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# Unannounced Inspection Report: Independent Healthcare

**Service:** St. Margaret of Scotland Hospice,  
Clydebank

**Service Provider:** St. Margaret of Scotland Hospice

9-10 July 2024

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## 1 Progress since our last inspection

### What the provider had done to meet the requirement we made at our last inspection on 16-17 August 2022

#### Requirement

*The provider must ensure that systems are in place to ensure emergency equipment is always in date.*

#### Action taken

Documented systems were now in place to ensure emergency equipment was checked regularly. All emergency equipment we looked at was in date. **This requirement is met.**

### What the service had done to meet the recommendations we made at our last inspection on 16-17 August 2022

#### Recommendation

*The service should invite patients, carers or family members to participate in groups or discussions about improving the service to ensure that the opinions and experiences of patients, carers and families are considered.*

#### Action taken

The hospice's current strategic plan (2023-2026) included an updated public participation strategy which stated that the hospice aimed to listen to the experiences of patients, families and carers. The quality improvement plan also stated that patients and families would be involved in the development of various services, for example the redevelopment of the community specialist palliative care service. However, this had not progressed as formal methods had yet to be developed to involve patients, carers or family members in helping the service to improve. A further recommendation has been given to support improvement in this area (see recommendation a on page 18).

#### Recommendation

*The service should ensure information on its website is accurate and up to date.*

#### Action taken

The hospice had upgraded its website since the last inspection. We found the website was now more user friendly and contained more up-to-date information. This included information on how to make a complaint. We were told further work was being carried out to add relevant documents, such as the strategic plan, to the website and to reflect the hospice's new branding.

### **Recommendation**

*The service should develop a whistleblowing policy and support staff to create a whistleblowing champion role. This would ensure that staff have the opportunity and confidence to raise concerns and promote a culture of speaking up.*

### **Action taken**

The hospice had recently updated its raising concerns policy for staff and identified two whistleblowing champions.

### **Recommendation**

*The service should carry out a staffing review using a recognised safe staffing tool.*

### **Action taken**

During the last inspection, we made a recommendation that a safe staffing tool should be used to support safe staffing levels. We recognise that there is no specific tool that is applicable for use in an independent hospice. Staffing will be discussed in more detail within the report.

### **Recommendation**

*The service should develop a process of formally reviewing all patient deaths, including patients who had intravenous (IV) and peripherally inserted central catheters (PICC) in place at the time of death, to ensure learning outcomes are identified and taken forward to improve future practice.*

### **Action taken**

Senior clinical staff we spoke with told us the hospice had not yet carried out an audit on patients with peripherally inserted central catheters (PICCs). Instead, a database had been developed with details of patients who had received PICCs since 2022. Although no timeframe was given, we were told that a formal review of the processes, procedures, learning outcomes and benefits to patients would now take place using this information. We were also told that the hospice would then consider whether it would publish the findings of this review. A further recommendation has been given to support improvement in this area (see recommendation b on page 28).

**Recommendation**

*The service should review patient care records and how information is displayed on the electronic record keeping system and improve how clinical care and pastoral care information is documented.*

**Action taken**

We found information recorded on the patient care records was detailed and thorough. This included clinical discussions, patient test results, and conversations with patients, families and staff.

**Recommendation**

*The service should ensure a process is in place to contribute to and obtain appraisals for any staff members working under practicing privileges from their respective NHS employer.*

**Action taken**

We saw a process was now in place to obtain NHS appraisals of staff working under practicing privileges in the hospice. We were told a process was also in place to allow managers in the hospice to contribute to the NHS appraisal process for these staff members.

## **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 St. Margaret of Scotland Hospice on Tuesday 9 and Wednesday 10 July 2024. We spoke with a number of staff, patients and families during the inspection. We received feedback from 23 staff members through an online survey we had asked the hospice to issue for us during the inspection.

