Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Robin House, Balloch

Service Provider: Children's Hospices Across Scotland

29-30 October 2024

NHS SCOTLAND

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Contents

1 Progress since our last inspection

What the provider had done to meet the requirement we made at our last inspection on 7-8 September 2021

Requirement

The provider must ensure a practicing privileges policy, induction and training programme, and contracts, are in place for all staff working under practicing privileges in the service.

Action taken

A practicing privileges policy and process was now in place. We saw an induction and full training programme in place for all staff. We noted that, at the time of the inspection, all staff were directly employed by the provider and no staff were working under practicing privileges. **This requirement is met.**

What the service had done to meet the recommendations we made at our last inspection on 7-8 September 2021

Recommendation

The service should review its processes to ensure mattresses remain fit for purpose at all times.

Action taken

A process was now in place for checking all mattresses. We saw documented evidence that individual mattresses were checked when a child was discharged and every month.

Recommendation

The service should ensure an anticipatory care plan is developed with input from the patient and their family for every patient admitted to the hospice.

Action taken

Anticipatory care plans were now in place in cases where this was appropriate with evidence of discussion with children and their families. We were told ongoing discussions with external healthcare professionals about patients' individual anticipatory care plans also took place.

Recommendation

The service should ensure a planned process of evaluating new services and strategies is in place.

Action taken

The service's quality and care assurance team had now incorporated an evaluation element when new services and strategies were implemented. The Children's Hospices Across Scotland (CHAS) at home service linked with families and carers for their input to help evaluate the care the service provided and any new projects that were introduced.

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 Robin House on Tuesday 29 and Wednesday 30 October 2024. We spoke with a number of staff and families during the inspection. We received feedback from 52 staff through an online survey we had asked the service to issue for us during the inspection.

Based in Balloch, Robin House is an independent hospital (a hospice providing palliative care/end of life care).

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For Robin 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 hospice had a clear vision and purpose. The new strategic plan set out the key areas of focus, in line with the vision and purpose. The hospice's annual report set out how the hospice was performing against identified key performance indicators. A clear governance structure was in place. Leadership was visible, and a wide range of meetings took place. The majority of staff felt supported by the senior management team.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
The hospice worked hard to ensure a wide range of support was available in the community and at home for children and their families. A range of policies helped to support safe care. A clinical audit programme and draft quality strategy, as well as risk management systems, helped to ensure the safe delivery of care. The service's quality improvement plan should be re-introduced. Children, families and staff should be informed about the impact their feedback has made on the service.	✓✓ Good
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The environment was clean and in a good state of repair. A refurbishment and re-decoration of the environment was planned. Patient care records were comprehensive. Families told us they really valued the support from the hospice and its staff. Staff told us they enjoyed working in the hospice. A review of infection prevention and control procedures must be carried out to ensure all staff are following national guidance for clinical waste and water safety.	✓✓ 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 Children's Hospices Across Scotland 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 four recommendations.

Implementation and delivery
Requirements
None
Recommendations
a The service should develop a formal process of keeping children, families and staff informed of the impact their feedback has on the service and how this may lead to improvements in how the service is delivered (see page 17). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.8

Implementation and delivery (continued)	
Recommendations	
b	The service should ensure that all audits are fully documented and entered onto the electronic reporting system (see page 21). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
c	The service should ensure that regular non-clinical audits are included in the existing audit programme (see page 22). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
d	The service should re-introduce its quality improvement plan to formalise and direct the way it drives and measures improvement (see page 22). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Results	
Requirement	
1	The provider must ensure that all staff follow national infection prevention and control guidance for the safe management of clinical waste and ensure that all infrequently used water outlets are flushed and appropriate records kept in line with current national guidance (see page 25). Timescale – immediate *Regulation 3(d)(i)(iii)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
None	

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

Children's Hospices Across Scotland, the provider, must address the requirement and make the necessary improvements as a matter of priority.

We would like to thank all staff at Robin 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 hospice had a clear vision and purpose. The new strategic plan set out the key areas of focus, in line with the vision and purpose. The hospice's annual report set out how the hospice was performing against identified key performance indicators. A clear governance structure was in place. Leadership was visible, and a wide range of meetings took place. The majority of staff felt supported by the senior management team.

