wellbeing or changes to their treatment plan. We saw that each stage of the patient care records had a system of checks and ongoing assessment to ensure that all entries were accurate.

We reviewed files for eight members of staff. We saw evidence of job descriptions and appropriate recruitment checks, including:

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

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

Results from our staff survey showed that:

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

Comments we received from staff were mostly positive and included:

- 'The service is functioning well overall with opportunities to further develop more structured reflective practice.'
- 'Work together as a team (team spirit).'
- 'They listen to service users and staff and also ensure they provide possible solutions.'
- 'Gives individuals as much independence as possible.'
- 'Having the opportunity to win more cygnet awards would help us to be recognised and build on more positive team work.'

After the inspection, we contacted the relatives and carers of some patients. They all told us that they were very happy with the care that their relatives were receiving and how they were contributing to the care plans. Typically, this was by helping staff to understand the lead up to, and triggering of, any challenging behaviours. They told us that staff were interested in any previous interventions that had been successfully used in alleviating these episodes. They said that they felt listened to, that their opinions were valued and that the team was very approachable. They also told us that they would meet with staff involved in their relative's care at least once a month, but this could be increased if it was necessary.

- 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

Healthcare Improvement Scotland

Edinburgh Office	Glasgow Office
Gyle Square	Delta House
1 South Gyle Crescent	50 West Nile Street
Edinburgh	Glasgow
EH12 9EB	G1 2NP
0131 623 4300	0141 225 6999

www.healthcareimprovementscotland.scot