Based in Clydebank, St. Margaret of Scotland Hospice is an independent hospital (a hospice providing palliative/end of life care).

The inspection team was made up of four inspectors and one external advisor with extensive experience in palliative medicine.

## What we found and inspection grades awarded

For St. Margaret of Scotland Hospice, the following grades have been applied.

<b>Direction</b>	<i>How clear is the service's vision and purpose and how supportive is its leadership and culture?</i>	
<b>Summary findings</b>		<b>Grade awarded</b>
<p>The provider had a clear vision and purpose, and the strategic plan outlined the hospice's core quality values. Several key performance indicators were used to measure how well the hospice was performing. Clear governance structures were in place with defined lines of reporting and accountability. Staff told us the leadership team was approachable, visible and supportive. As the provider was currently undergoing a period of change and rebranding, strategy documents were being reviewed and updated to reflect this.</p>		<p>✓✓ Good</p>
<b>Implementation and delivery</b>	<i>How well does the service engage with its stakeholders and manage/improve its performance?</i>	
<p>The provider had processes and procedures to support the safe delivery of care. Feedback received from patients and families was regularly reviewed. We saw evidence of appropriate staff recruitment processes, with a detailed probationary period and in-house training programme. Training sessions were being developed for external healthcare professionals. Quality assurance and risk management processes, including a quality improvement plan, risk register and audit programme, helped the hospice to continually demonstrate improvements.</p> <p>We have concerns about the sustainability of both the community and medical teams. During the inspection, to help us better understand the hospice's current medical staffing model and clinical workforce, we asked the hospice to complete Healthcare Improvement Scotland's workforce data template. This would provide assurance that the appropriate staffing levels were in place to provide safe and high-quality services. Despite requests, the hospice has not returned the completed template as part of the inspection process. While recruitment plans are in place, we remain concerned about the long-term sustainability of staffing and the impact on patient care should the hospice be unable to successfully recruit.</p>		<p>✓ Satisfactory</p>



Results	<i>How well has the service demonstrated that it provides safe, person-centred care?</i>	
Summary findings	Grade awarded	
<p>Patients and families spoke positively about the hospice. Staff told us they felt proud to work in the hospice. The environment was clean and uncluttered with good infection control measures in place. The patient care records we reviewed were well completed. Staff files contained information about all aspects of recruitment, induction, training and appraisal.</p> <p>Although a full review of the use of peripherally inserted central catheters (PICCs) in the hospice was planned, patient outcomes from this should be shared with the wider palliative care community. A recommendation has been made to support improvement in this area.</p>	✓✓ 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 St. Margaret of Scotland Hospice to take after our inspection

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

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

This inspection resulted in one requirement and two recommendations.

Implementation and delivery	
<b>Requirement</b>	
<b>1</b>	<p>The provider must ensure sustainable staffing and workforce resources for the care being delivered (see page 22).</p> <p>Timescale – by 6 January 2025</p> <p><i>Regulation 12(a)</i> <i>The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011</i></p>
<b>Recommendation</b>	
<b>a</b>	<p>The service should develop formal methods to support patients, carers or family members to participate in groups or discussions about improving the service to ensure that their opinions and experiences are considered (see page 18).</p> <p>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.6</p> <p>This was previously identified as a recommendation in the August 2022 inspection report for St. Margaret of Scotland Hospice.</p>

Results
<b>Requirements</b>
None
<b>Recommendation</b>
<p><b>b</b> The service should ensure patient outcomes from the use of treating patients using peripherally inserted central catheters (PICCs) in a hospice are identified and shared with the wider palliative care community (see page 28).</p> <p>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19</p> <p>This was previously identified as a recommendation in the August 2022 inspection report for St. Margaret of Scotland Hospice.</p>

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](#)

St. Margaret of Scotland Hospice, the provider, must address the requirement and make the necessary improvements as a matter of priority.