Clear vision and purpose

Robin House is one of the two children's hospices delivering care to children and young people across Scotland as part of Children's Hospices Across Scotland (CHAS). The hospice offers palliative, respite and end-of-life care to babies, children and young people up to the age of 21 years with a wide range of life-limiting conditions that require assessment and management of complex symptoms and conditions requiring specialist care. The hospice also provides extensive support to family members.

The hospice's vision, which was part of the provider's strategic plan (2024-2028), was to deliver world-class care for children and their families. We were told there was extensive family involvement in developing this vision and strategy.

Key areas of focus aligned with the hospice's vision and purpose were set out in the strategic plan. These included the three critical stages of a family's journey with the hospice including:

- learning their child is seriously ill and may die young
- living well, and
- dying well and bereavement.

Information about each area identified in the strategic plan was clearly displayed throughout the hospice and on its website.

The hospice measured its performance to ensure it was meeting its vision and purpose using:

- patient and family feedback
- staff surveys and meetings, as well as staff education and training
- audit results
- accidents and incidents, and
- progress against the strategic plan.

The hospice had identified key performance indicators for all aspects of care to help measure its performance. This included:

- admissions
- medicines management, and
- engagement with families.

The hospice produced an annual report which was discussed at Board meetings. The report included information on progress against key performance indicators, updates on project activity, and patient and family engagement. This information was available to all staff through the hospice intranet and was also displayed throughout the hospice. The public could access the report on the hospice's website. Other publications produced by the hospice included:

- an impact report which focused on services delivered and available to children and young people from CHAS in homes, hospices and in hospitals, and
- an economic evaluation of the services provided.

The provider had also commissioned a series of studies to show the demographics and phases of illness of children across Scotland with life-limiting illnesses. The Scottish Government had referenced the most recent study in the development of its new palliative care strategy.

All reports and publications produced had associated strategic objectives and key performance indicators to allow the hospice to measure its progress against them.

- No requirements.
- No recommendations.

Leadership and culture

A range of staff worked in the hospice, including:

- nursing and medical teams
- maintenance, housekeeping and catering
- income generation team
- spiritual care and volunteers
- CHAS at home services
- therapists, and
- Diana Children's Nurses who work in hospitals and communities helping to provide palliative care to children and families, and support staff by delivering training and education.

The hospice's governance and leadership structure had well defined lines of reporting and accountability. Operational responsibilities and the day-to-day running of the hospice were carried out by the senior management team. Senior management was visible and promoted an 'open door' policy for staff.

The provider's board of directors was responsible for the overall governance of CHAS. Board meetings took place every 2-3 months to review progress against the strategic plan as well as reviewing performance against agreed plans and budgets. Various committees reported to the Board including:

- clinical and care governance committee
- corporate governance and risk committee, and
- finance and audit committee.

Various other groups met every 2–3 months and reported to the senior management team, and the clinical and care governance committee. These included the care services governance group, and the medicines optimisation and governance group. This included reporting on progress with the hospice's new digital strategy and draft quality strategy. The quality strategy will aim to ensure the provider focuses on delivering high quality person-centred care, helping to include families, young people and staff in how the service continues to develop.

Other subgroups who reported into both of these groups included independent prescribing groups and the care services operational governance group. We saw agendas and minutes from a range of these meetings.

The associate nurse director was currently reviewing a national safe staffing tool to decide whether this would be a helpful tool for the hospice to use. This would provide assurance that the appropriate staffing levels were in place to provide safe and high-quality services.

The hospice was also completing a 'deep dive' working closely with the finance and human resources teams on staff expenditure and costs with the aim of producing a live e-rostering system. This will enable staff to find out their shift pattern and request their working days in advance.

Daily staff meetings (huddles) took place where patient care and staffing were discussed alongside safety and operational issues. We saw minutes from these daily meetings which showed all staff groups were represented.

We were told a weekly huddle also took place between Rachel House in Kinross and Robin House with the head housekeepers, administrative staff, catering team lead and transport manager, discussing any operational issues from the previous week and planning for the week ahead.

We saw staff were involved in offering suggestions and ideas to help improve the quality of the service and the patient experience. The head of quality and care helped staff to develop and implement any improvement ideas. For example, an education strategy was being developed to support staff to develop the correct skills and competencies for their roles. This included reviewing the current induction programme.

