Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

# Unannounced Inspection Report: Independent Healthcare

**Service:** Spire Murrayfield Hospital, Edinburgh

**Service Provider:** Spire Healthcare Ltd

25–26 May 2026

NHS SCOTLAND

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# Contents

# 1 Progress since our last inspection

## What the service had done to meet the recommendations we made at our last inspection on 20 August 2024

### Recommendation

*The service should ensure that the safe recruitment of staff is completed in line with Safer Recruitment Through Better Recruitment guidance (September 2023), including the obtaining of two references and the practicing and privileges policy should be updated to reflect this.*

### Action taken

During our inspection, we looked at a selection of staff files and saw that two references had been obtained for all members of staff that the service recruited or granted practicing and privileges to.

# 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 Spire Murrayfield Hospital on Monday 25 and Tuesday 26 May 2026. We spoke with a number of staff and patients during the inspection. We received feedback from 62 staff members through an online survey we had asked the service to issue for us during the inspection.

Based in Edinburgh, Spire Murrayfield Hospital is an independent hospital providing non-surgical and surgical treatments.

The inspection team was made up of two inspectors on day 1 and three inspectors on day 2 of the inspection.

## What we found and inspection grades awarded

For Spire Murrayfield 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's purpose is demonstrated through its values, embedded in the strategic plan, pathways, policies and procedures. Its vision and key priorities were in line with the business, development and access strategy. The service's purpose, vision and values are key to staff performance strategies. Key performance indicators were regularly monitored and reported. Benchmarking processes were in place and continually monitored. A clear governance structure was in place.<br><br>Staff were empowered to raise any concerns. The leadership team was visible and staff spoke very positively about the changes and culture in the hospital. | ✓✓✓ Exceptional |
| **Implementation and delivery** | *How well does the service engage with its stakeholders and manage/improve its performance?* |
| Patient experience was regularly assessed and used to continually improve how the service was delivered. The service held patient feedback forums. 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. Yearly staff surveys helped the service plan and develop staff. A quality improvement plan was in place. The effectiveness of improvements made as a result of patient feedback should be evaluated. | ✓✓ Good |

| Results | *How well has the service demonstrated that it provides safe, person-centred care?* |
|---|---|
| **Summary findings** | **Grade awarded** |
| The care environment and patient equipment were clean, equipment was fit for purpose and regularly maintained. Sanitary fittings were cleaned in line with national guidance. Patient care records were fully and accurately completed. Pharmacy staff provided a good standard of medicines management. All staff pre-employment checks had been carried out, including for staff working under a practicing privileges contract. We observed positive interaction between staff and patients. 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. | ✓✓ Good |

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

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

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

## What action we expect Spire Healthcare Ltd to take after our inspection

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

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

This inspection resulted in no requirements and two recommendations.

| Implementation and delivery | |
|---|---|
| **Requirements** | |
| | None |
| **Recommendation** | |
| **a** | 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 (see page 18).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19 |

| Results | |
|---|---|
| **Requirements** | |
| | None |

| Results | |
|---|---|
| **Recommendation** | |
| **b** | The service should securely destroy original Disclosure Scotland PVG records in line with current legislation and implement a system to record PVG scheme identification numbers for all staff (see page 26).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.24 |

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

We would like to thank all staff at Spire Murrayfield 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's purpose is demonstrated through its values, embedded in the strategic plan, pathways, policies and procedures. Its vision and key priorities were in line with the business, development and access strategy. The service's purpose, vision and values are key to staff performance strategies. Key performance indicators were regularly monitored and reported. Benchmarking processes were in place and continually monitored. A clear governance structure was in place.**

**Staff were empowered to raise any concerns. The leadership team was visible and staff spoke very positively about the changes and culture in the hospital.**

#### *Clear vision and purpose*

Spire Murrayfield Hospital is part of Spire Healthcare Limited, the provider. The provider's purpose was to make a difference to peoples' lives through outstanding personalised care, and vision to be recognised as a world class healthcare business. The hospital's values were:

- caring is its passion
- doing the right thing
- driving clinical excellence
- delivering on its promise
- keeping it simple, and
- succeeding and celebrating together.