We would like to thank all staff at St. Margaret of Scotland Hospice 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
<i>How clear is the service's vision and purpose and how supportive is its leadership and culture?</i>	

#### Our findings

The provider had a clear vision and purpose, and the strategic plan outlined the hospice's core quality values. Several key performance indicators were used to measure how well the hospice was performing. Clear governance structures were in place with defined lines of reporting and accountability. Staff told us the leadership team was approachable, visible and supportive. As the provider was currently undergoing a period of change and rebranding, strategy documents were being reviewed and updated to reflect this.

#### *Clear vision and purpose*

St. Margaret of Scotland Hospice provides care for adults with life-limiting conditions that require assessment and management of complex symptoms and specialist care. This was provided by a specialist multi-professional team. The hospice's vision was to be regarded as a centre of excellence for the provision and teaching of specialist palliative and complex clinical care.

The hospice had a set of core quality values around service, dignity, compassion, justice and advocacy. These were used to direct and inform all of the care provided by the hospice. These values were clearly displayed throughout the hospice and were also on the hospice's upgraded website. A mission statement was also displayed in the hospice which described how staff would deliver on these core values.

The hospice had several ways to determine if it was meeting its core values and mission statement. This included measuring its performance using key performance indicators including:

- patient and carer satisfaction
- admissions/discharges
- staff satisfaction/recruitment/retention/education
- audit results
- accidents and incidents

- quality improvement, and
- strategic development.

At the time of our inspection, we recognised that the hospice was going through a period of change after the planned recent withdrawal of the Religious Sisters of Charity. Changes to the governance arrangements at Board level had taken place, including the appointment of a new Chair, and we noted that the new Board was now making plans to meet on a more regular basis. A rebranding of the hospice was under way to reflect these changes. We were told the current strategic plan (2023-2026) would be reviewed and updated to reflect these changes. This would include an independent review of corporate governance by an external consultant based on NHSScotland good governance guidance. There will also be a review of operational management, including long-term workforce planning, as there have been recent changes to the medical staff workforce. Long-term funding for the hospice, delivery of the existing refurbishment plans and upgrading of some of the hospice buildings would also be included in this change programme. We will follow up on the progress of the new governance arrangements at future inspections.

We noted the hospice's new website continued to be developed and, once fully operational, the strategic plan and other relevant documents would be uploaded to make these visible and accessible to the public. We will follow up on the progress of the new website at future inspections.

- No requirements.
- No recommendations.

### ***Leadership and culture***

A wide variety of staff helped to make sure all patients' needs could be met. This included:

- palliative care nurses
- medical staff
- physiotherapists
- occupational therapists
- housekeeping staff
- maintenance staff, and
- a visiting chaplain.

A number of volunteers also provided support to the hospice.

The hospice's governance and leadership structure had well defined lines of reporting and accountability. The senior management team managed the day-to-day running of the hospice. Senior managers carried out regular walkrounds to be visible and contactable for staff, and to help understand any staff pressures or challenges. We saw evidence that the findings of the walkrounds were recorded as part of the weekly senior nursing meetings and monthly clinical governance committee meetings, with action plans developed for any areas of improvement identified.

An established clinical governance system was made up of a number of subgroups that reported to an overarching clinical governance committee. The subgroups included:

- medicine management
- policies and protocols
- medical meetings
- health and safety which includes infection control and risk management, and
- audits and research.

These subgroups reported into the monthly clinical governance committee meeting.

A report was then prepared for the hospice's Board which detailed clinical governance matters arising from the subgroups as well as other governance issues in the hospice.

A number of regular meetings were held, including staff and ward meetings. These provided opportunities to share information about clinical governance, quality improvement and risk matters, as well as day-to-day issues. Staff were encouraged to raise any suggestions for improvements at their ward meetings. We saw minutes from the monthly clinical governance committee meetings and weekly senior nursing meetings.

