Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Graham Anderson House, Glasgow

Service Provider: The Disabilities Trust

27-28 September 2023

NHS SCOTLAND

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Contents

1 Progress since our last inspection

What the provider had done to meet the requirements we made at our last inspection on 7 December 2021

Requirement

The provider must review its infection prevention and control policy to make sure it reflects the way the service operates. The policy must be in line with Scottish guidance and make it clear what staff are expected to do.

Action taken

This requirement was escalated to senior managers at the provider's head office, who have reviewed, amended, and updated the infection prevention and control policy to ensure it is accurate and aligned with Scottish guidance. Clear guidance was also available to all staff. **This requirement is met.**

Requirement

The provider must ensure the environment is maintained appropriately to allow for effective decontamination.

Action taken

The provider updated and refurbished the environment and we saw an ongoing programme of improvement. **This requirement is met.**

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 Graham Anderson House on Wednesday 27 and Thursday 28 September 2023. We spoke with a number of staff, patients and carers during the inspection. We received feedback from 40 staff members through an online survey we had asked the service to issue for us during the inspection.

Based in Glasgow, Graham Anderson House is an independent hospital providing specialist assessment and rehabilitation for people with a non-progressive acquired brain injury.

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For Graham Anderson House, 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 clear mission statement and defined aims and objectives. There are key performance indicators to allow the service to measure their performance and to ensure continuous improvement is embedded in the delivery of care. The service had a skilled and diverse staffing complement to meet the complex needs of patients with complex brain injury. There were clear lines of reporting and escalating concerns. The staff chart and reporting lines were displayed in the service.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Family and carers were involved before admission to plan care and goals. Safer recruitment processes were in place and a duty of candour report was published every year. Risk assessments and audits were in place for all environmental and clinical activities. We noted there was a comprehensive audit programme to ensure quality in the service. The provider must ensure policies and procedures are in place with specific guidance and responsibilities of staff who dispense medication. The complaints policy must be updated, and an effective process must be put in place to manage patient safety alerts.	✓Satisfactory
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
We saw safer recruitment processes were followed. The majority of staff described the provider as a good employer. The service was clean with ongoing refurbishment in place. Patient care records were completed and comprehensive. The provider must ensure appropriate procedures are carried out for the prevention of infection and control and some staff told us communication could be improved.	✓✓ 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: http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/ihc_inspection_guidance/inspection_methodology.aspx

Further information about the Quality Assurance Framework can also be found on our website at: https://www.healthcareimprovementscotland.org/scrutiny/the_quality_assurance_system.aspx

What action we expect The Disabilities Trust 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 six requirements and three recommendations.

Implementation and delivery	
Requirements	
1	The provider must notify Healthcare improvement Scotland of certain matters as detailed in our notifications guidance (see page 19). Timescale – by 1 December 2023 *Regulation 5(1)(b)* *The Healthcare Improvement Scotland (Applications and Registration) Regulations 2011*

Implementation and delivery (continued)	
Requirements	
2	The provider must introduce a maintenance programme for the laundry facilities to ensure temperatures are reached for effective decontamination (see page 19). Timescale – by 1 December 2023 *Regulation 3(d)(i)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
3	The provider must ensure policies and procedures are in place with specific guidance and responsibilities for staff who dispense medication (see page 19). Timescale – by 1 December 2023 *Regulation 3(d)(iv)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
4	The provider must update its complaints policy to include the full name, address, telephone number and email address for Healthcare Improvement Scotland, including a statement making it clear that patients and carers have a right to complain to Healthcare Improvement Scotland at any time. The feedback form available in public areas must also be updated with Healthcare Improvement Scotland's contact information (see page 19). Timescale – by 1 December 2023 *Regulation 15(6)(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
5	The provider must ensure they have an effective process to manage patient safety alerts so that on receipt, they are disseminated and acted on appropriately, with any action documented and reported at future governance meetings (see page 21). Timescale – by 1 December 2023 *Regulation 3(d)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

Implementation and delivery (continued)	
Recommendations	
a	The service should monitor and evaluate the improvements made as a result of staff feedback, to determine whether actions taken have led to the anticipated improvements (see page 15). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
b	The service should have clear guidance in writing for staff using cleaning products specifying concentrations and areas for use (see page 19). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.27