These values were embedded in its strategic plan and were reflected in the strategic priorities, pathways, policies and procedures. The hospital's purpose, values and key priorities were embedded as part of its 'ward to board' assurance system. The hospital used these as the key reference points for staff in its 'enabling excellence' plan as part of the systematic performance and appraisal systems.

The hospital, as part of Spire Healthcare Ltd, benefitted from a central resource, supporting a framework for patient care planning, as well as its:

- assessment
- delivery, and
- evaluation.

This framework was supported by a quality improvement framework, with a defined methodology and educational programme. The framework provided a structured approach to quality improvement throughout the organisation.

The provider had a corporate strategy and each hospital set its own local hospital strategy, which could include local performance growth opportunities. The hospital management team provided evidence to demonstrate that it had taken the provider's key performance indicators (KPIs) from the corporate plan and had applied it to the hospital locally. These included:

- attract and grow new consultants and grow the medical society
- build on quality, including patient experience through the patient engagement strategy
- consider offering apprenticeships
- increase the awareness of leading a quality improvement hospital, linking to quality strategy
- increase workforce leadership capabilities through training and education
- invest in the workforce, and
- refurbish the estate and upgrade the wards and theatres.

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 departments discussed KPIs at:

- departmental meetings
- head of department meetings held every 2 months, and
- safety, quality and risk meetings held every 3 months.

The audit management and tracking system (AMaT) supported the provision of safe and effective high-quality care. This allowed the service to demonstrate good leadership, a strong governance structure and increased the opportunity for benchmarking and KPI measurement.

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

KPIs were widely shared and discussed across the hospital's schedule of meetings, in line with the 'Spire Standards for Integrated Governance.'

Short-life working groups were set up in line with the provider's KPIs for the local review and implementation.

We were also told that a programme of site visits helped monitor KPIs. The site visits included central audit teams, site assurance visits and peer reviews with heads of departments and senior management teams.

- No requirements.
- No recommendations.

### *Leadership and culture*

The hospital's staffing resource was made up of:

- allied health professionals
- catering staff
- estates staff
- healthcare support workers
- house-keeping staff
- medical staff
- reception and administrative staff, and
- registered nurses.

The hospital had its own pharmacy department, including an oncology pharmacist to manage the oncology day treatment unit.

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

- director of clinical services
- director of operations
- heads of department, and
- hospital director.

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:

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

The hospital had a comprehensive and inclusive programme of departmental and staff meetings. The topics covered consisted of:

- blood transfusion
- clinical governance
- falls committee
- health and safety
- infection prevention and control
- medical advisory committee
- medicines management committee
- point of care committee
- VTE (term used to describe blood clots) committee, and
- water and ventilation safety.

We were told that the monthly clinical effectiveness meeting had been replaced with a weekly rapid response meeting. We attended this meeting and saw that topics discussed included:

- audits, including cleanliness and hand hygiene
- complaints
- compliments reporting for staff
- duty of candour notifications
- HIS notifications
- near misses
- new and emerging risks
- status of incident investigations, and
- submitted patient incidents.

We saw agendas, minutes and an action tracker for the weekly rapid response meetings.

Regular meetings were held with all heads of departments. The minutes showed that information and strategic plan updates were shared at these meetings. We saw evidence that the meetings allowed comprehensive discussions between each department. Actions and updates on previously agreed actions were recorded. Service improvements were also discussed at the different management and governance meetings.

The provider's most recent unannounced patient safety and quality review of Spire Murrayfield Hospital took place between 31 March–1 April 2026. This review looked at infection prevention and control, integrated quality governance and medical professionals standards. We saw evidence of completed action plans as a result of this review.