We attended a daily staff team briefing where current and ongoing priorities in the hospice and patient care were discussed. Infection prevention and control issues were also discussed. This meant that staff were regularly kept up to date with any changes or ongoing issues. We saw evidence that these daily staff team briefings were documented and available for staff to view.

Staff we spoke with during the inspection, and those who responded to our online survey, told us that the senior leadership team and department leads were very approachable, supportive and visible. Staff told us that they felt empowered to speak up and felt safe to do so. For example, staff had suggested and were involved in developing policies for offering alternative pain relief to patients.

Comments we received from speaking with staff and from our online survey included:

- ‘Clear and present leadership.’
  - ‘The senior team are very supportive and set a good example to others.’
  - ‘I understand and support the values of the Hospice and see how this drives a positive culture.’
- 
- 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
<i>How well does the service engage with its stakeholders and manage/improve its performance?</i>		

### Our findings

The provider had processes and procedures to support the safe delivery of care. Feedback received from patients and families was regularly reviewed. We saw evidence of appropriate staff recruitment processes, with a detailed probationary period and in-house training programme. Training sessions were being developed for external healthcare professionals. Quality assurance and risk management processes, including a quality improvement plan, risk register and audit programme, helped the hospice to continually demonstrate improvements.

We have concerns about the sustainability of both the community and medical teams. During the inspection, to help us better understand the hospice's current medical staffing model and clinical workforce, we asked the hospice to complete Healthcare Improvement Scotland's workforce data template. This would provide assurance that the appropriate staffing levels were in place to provide safe and high-quality services. Despite requests, the hospice has not returned the completed template as part of the inspection process. While recruitment plans are in place, we remain concerned about the long-term sustainability of staffing and the impact on patient care should the hospice be unable to successfully recruit.

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

The hospice's upgraded website now included information on:

- inpatient and outpatient services
- how to access 24/7 telephone advice, and
- community services.

A number of patient information leaflets were available at reception, such as general information leaflets for patients and families, and about infection prevention and control. The hospice's current strategic plan was also available in the public areas. Staff photographs with their job role were displayed throughout the hospice to help patients and families identify staff members.



Before a patient was admitted, a thorough process of gathering and reviewing information about the patient was carried out. Patients and their carers were contacted before admission to obtain more information about their expectations of the admission, their spiritual and possible clinical needs, and their likes and dislikes. Patients were often visited at home by staff to help alleviate any concerns from the patient and their family before they agreed to be admitted.

As a result of the COVID-19 pandemic, the day hospice services had been paused. This service had now reopened in January 2024. This was currently available one day a week for patients in the community with a plan to expand this in the future. Patients had the ability to meet with other patients, had access to clinical support and received complementary therapies, such as aromatherapy massages.

Feedback forms were available to patients and families to gather their views about the hospice at any time. These were reviewed regularly and results fed back to staff. Results from an audit of patient feedback carried out in February-May 2023 on St Joseph's Ward inpatient unit was also available on the hospice's upgraded website. We saw that the feedback form asked for any suggestions to improve their experience. All feedback from the forms we reviewed was positive, and we were told that any informal feedback was dealt with as soon as possible to help improve a patient's or family member's experience. Patients we spoke with told us they felt able to raise any issues or concerns they had, and felt that these would be dealt with.

A staff survey had recently been sent out that included questions about leadership and culture. At the time of our inspection, the results were still to be formally fed back to staff. However, results we saw supported that of our own survey and highlighted that staff felt positive about working in the hospice and about the support they received from the senior management team.

Staff information noticeboards in the inpatient unit displayed information on how to complete learning tools and nursing care charts, for example pressure area assessment tools.

Staff had free access to the hospice gym, swimming pool and various complementary therapies.

### **What needs to improve**

The hospice's current strategic plan (2023-2026) included an updated public participation strategy which stated that the hospice aimed to listen to the experiences of patients, families and carers. The quality improvement plan also stated that patients and families would be involved in the development of

various services, for example the redevelopment of the community specialist palliative care service. However, this had not progressed as formal methods had yet to be developed to involve patients, carers or family members in helping the service to improve (recommendation a).