Results	
Requirement	
6	The provider must ensure appropriate procedures are carried out for the prevention and control of infection in particular: • a process for the disposal of single-use equipment after use, and • develop a risk assessment and action plan for the decontamination of hands (see page 24). Timescale – by 1 December 2023 *Regulation 3(d)(i)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendation	
c	The service should clearly record if patients have been offered advocacy services and if these have been refused (see page 24). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.20

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/find_a_provider_or_service.aspx

The Disabilities Trust, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at Graham Anderson House 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 clear mission statement and defined aims and objectives. There are key performance indicators to allow the service to measure their performance and to ensure continuous improvement is embedded in the delivery of care. The service had a skilled and diverse staffing complement to meet the complex needs of patients with complex brain injury. There were clear lines of reporting and escalating concerns. The staff chart and reporting lines were displayed in the service.

Clear vision and purpose

The provider, a charity, recently renamed from The Disabilities Trust to Brainkind had developed an 8-year strategic plan for all its services.

We saw the service had clearly displayed values in the main reception area. They also had a clear mission statement and defined aims and objectives. There were key performance indicators to allow the service to measure its performance and to ensure continuous improvement was embedded in the delivery of care. These included:

- to have a committed, well inducted, robust, and skilled workforce
- to work towards full occupancy to enable the business to be sustainable
- to remain within the set budget, and
- to ensure we have the correct and efficient resources to do the job as best we can.

The service held its first strategy meeting of the new 8-year strategy plan in July 2023, where it looked at the vision and the progress made to develop the service in line with the objectives of the service provider. We saw minutes of this meeting along with an action plan with named individuals responsible for each action.

The service had an annual report, a quarterly regional review, and an audit of all aspects of the service, leading to an action plan and ongoing review. The service had just recently undergone an external quality assurance review against the new regulatory framework and had created an action plan of findings. This is a work in progress for the service.

- No requirements.
- No recommendations.

Leadership and culture

The service had a skilled and diverse multidisciplinary staffing complement to meet the complex needs of patients with a brain injury. The service used a responsive staffing tool and constant monitoring to determine when increased staffing is necessary to ensure a safe patient environment to meet the real-time needs of specific patients.

The service had effective governance processes to recognise the complex staffing group covering nursing, support workers, occupational therapists, physiotherapists, neurophysiologists, psychologists and psychiatrists. We saw the reporting structure displayed on a noticeboard and the service manager undertakes a physical walkround twice a day to offer the opportunity for any staff member to feedback concerns or issues.

We saw clear lines of escalation from local to corporate meetings, including action plans and corporate audit of progress. The leadership team was accountable for the key performance indicators being met on a quarterly basis.

We saw the service had recently sought feedback from staff, asking them to complete a suggestion questionnaire of what three things they would improve for the patients, staff and the service. We were told the results were being reviewed and suggested changes will then be shared with staff. We will follow this up at the next inspection.

A staff representative from the service attended a colleague forum that was held remotely across the provider's other sites every 2 months. Staff across the other sites shared ideas, promoting staff wellbeing and any concerns raised by colleagues. Suggestions from the group included creating a menopause wellbeing forum with positive feedback from staff. An online platform had also been created for activity coordinators to share recreational activity ideas, resources and advice.

The provider recognised its staff in a variety of ways. This included:

- A staff recognition scheme where staff could nominate other staff members for going above and beyond their role.
- A thank you board on the staff intranet.
- A suggestion box in the staff room gave staff the opportunity to leave positive comments for each other.
- A long service award was also given to staff that worked in the service for 10 years or more.

- 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

Family and carers were involved before admission to plan care and goals. Safer recruitment processes were in place and a duty of candour report was published every year. Risk assessments and audits were in place for all environmental and clinical activities. We noted there was a comprehensive audit programme to ensure quality in the service.

The provider must ensure policies and procedures are in place with specific guidance and responsibilities of staff who dispense medication. The complaints policy must be updated, and an effective process must be put in place to manage patient safety alerts.