We attended the daily team leads meeting, where any local staffing issues were identified and solved.

Following this was the main 'daily huddle', which we also attended. We saw that this was well attended with representatives from all departments attending. The meeting was managed efficiently, with each department reporting on:

- staffing levels
- whether it was safe to carry out the day's business, and
- whether the department had experienced, or was expecting any issues that may compromise the safety of patients in the hospital.

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

The service had reviewed the efficiency of the patient pathway and as a result had rearranged admission times, which had led to improved patient experience and an improvement in the theatre's efficiency.

Two leadership programmes, called 'Mastering Management' and 'LEAP (Learn, Engage, Apply, Perform)' were available to staff depending on job role, personal and professional development requirements. We saw that several members of staff had completed these programmes and that two of the hospital's charge nurses were currently in the process of completing them. Clinical supervision was available to staff on request.

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

valued them. One member of staff commented that the culture and working practices were the best they had been in the long time they had worked at the hospital.

We saw evidence that the director of clinical services had submitted a business plan to the provider following a review process of theatre staffing to achieve a rebalance of the skill mix. This had been successful, resulting in further recruitment of staff which allowed for consistent staffing levels across different clinical areas.

A 'freedom to speak up' system was in place, where staff could speak with a nominated freedom-to-speak-up 'guardian' in confidence if they had any concerns. Staff we spoke with were clear about their roles, responsibilities and how they could raise any concerns they had.

The leadership team worked well together and was open to ideas for improvement. Staff told us they felt empowered to speak up and felt safe to do so.

Staff were kept up to date through:

- email
- newsletters
- safety briefs, and
- ward staff meetings every 6 weeks.

- No requirements.
- No recommendations.

## Key Focus Area: Implementation and delivery

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

### Our findings

**Patient experience was regularly assessed and used to continually improve how the service was delivered. The service held patient feedback forums. 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. Yearly staff surveys helped the service plan and develop staff. A quality improvement plan was in place. The effectiveness of improvements made as a result of patient feedback should be evaluated.**

***Co-design, co-production*** *(patients, staff and stakeholder engagement)*
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 given a feedback survey to complete when discharged. We saw that patients could leave feedback on the service website, and that the service then responded to directly to this feedback. We reviewed a selection of patient surveys the service had carried out, which showed high levels of patient satisfaction particularly in patient care, with patients naming individual staff members in recognition of their care and attention.

The service had a patient experience feedback group in place. We saw evidence that feedback was analysed monthly and results were shared at staff meetings.

As part of its continuous improvement plan, the hospital employed a patient experience co-ordinator. Their role was to support patients throughout their admission and stay in the hospital, helping to ensure their experience was as comfortable as possible. Information gathered through this role was monitored and evaluated by the senior management team to inform service improvements and enhance patients' experience.

‘You said, we did’ boards were displayed through the hospital, with examples of improvements made after feedback. These included:

- as a result of general enquires, the service had recently recruited a clinical nurse specialist for endometriosis (a specialist area of gynaecology) and was aiming to gain accreditation for gynaecology services
- the outpatient team informed reception of any delays (so patients were informed on arrival) and,
- changes to the patient food menu.

All patient feedback for the ward staff was displayed on a board, which the patient co-ordinator regularly updated.

The hospital’s departments and wards used electronic patient leaflets. These were available in different formats and languages and could be accessed through a QR code.

A staff survey asked a comprehensive set of questions and was carried out every year. Results from the most recent survey showed a high level of satisfaction, which had improved from previous surveys and this had been acknowledged across the provider’s organisation. Results were shared with staff through a presentation that included examples of feedback from staff and actions taken as a result. Minutes of monthly staff meetings and daily team briefs demonstrated that staff could express their views freely. Staff we spoke with also confirmed this.

Staff received regular newsletters, regular emails and could attend meetings and forums. This allowed staff to keep up to date with changes in the service. Staff told us they received information and training on new initiatives and when legislation changed, such as data protection. This made sure staff felt part of the service and could discuss improvement suggestions.