As well as staff from within the hospice, patients also had support from GPs, district nurses and other primary care staff, as needed. We met with staff involved in the hospice's community specialist palliative care team. This provides services including virtual and telephone reviews, home visits and focused outpatient reviews. We were told a significant number of patients were currently receiving support from this team. One specialist nurse was responsible for reviewing and managing all of the referrals to the team, supported by senior management team members. They told us that they felt supported to carry out their role at this time. However, both staff we spoke with, and the senior management team, was aware that an increase in staffing numbers was needed to ensure the sustainability of this service and was currently advertising for staff. We will continue to follow up progress with this.

- No requirements.

#### **Recommendation a**

- The service should develop formal methods to support patients, carers or family members to participate in groups or discussions about improving the service to ensure that their opinions and experiences are considered.

#### ***Quality improvement***

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

The hospice fully understood Healthcare Improvement Scotland's notification process and the need to inform Healthcare Improvement Scotland of certain events or incidents that occurred.

A wide range of up-to-date policies were in place, including:

- medicine management
- protection of vulnerable adults
- health and safety, and
- infection control.

Incidents were recorded and managed through both a paper and an electronic incident management system. A formal review process was in place with any learning outcomes and lessons learned from incidents shared and discussed at staff and leadership meetings. We saw different examples of incidents that staff had reported and saw evidence that the hospice's process had been followed in each case.

The hospice's complaints policy set out the processes and procedures to follow in the event of a complaint or concern being raised. Information on how to make a complaint was displayed in the hospice and was also now published on the website. This included information on how to contact Healthcare Improvement Scotland. We noted the hospice had received no complaints since our last inspection in 2022. We were told that staff had received training in complaints handling. Staff told us that any concerns mentioned by patients or carers were handled sensitively and dealt with as soon as possible. This helped to ensure the needs of the patient and family members were being met, demonstrating a person-centred approach.

Duty of candour is where healthcare organisations have a professional responsibility to be honest with patients when something goes wrong. The hospice had an up-to-date duty of candour policy, and staff were trained in duty of candour principles. The hospice's 2022/23 duty of candour report had been published on its upgraded website. We noted the 2023/24 report was awaiting sign off from the Board before being uploaded onto the website.

The maintenance team looked after the day-to-day management of the building and equipment. This included electrical, fire and water safety checks, and any repairs that staff reported through the hospice's electronic reporting system. Any specialist servicing and repairs that the maintenance team could not carry out was contracted to external specialists. We were told that the Scottish Fire and Rescue Service carried out regular, planned visits to the hospice and offered fire safety advice.

We reviewed the hospice's medicine management procedures. Support from a pharmacist and pharmacy technician was provided by NHS Greater Glasgow and Clyde. We saw a thorough process for the safe management of medicines included:

- discharge prescriptions
- medicine prescription charts
- medicine reconciliation (recording patients' current medication)
- regular checks of medicine expiry dates

- safe storage of medicines, and
- the process for ordering controlled drugs (medications that require to be controlled more strictly, such as some types of painkillers).

The hospice regularly audited the prescribing practices and medicines being used. Medicines were stored appropriately and securely. Training in medicine administration was included in the staff induction programme and staff completed refresher training every year.

Patient care records were held electronically on a password protected, secure system. The hospice was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights) to ensure confidential information was safely managed.

A detailed process of documenting patient information, consultations and assessments took place. Paper copies of assessment tools were kept at the patients' bedsides to allow staff to complete these while providing care. These were then regularly scanned into the electronic system.

Assessments, care plans and relevant observation charts completed from admission included:

- risk of falls assessment
- assessment of pressure ulcers
- nutritional review
- pain assessment, and
- assessment of the patient's ability to understand information.