Staff we spoke with were mostly positive and engaged with the service and about how care was delivered. Feedback we received from speaking with staff and from our online survey included:

- 'I have always found that the leadership within the organisation has promoted a positive environment.'
- 'The leadership teams are very supportive.'
- 'Generally, there is positivity within the leadership but sometimes the pace is too fast and there is little time to embed change.'
- 'Some senior staff are supportive and respectful.'

  - 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

The hospice worked hard to ensure a wide range of support was available in the community and at home for children and their families. A range of policies helped to support safe care. A clinical audit programme and draft quality strategy, as well as risk management systems, helped to ensure the safe delivery of care.

The service's quality improvement plan should be re-introduced. Children, families and staff should be informed about the impact their feedback has made on the service.

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

The hospice's website had a range of information available to the public, including the different types of specialist care and support offered, as well as corporate and strategic information about the service and the provider.

The provider's outreach service offered care to children and families in their own homes. The team consisted of both paid and volunteer staff, and included clinical and social work teams, transitional support for older children, and advice on financial and energy support. The provider also worked with external corporate organisations to make flights accessible for families living on the islands to help them to attend the hospice.

Families also had access to paid and volunteer staff who supported them in the home, for example by providing support for siblings, help with household tasks and providing play activities for children. The provider also offered residential nights or weekends away for siblings.

The hospice's user and involvement policy was part of its participation strategy. This aims to ensure that people using CHAS feel they can comment on and contribute to the development of the service. Both the user and involvement policy and participation strategy will be included in the service's quality strategy.

As well as welcoming verbal feedback, feedback cards were available for children and families to complete at any time. If these were not anonymised, staff would contact the person to acknowledge their suggestions and discuss any action to be taken. Information was then recorded in a compliments, suggestions, concerns and complaints spreadsheet which was only accessible to certain staff members. We were told the hospice was developing an alternative process for recording and accessing this information. Feedback from families and young people was shared with staff, and was also displayed on the hospice's website. The hospice also used the national 'Care Opinion' website to source feedback from the general public as well as people who used the service.

Analysis of feedback, complaints and concerns received from children and families was discussed at the care services operational governance group and reported to the clinical and care governance committee.

We saw examples of changes and improvements made to the service as a result of feedback from children and families including:

- replacing all televisions throughout the hospice
- improving the wi-fi service
- providing new mattresses for family residences, and
- having jugs available for juice and drinks for families to use.

Feedback from staff was gathered through an annual staff survey, suggestions boxes, one-to-one supervision sessions which took place every 6–8 weeks, and through appraisal and clinical appraisal sessions.

A wide range of information was available for staff on noticeboards throughout the hospice. This included educational information, for example on medicine management, information on quality improvement, such as the hospice's new strategic plan, and information on mental wellbeing.

The Diana Children's Nurses work in partnership with universities across Scotland to contribute to research into paediatric palliative and end of life care.

What needs to improve

Although several methods were used to obtain feedback from children, families and members of staff, no formal process was in place to ensure that people were informed of, and understood, any changes or improvements made as a result of their feedback, and how this may then influence how the service is delivered (recommendation a).

- No requirements.

Recommendation a

- The service should develop a formal process of keeping children, families and staff informed of the impact their feedback has on the service and how this may lead to improvements in how the service is delivered.

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 service was fully aware of Healthcare Improvement Scotland's notification process and when to inform us of certain changes or incidents that occur.

The hospice had a range of up-to-date policies which were available to staff on the hospice's intranet system. These included:

- infection prevention and control
- medical arrangements, including emergencies
- healthy and safety, and
- child and adult protection (safeguarding).

We were told the hospice's complaints policy was currently under review and was progressing through the required governance structures for approval. We reviewed two complaints the hospice had received within the last year. We saw these complaints had been well managed with all parts of the complaint responded to in detail and any learning the hospice was taking forward as a result of the complaint identified.

Any adverse events that occurred were recorded on an electronic reporting system. We reviewed three adverse events investigations. All had identified good practice, as well as lessons learned and recommendations to be taken forward, such as introducing an early warning score chart. This chart can be used to identify acute deterioration in a patient, including sepsis (a life-threatening reaction to an infection). Learning was shared with staff through daily briefings, team meetings and training days. We were told if a child was transferred to hospital as an emergency, a case note review would always be carried out and any learning shared with staff and at the care services operational governance group.

The hospice had a duty of candour policy (where healthcare organisations have a professional responsibility to be honest with people when something goes wrong). We saw that the hospice's annual duty of candour report was available to view on its website. Staff were trained in the duty of candour principles.