The service recognised its staff in a variety of ways, including acknowledging positive feedback from patients. Staff members could nominate other members of staff for recognition of outstanding service. A ‘long service award’ was also given to staff that had worked in the service for 5 years or more. Recipients were given a certificate of recognition and a voucher to spend. Further awards were given with every extra 5 years of service. A benefits programme was in place for staff, which included:

- access to savings schemes
- private healthcare, and
- wellbeing support.

We saw that complimentary coffee, tea, fruit and snacks were available for all staff to access all day, every day.

The provider's human resources (HR) department had an initiative at its Scottish hospitals called a 'people clinic'. Staff could use this clinic to chat with one of the HR advisors about any issues or seek advice.

### What needs to improve

We saw evidence to demonstrate that the service listened to feedback and acted on any issues raised as a result, as summarised in the 'you said, we did' boards. However, this information did not include an evaluation of how effective the improvements had been (recommendation a).

- No requirements.

### Recommendation a

- 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.

### *Quality improvement*

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

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

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

A comprehensive medicines management policy was in place.

Accidents and Incidents were recorded and managed through an electronic incident management system. Each one was reviewed and reported through the clinical governance framework.

The outcomes of the discussions from these meetings were shared at regular staff meetings. Any incidents that an individual member of staff had been involved in were also discussed at the incident debrief, one-to-one meetings and at staff appraisals. Any trends identified were escalated for review by the senior management team, to assess training needs.

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

The service's complaints procedure was prominently displayed in the service and published on the provider's website. We saw evidence that complaints were well managed and lessons learned were discussed at staff and management meetings. The service subscribed to the Independent Sector Complaints Adjudication Service (ISCAS), an independent adjudication service for complaints for 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 appropriate training. The service had published a yearly duty of candour report. We saw evidence that the service had followed its own procedure when dealing with these incidents and shared learning with staff.

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

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

The medicines fridges were checked regularly, including its contents and daily temperatures. Staff we spoke with knew the process for reporting faults.

We saw emergency equipment trolleys were checked daily and were 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 and in the event of a fire.

The service's recruitment policies described how staff would be appointed. We reviewed five files of employed staff and five files of individuals granted practicing privileges (staff not employed directly by the provider but given permission to work in the service). All 10 files were well organised, we saw evidence of clear job descriptions and that appropriate recruitment checks had been carried out, including:

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

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

The housekeeping team had recruited additional staff who had completed a 3-month induction programme. This included working alongside a current member of staff with objectives reviewed at 4, 8 and 12 weeks. All mandatory electronic learning modules were completed during this time and new staff could not commence cleaning duties until they completed these mandatory modules. Staff also attend a full-day, face-to-face induction information session in the hospital where they met members of senior management, including the hospital director.

All staff were allocated mandatory and role-specific online learning modules. Mandatory training included safeguarding of people and duty of candour. Team leaders, heads of departments and the senior management team used an online platform to monitor compliance with mandatory training completion. Staff told us they received enough training to carry out their role. We saw evidence in staff files and training reports of completed mandatory training, including for medical staff with practicing privileges.

The infection control and prevention nurse also delivered on-site training to staff. Staff told us time for training was usually protected. The lead pharmacist delivered training to hospital staff and had developed training videos, which staff could access at any time. These videos were also used as part of the induction programme for new pharmacy staff working in the department, along with local competency forms specific to the provider's services in Edinburgh.

The hospital supported non-medical prescribing training to support staff members' continuous professional development. We saw that several staff members had successfully completed the training and were practising as non-medical prescribers.

Staff appraisals were carried out regularly and recorded on an online appraisal system. 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. Where appraisals were overdue, we saw that an action plan was in place to address this.

We were told and saw that staff attended ward meetings and minutes of these were available in paper format and sent in email to all staff. Staff were encouraged to attend these meetings.