As well as daily staff team briefings, we were told that members of the multidisciplinary team also discussed the current patient waiting list on a daily basis and used an electronic admissions tool to help prioritise patient admissions based on patient need.

Regular tests were carried out as part of the ongoing assessment of patients. This included blood tests, electrocardiograms (ECGs) (to check the rhythm, rate and electrical activity of a person's heart) and urine testing. We were told this was to detect any abnormalities that may impact on the patient's symptoms and condition, and to allow staff to offer treatments that may help. Patients could be offered intravenous (IV) infusions to help with dehydration, or blood transfusions to alleviate symptoms of anaemia. As reported at our inspection in 2022, the hospice provides patients with the option of having a peripherally inserted central catheter (PICC) to allow a more comfortable intravenous (IV)

access. This is a thin flexible tube that is inserted into the upper arm and allows easy access for intravenous fluids. The hospice worked with NHS Greater Glasgow and Clyde's intravenous access nurse-led team to facilitate and provide this treatment.

An up-to-date recruitment policy helping to ensure staff were safely recruited was in place. Paper copies of staff files were held securely in the hospice. We saw evidence that appropriate background checks were obtained including ID check, references and appropriate qualifications. Each member of staff had a signed contract and an up-to-date Disclosure Scotland Protecting Vulnerable Groups (PVG) background check. A process was also in place to carry out yearly checks of staff, such as ensuring their professional registration remained up to date.

One member of staff had an 'honorary contract' in place which allowed them to work in the hospice whilst also working for an NHS board. We saw that all the appropriate processes and checks were in place for this.

We saw evidence that all staff completed a generic and a role-specific induction programme that included a thorough process of supervision and observation. New staff completed a probationary period where regular meetings were documented with their mentor and an ongoing assessment made of their development. New staff also completed an induction and competence workbook.

We also saw evidence that staff appraisals were completed every year and included setting professional development objectives.

We were told monthly 'toolbox' talks had been introduced covering topics such as infection prevention and control, regulation and quality improvement. These brief training sessions acted as a refresher for more in-depth training sessions, and aimed to be easier for staff to understand. As part of ongoing learning, senior staff also regularly held policy teaching sessions following the daily staff team briefings. This could include subjects such as duty of candour. Healthcare assistants also had the opportunity to train and complete competencies in taking blood samples and carrying out ECGs.

We were told the hospice was working with Glasgow Caledonian University to provide a 15-week training module to advanced practitioners in subjects such as breaking bad news and symptom management. The hospice was also developing 3-day training sessions for external healthcare professionals, for example for advanced paramedics and community pharmacy teams to help them develop their experience and knowledge in palliative care.

### **What needs to improve**

We were told recruitment had been challenging for the hospice. At the time of the inspection, there were no junior doctors working in the hospice. Due to senior staff leaving the medical team, and the lack of junior medical staff, four consultant doctors were covering the medical rota. Only one of them had specialist palliative medicine qualifications. An external agency of specialist palliative medicine consultants was being used to help support the out-of-hours service. Staff met every week with the external agency to discuss patients with complex medical needs. Although we were told that a new consultant doctor would be starting soon, they were not a specialist palliative medicine consultant. A staffing contingency plan had been developed by the hospice identifying actions to help with the current medical staffing numbers. The hospice planned to advertise for two new palliative medicine consultants. There were also plans to develop a programme for first and second year trainee doctors to work and gain experience in the hospice from 2025. However, no timescales were given for advertising these posts nor developing the trainee doctor programme.

During the inspection, to help us better understand the hospice's current medical staffing model and clinical workforce, we asked the hospice to complete Healthcare Improvement Scotland's workforce data template. This would provide assurance that the appropriate staffing levels were in place to provide safe and high-quality services. Despite requests, the hospice has not returned the completed template as part of the inspection process. However, the hospice devised its own workforce template which was received before publication of this report. While recruitment plans are in place, we remain concerned about the long-term sustainability of staffing and the impact on patient care should the hospice be unable to successfully recruit (requirement 1).