Co-design, co-production *(patients, staff and stakeholder engagement)*
With the patient's consent, the service involved patients' families and carers in identifying goals and care planning before the patient was admitted. The discharge process began from admission, and appropriate care packages and plans were discussed and implemented before discharge was considered. This included involvement from local authorities and the provider's legal team if the patient lacked the capacity to consent to the necessary factors, they would need to move on from the service successfully.

The service was effective in gaining feedback from patients with a varying ability to communicate. They used easily understood line drawings of simple facial expressions and photographic images of easily understood situations to convey emotions. Staff also spent a lot of time understanding what the individual patients really enjoyed doing and made that possible both inside and outside the service.

The service engaged with staff in a variety of ways. For example, a range of staff meetings took place regularly and weekly staff newsletters to help keep staff engaged and provide up-to-date information about the direction of the service. An all-staff survey was carried out every year by the provider. The most recent staff survey asked what three things needed to change to create a new culture and staff were asked for feedback about the new strategy. We saw the service completed a local action plan for the areas highlighted in the survey. One

improvement identified was the need for improved communication with staff. The service told us they had implemented additional staff meetings and an online messaging system to inform staff of any tasks or changes made within the service.

Staff we spoke with gave examples of where they had suggested changes in patient care and engagement.

- The speech and language therapy team created a document of pictures and diagrams to assist communication with non-verbal patients.
- An afternoon tea in a cat cafe was arranged for a patient who loves animals.
- Another patient participated in a Lego competition in a city retailer as they loved Lego building.

We spoke with the patients, who said they had enjoyed these events. One patient had their cat keyring attached to their belt.

What needs to improve

We saw evidence to demonstrate the service listened to staff feedback and acted on any issues raised as a result. 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 the improvements made as a result of staff feedback, to determine whether actions taken have led to the anticipated improvements.

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.

The registered manager understood the notification process to Healthcare Improvement Scotland, and we saw incidents and accidents were appropriately reported to us within the specified timeframes.

We saw evidence of policies and procedures to ensure the delivery of safe, person-centred care for:

- duty of candour
- infection control
- information management, and
- safeguarding (public protection).

The service also had a range of organisational and local policies and procedures, which the policy review group reviewed regularly. These were available on the staff intranet. The local policies reflected Scottish legislation and were reviewed by the hospital management team before implementation.

We saw that any maintenance work that could not be carried out by the service's maintenance staff was assigned to external contractors. We saw records of safety checks on fire safety equipment, fire doors and water flushing. An overview was kept by the maintenance team on site to ensure the programme of checks was carried out in good time. We were told that the maintenance team held regular unannounced fire drills, and the results were fed back to staff and management. We saw evacuation information displayed in the service, including comprehensive details of who should be contacted, including utilities and external agencies, and the contingency plans if the building could not be accessed again.

When a patient was discharged, the maintenance team checked the bedroom and repainted it as standard before the next patient was admitted.

Patients' laundry was laundered in onsite professional washing machines and tumble dryers.

Incident and accidents were recorded using an electronic incident reporting system. These were also reported to the provider's clinical governance group who had access to the system. They could track and input further queries directly to the service's senior management. The information recorded included:

- a description of the incident and immediate actions taken
- the action plan for improvement, and
- any areas of good practice.

We saw evidence of incidents being discussed at staff meetings and minutes were displayed on staff noticeboards.

Duty of candour is where healthcare organisations have a professional responsibility to be honest with patients when something goes wrong. The service had a duty of candour policy, and an annual report was available on the provider's website. Staff also had training on duty of candour principles as part of their training schedule.

Patients were referred to the service through the NHS or their local authority. There was an up-to-date admission, transfer and discharge policy.

While in the service, patients were temporarily registered with a local GP and medication was supplied by a local pharmacy. We saw clear policies in place for the prescribing, ordering and administering medication for registered nursing staff. There were also standard operating procedures for registered nursing staff covering all aspects of medicine management.

The service used an electronic patient care record system that was password protected. We saw some paper records, which was stored securely in the nurse's office until it was added to the electronic system. The service was registered with the Information Commissioner's Office (an independent authority for date protection and privacy rights).