- No requirements.
- No recommendations.

### *Planning for quality*

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

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

The service 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 service had a detailed audit programme in place, which helped make sure it 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 taken forward. The infection prevention and control nurse for the service carried out extensive audits in all departments and supported areas with any actions arising as a result.

The audit programme included audits of:

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

The pharmacy department carried out a range of audits every 3 months, including storage of drugs in the department. All audits and audit information was stored on the local electronic system. Action plans were generated and in place, with dates and persons responsible if any issues or areas for improvement arise from the audits carried out.

The service's quality improvement plan reflected the provider's overall quality improvement plan, was in line with the service's objectives and included short-term goals and longer-term quality improvement, including:

- implementation of a quality improvement dashboard
- introduction of staff recognitions awards
- pain management pathway, and
- review of access and booking process for 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 were clean, equipment was fit for purpose and regularly maintained. Sanitary fittings were cleaned in line with national guidance. Patient care records were fully and accurately completed. Pharmacy staff provided a good standard of medicines management. All staff pre-employment checks had been carried out, including for staff working under a practicing privileges contract. We observed positive interaction between staff and patients. 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.

The environment and equipment, including sanitary fittings we saw had been cleaned with the appropriate chlorine-based solution in line with current infection control guidance. Cleaning checklists were completed in all areas and departments. Toilets were provided throughout the service, including facilities for people with disabilities. We saw that checks were carried out on these facilities regularly throughout the day and recorded.

We also saw that all areas of the hospital were checked and the head housekeeper, along with the person in charge of the area carried out audits. They would use a checklist for the audit and would give a ‘star rating’ grade once it was complete. Any outstanding issues identified during these reviews were highlighted to the person in charge and staff were informed. Action plans with completion and review dates were generated. Senior management then reviewed the action plans and actions taken.

All cleaning materials and equipment were stored in appropriate areas throughout the hospital with limited access for staff only. This included a locked

cupboard for materials under Control of Substances Hazardous to Health (COSHH).

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

- ‘Lovely clean facility.’
- ‘Very clean.’
- ‘Everything from the reception area, to the toilets, to the treatment rooms are spotless.’
- ‘Great facility and food is good.’

We reviewed seven paper-based patient care records. 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:

- assessment and consultation
- documentation of the discussion about the treatment plan
- patient consent to treatment and to share information with their GP or other relevant healthcare professional where appropriate, and
- risk assessments.

We saw evidence that aftercare had been discussed with patients before their discharge from the service.

We saw evidence of good standards of medicines management. This included completed records of stock checks and medicines reconciliation (the process of identifying an accurate list of the patient’s current medicines and comparing it with what they are actually using).

We noted the hospital’s Home Office certificate for stocking, prescribing and dispensing controlled drugs was valid and in-date.

We saw that the pharmacy department had a small ‘out of hours’ stock of medicines for discharging patients in the evening or at weekends if required. A local policy was in place to help make sure medicines were safely administered.

To help assess the safety culture in the clinic, we followed a patient’s journey from the ward through theatre, recovery room and back 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.

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

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

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

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

- ‘I think the hospital gives it's all to ensure patient safety and the highest standard of care.’
- ‘The area I feel that we have improved the most in over the past 5 years is how we support our patients and each other.’
- ‘Prioritises the patient; people work flexibly to support good outcomes.’

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

- ‘Couldn’t fault the care, staff are all great and very attentive.’
- ‘Nursing staff have been amazing, they constantly come in and check on you and keep you updated, about what is happening.’
- ‘They definitely look after you well, even the food is lovely, would recommend to others.’

### What needs to improve

From the staff files we reviewed, we saw that the service had not securely destroyed some of original certificates received from Disclosure Scotland in line with current legislation We were told that this was a result of a change to the provider’s process (recommendation b).

- No requirements.

### Recommendation b

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

# 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