### **Requirement 1 – Timescale: by 6 January 2025**

- The provider must ensure sustainable staffing and workforce resources for the care being delivered.
  
- No recommendations.

### ***Planning for quality***

The hospice's risk management strategy defined risk and risk management and referred to the training and responsibility of all staff in identifying risks in the hospice. We saw a range of risk assessments had been carried out to protect patients, staff and visitors. These included moving and handling, and environmental and patient safety risk assessments. These were incorporated

into a comprehensive risk register to help ensure identified risks were regularly reviewed and updated.

We saw evidence that regular infection prevention and control audits were carried out following national infection prevention and control guidance. For example, audits were carried out for by a range of staff members on topics such as:

- control of the environment
- management of care equipment
- hand hygiene, and
- waste, including sharps disposal.

We saw that auditing of patient care records was included in the audit programme. This covered areas such as completion of patient contact details, consent and power of attorney information. This is when someone is given legal authority to make decisions on behalf of another person, such as about their wellbeing or financial matters. These audits helped to ensure patient care records were being fully and accurately completed. Additional audits included medicines management, checking mattress and mattress covers, and reviewing patient and relative feedback.

The hospice's quality improvement plan contained a range of service improvement plans, including reviewing the audit programme, plans to expand the complementary therapy programme and an ongoing review of the 24/7 telephone advice line. The plan was 'live' and regularly updated. We saw evidence of progress with the quality improvement plan being discussed at the various subgroups and the clinical governance committee meetings.

We were told that staff were given verbal feedback following certain audits to allow them to take any immediate necessary actions to improve their practice, such as hand hygiene. We saw evidence that, where areas for improvement had been identified, planned actions and timescales for completion were documented. All audit results we saw showed good results. Results of audits were shared with staff at the daily staff team briefing, at staff meetings and through the wider corporate governance structures, including senior management team and clinical governance meetings.

The hospice was a member of Hospice UK and benchmarked its service using the Hospice UK processes. This included reviewing itself against aspects such as:

- slips, trips and falls
- incidents and accidents, and
- tissue viability (reviewing patients' skin and soft tissue wounds such as pressure ulcers).

This allowed the hospice to be compared to similar sized services, identify any gaps and improve how the service was delivered.

- 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

**Patients and families spoke positively about the hospice. Staff told us they felt proud to work in the hospice. The environment was clean and uncluttered with good infection control measures in place. The patient care records we reviewed were well completed. Staff files contained information about all aspects of recruitment, induction, training and appraisal.**

**Although a full review of the use of peripherally inserted central catheters (PICCs) in the hospice was planned, patient outcomes from this should be shared with the wider palliative care community. A recommendation has been made to support improvement in this area.**

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

The environment was clean and clutter free. Appropriate cleaning products, including chlorine-based products for sanitary fixtures and fittings, and colour-coded cleaning equipment, were being used in line with national infection prevention and control guidance. Staff used 'I am clean' labels which were dated and attached to equipment after cleaning to show that equipment was ready for use again. The equipment we saw was clean and well maintained. Cleaning schedules were completed, and the head of housekeeping was responsible for regularly reviewing these.

We saw good compliance with infection prevention and control procedures. This included the safe disposal of clinical waste and medical sharps such as syringes and needles. We saw a good supply of alcohol-based hand rub, and appropriate personal protective equipment such as disposable gloves and aprons. Posters provided guidance for staff on appropriate methods of using personal protective equipment and the correct hand washing procedure. We saw evidence that staff had completed infection prevention and control training.

The laundry room had an effective system to make sure dirty and clean laundry was kept apart, and this area was found to be particularly well kept and organised.

During the inspection, we reviewed 12 patient care records and saw that patient details were well documented. This included patients' next of kin and GP contact details, and consent to treatment, to taking photographs of pressure ulcers and to sharing information, as needed.