Policies were in place for recruitment, induction and staff development. Staff files contained a checklist to help make sure that recruitment processes and pre-employment checks had been carried out. The provider's human resources department supported the service with the recruitment process. Systems were in place to ensure all staff had an up-to-date Protecting Vulnerable Groups (PVG) background checks.

We saw clear policies and checklists to ensure all aspects of induction were covered for new staff. All staff members completed a 2-week induction programme which involved face-to-face training, e-learning and webinars. New staff shadowed a more experienced member of staff to gain practical experience before commencing their role. General induction topics included:

- safeguarding
- data protection
- infection prevention and control, and
- brain injury training.

There was a 6-month probation period for new staff. During this time, their performance was monitored and reviewed before a decision was made to offer a permanent contract.

Senior management used an online platform to monitor compliance with mandatory training. We saw evidence that senior management monitored and ensured compliance with mandatory training.

We saw evidence of in-house training from specialist clinicians, such as dysphagia communication, challenging behaviours and psychology. This helped staff to provide specialised care and support to patients with complex needs. We were told staff could access training for particular areas of interest if suitable to meet the needs of the service.

We saw the service manager asked staff to complete safeguarding questionnaires and provide examples of safeguarding issues and how these would be reported. We were told the service would also use examples of safeguarding incidents within care settings that had been published nationally to help raise staff awareness. This helped to identify any safeguarding training needs or further development with staff.

Staff performance and personal development was monitored through supervision and yearly appraisals. We saw appraisals were linked to the provider's values. Staff were asked to reflect how they met the provider's values at work and set objectives and personal development goals for the year ahead. The appraisals we saw had been completed comprehensively.

The service proactively managed its staffing complement to help make sure that an appropriate skill mix and safe number of staffing was provided. Staffing rotas were compiled 4-6 weeks in advance, and we were told the service used a permanent pool of bank staff and agency nurses to help cover staffing gaps to maintain safe and effective staffing levels.

What needs to improve

Although the provider understood the notification process to Healthcare Improvement Scotland, a number of directors had changed in the last few months on Companies House that have not yet been received (requirement 1).

We did not see evidence of the washing machines being maintained to ensure that the temperature was consistently high enough to meet the national guidance for safe management of linen (requirement 2).

We saw a support worker had recently completed medication competency training. This gave them responsibility to administer medication within their role. We were told registered nurses within the service provided oversight and support to the support worker. However, there no policy or standard operating procedure outlining the support worker's responsibilities and what procedures they must follow should the patient require medication (requirement 3).

Within the service's complaints policy, the appendix for patients, carers and relatives did not contain the contact details for Healthcare Improvement Scotland. The service also had a publicly available feedback form that also had no reference to Healthcare Improvement Scotland (requirement 4).

We did not see specific instructions on the cleaning schedules as to what dilution of cleaning products should be used and in what concentration (recommendation b).

Requirement 1 – Timescale: by 1 December 2023

- The provider must notify Healthcare improvement Scotland of certain matters as detailed in our notifications guidance.

Requirement 2 – Timescale: by 1 December 2023

- The provider must introduce a maintenance programme for the laundry facilities to ensure temperatures are reached for effective decontamination.

Requirement 3 – Timescale: by 1 December 2023

- The provider must ensure policies and procedures are in place with specific guidance and responsibilities for staff who dispense medication.

Requirement 4 – Timescale: by 1 December 2023

- The provider must update its complaints policy to include the full name, address, telephone number and email address for Healthcare Improvement Scotland, including a statement making it clear that patients and carers have a right to complain to Healthcare Improvement Scotland at any time. The feedback form available in public areas must also be updated with Healthcare Improvement Scotland's contact information.

Recommendation b

- The service should have clear guidance in writing for staff using cleaning products specifying concentrations and areas for use.

Planning for quality

The service's risk management policy covered all areas of risk including the regional and local service. This covered all aspects of risk and categories. These included:

- health and safety
- environment
- quality
- information technology and data protection, and
- medication.

An up-to-date fire risk assessment was in place. We also saw specialist risk assessments for managing key building risks such as legionella (a water-based infection). These risks were regularly reviewed and approved at regional operational team meetings and local operational team governance meetings. We saw that risk-themed reports were shared with staff that included lessons learned from any accidents or incidents.