Copies of patients' power of attorney documents were stored in the patient care records, where applicable.

Throughout the patient care records, discussions about plans for care, expectations, and the spiritual needs of patients and families were documented. For example, each patient care record we reviewed documented the patient's preferred place for care and preferred place to die. We saw evidence that a do not attempt cardiopulmonary resuscitation (DNACPR) document was completed where appropriate. This refers to the emergency treatment given to a patient when their heart stops or they stop breathing. This was done with the involvement of patients and families.

Consent was completed for patients with a PICC line in place. We saw the referral process was also documented for relevant patients to NHS Greater Glasgow and Clyde's intravenous nurse-led access team.

A multidisciplinary team meeting was held every day to discuss each patient, their goals and ongoing treatment plans. We attended a daily staff team briefing and a multidisciplinary team meeting. We noted that discussion was encouraged, with many staff members contributing and discussing different options available for patients. A proactive approach to discharge planning was in place where this was possible, or according to the patient and family's wishes. During both of these meetings, time was taken for reflection on patients who had recently died and support was provided to staff.

As highlighted in the last inspection report, offering patients regular intravenous (IV) treatments through a PICC line is not typical practice in a hospice. We noted that this procedure had been offered to patients in the hospice since 2022. Staff told us they felt PICCs were beneficial and allowed them to care for patients in the best way. Patients we spoke with who had a PICC line told us they felt the benefit of having regular intravenous (IV) treatments. During the inspection, we reviewed 12 patient care records for patients who had a PICC line. We had no

concerns about the decision-making process for these patients and the care provided. We noted that the hospice had produced a poster presentation on their use of PICC lines, which was shared on an online Scottish palliative care forum in October 2022.

We spoke with a number of patients and families. Patients told us the care was 'second to none', and that they felt 'more than just a patient' to staff. We were told about situations where patients had been unable to eat or walk before being admitted to the hospice and, since their admission, were enjoying their food, putting on weight and going to the toilet independently. Patients told us they now feel they were 'living again', and that they received 'nothing but good care'. Some spoke of their pain having improved and there was no delay in pain relief should they need it. Families told us 'the care is excellent' and that their loved ones had the opportunity to enjoy the gardens, have complementary therapies and to go to mass every day should they wish to.

All patients we observed looked well cared for, comfortable and had easy access to the nurse call system, drinks and their walking aids. We saw that staff had good personal interactions with patients.

From the five staff files reviewed, we found all were fully completed and contained information about all aspects of recruitment, induction, training and appraisal.

Through our online survey, staff told us:

- 'I feel privileged to work here.'
- 'The hospice has a positive culture. It is a disciplined environment which promotes consistency, continuity, maintenance of professional boundaries...'
- 'All we are asked to do is our best in all circumstances and seek help when we reach our limitations.'

### **What needs to improve**

Although a recommendation was made at our last inspection, an audit on patients who had received PICC treatments had not yet taken place. A database had been developed with details of patients who had been treated using PICC lines since 2022. We were told that a thorough review of the processes and procedures and the advantages to patients would now be carried out. We were also told that, following the review taking place, the hospice would consider publishing its findings (recommendation b).

While we found all areas of the hospice were clean and tidy, some areas would benefit from refurbishment. The hospice had previously planned to refurbish the St Joseph's Ward inpatient unit to create additional single bedrooms with ensuite facilities. We were told this had been delayed and would be completed at a later date. We had highlighted the need for refurbishment in our previous inspection report. We will continue to follow this up at future inspections.

- No requirements.

#### **Recommendation b**

- The service should ensure patient outcomes from the use of treating patients using peripherally inserted central catheters (PICCs) in a hospice are identified and shared with the wider palliative care community.

## 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](http://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](mailto: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](mailto: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.scot](http://www.healthcareimprovementscotland.scot)