We saw evidence of programmes of audits for clinical and non-clinical areas to help ensure patient care and treatment were consistent and safe. We saw action plans were produced detailing timescales and they were signed off by senior management. All staff were involved in the audit process, and we saw evidence of this on staff noticeboards, with an average of six audits each month being carried out. Audits included:

- infection prevention and control
- nutrition and hydration, and
- patient care records.

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 detailed procedures in an easily accessible folder kept at reception that staff were aware of. There were arrangements for patients to use the provider's other facilities onsite should they not be able to return to the building.

What needs to improve

The service received patient safety alerts. On receipt, these were sent to the senior team for action. There was no record of review or documented action or if further intervention was required (requirement 5).

Requirement 5 – Timescale: by 1 December 2023

- The provider must ensure they have an effective process to manage patient safety alerts so that on receipt, they are disseminated and acted on appropriately, with any action documented and reported at future governance meetings.

- 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

We saw safer recruitment processes were followed. The majority of staff described the provider as a good employer. The service was clean with ongoing refurbishment in place. Patient care records were completed and comprehensive. The provider must ensure appropriate procedures are carried out for the prevention of infection and control and some staff told us communication could be improved.

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

The environment was clean and well maintained. We saw cleaning schedules for all areas were completed to show that cleaning had taken place. Adequate supplies for cleaning products and equipment were available. There was a good supply of personal protective equipment such as gloves, masks and aprons.

We reviewed five staff files and found all contained the required background checks to show staff had been safely recruited. This included:

- professional registration checks and qualifications where appropriate
- Protecting Vulnerable Groups (PVG) status, and
- references.

We also saw in each staff file reviewed that they included an induction, supervision and appraisal programme.

We saw a process was in place to ensure ongoing reviews of professional registrations and regular PVG checks were carried out, as required.

As part of our inspection, we asked the service to circulate an anonymous staff survey. From our staff survey, 89% of the staff who responded said they would recommend the organisation as a good place to work. However, only 54% felt they were able to influence how things were done in the organisation. Comments included:

- 'I really enjoy my job here and wouldn't hesitate to recommend this as a good place to work.'
- 'The service really cares about their staff and patients. Everyone is kind and always willing to provide additional support where necessary.'
- 'Communication overall within the service can be poor, often with communication not being sent overall and people not being notified of changes until they're in the process of being done.'
- 'Though there are occasionally opportunities to voice our thoughts, these are rarely taken up.'

We reviewed five patient care records and they all contained comprehensive information and were fully completed. This included clinical assessments, capacity for consent, detailed medication history and risk assessments. All patient care records included care plans that assisted in supporting and managing patient care. These were all up to date, and the service had an alert system on each patient care record that allowed staff to see if anything was due for renewal.

What needs to improve

During the inspection, we saw some instances where the service did not comply with national infection prevention and control guidance in relation to single-use equipment. For example, medicine cups and syringes were cleaned by staff and then re-used. We discussed this with clinical and senior managers, and we saw information was immediately provided to staff that all single-use equipment must be disposed of after one use. In one of the treatment rooms, we saw a tap was broken and this prevented staff from being able to decontaminate their hands. We were told this had been reported. However, there was no risk assessment or action plan in place (requirement 6).

The service should consider the involvement of advocacy which is an independent service that can give patients advice and support with their stay in hospital. This service is offered but not documented as to whether the patient wished to speak to them (recommendation c).

Some staff told us that communication could be improved, and we discussed this with the service. We will follow this up at the next inspection.

Requirement 6 – Timescale: by 1 December 2023

- The provider must ensure appropriate procedures are carried out for the prevention and control of infection in particular:
  a) a process for the disposal of single-use equipment after use, and
  b) develop a risk assessment and action plan for the decontamination of hands.

Recommendation c

- The service should clearly record if patients have been offered advocacy services and if these have been refused.

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: https://www.healthcareimprovementscotland.org/scrutiny/the_quality_assurance_system.aspx

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

Telephone: 0131 623 4300

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
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

0131 623 4300

Glasgow Office
Delta House
50 West Nile Street
Glasgow
G1 2NP

0141 225 6999

www.healthcareimprovementscotland.org