During the inspection, we spoke with the hospice's pharmacist who told us the hospice regularly completed Healthcare Improvement Scotland's medicines management audit tool as part of their rolling audit programme. Results showed very good compliance. Medicines were stored appropriately and securely in the inpatient unit. A number of medicine management standard operating procedures were in place, including the safe administration of medicines, the storage of medications, and the supply and arrangements for the management of controlled drugs (medicines that require to be controlled more strictly, such as painkillers). Information on medicines was readily available to staff throughout the hospice including in the treatment room and on dedicated medicines noticeboards. A monthly 'medicine mindfulness' folder was available in the inpatient unit which provided staff with a brief monthly update of relevant medicine information. There were a number of medicine management groups including the controlled drugs governance team and the medicines optimisation group. We saw evidence of agendas and minutes for these groups.

We saw that a wide range of medicine audits were regularly carried out. This included audits on controlled drugs, patient medication administration charts and medicine omissions (where routine medicines have not been given to a patient). We saw that actions for improvement were shared with staff and any issues from the medicines optimisation group were also discussed at the clinical care and governance meeting.

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

Admission to the hospice was thoroughly documented. This included the child and family's contact details, next of kin and GP details. There was also a detailed contact list of all external healthcare professionals involved in the child's care. We saw that this was reviewed and updated as the child got older.

A significant number of children and families were well known to staff and had been admitted to the hospice on several occasions over many years. A number of documents remained in place between each admission and these were reviewed before and during each new admission, for example consent to share information and emergency care. These would be updated every year or when the child's condition changed.

Parts of the patient care records were stored both on the electronic system and used as a paper copy. The electronic patient care records highlighted specific areas of daily care, for example personal care, respiratory care and nutrition.

Each child had a nominated member of staff who acted as a 'key worker' and kept in regular contact with the family. If an admission was planned, they contacted the family about any changes to the child's condition, care or medicines. This also involved a discussion about the child's aims for the admission. This meant that staff were fully aware of any changes in place and the child's wishes before they arrived at the hospice.

A process was in place to ensure that suitably qualified staff were recruited safely. All staff files were stored on a password-protected electronic human resources system. Appropriate pre-employment checks were completed, including references and an update of the Disclosure Scotland Protecting Vulnerable Groups (PVG) background check.

Volunteers who worked in the hospice also underwent a number of recruitment checks, including an update of their Disclosure Scotland status.

The hospice had an up-to-date recruitment policy. New staff completed a 4-day induction programme and received a welcome pack containing useful information, for example what to expect on the first day and information on staff wellbeing. Training in medicine administration was also part of the staff induction programme. This involved theoretical practice and competency-based training.

A wide-ranging education programme covered both mandatory and role-specific training for staff. This included basic life support, training in risk assessment, and moving and handling.

Every 6 weeks, key workers were allocated an administration day which took them out of the clinical environment and allowed them time to contact and check in on families, or to take time for their own training or to update documentation. They also had the opportunity to take part in clinical supervision. This involves staff reflecting on their practice and developing learning from this. Staff we spoke with told us they found these days useful.

Staff met with their line manager every 6-8 weeks for a one-to-one meeting, giving them an opportunity to discuss any issues or learning needs. Professional development objectives were set and reviewed at these meetings. Senior staff underwent an annual appraisal process.

The provider was currently developing and rolling out a leadership development programme. This will provide guidance on the manager role, highlighting what managers are expected to achieve. The competencies will be built and modelled on CHAS values and behaviours, and will be used for recruitment, induction, setting standards, performance management, change and improvement. This will also include a range of learning and development tools to support managers.

We saw that a member of staff was currently undertaking an external leadership programme which had been developed collaboratively by NHS Greater Glasgow and Clyde and a number of Scottish hospices.

- No requirements.
- No recommendations.

Planning for quality

The hospice carried out a wide range of clinical and non-clinical risk assessments. The risk assessments were documented in the operational or strategic risk registers, as appropriate. These detailed the risk owner and the actions taken to mitigate or reduce any identified risks. These risk assessments were discussed at the corporate governance and risk committee meetings.

An audit programme covering clinical audits helped to make sure the hospice delivered consistent safe care for patients and identified any areas for improvement. Examples of audits included medicines audits and audits of patient care records. We were told specific audits would also be carried out if an issue was identified as a result of an adverse event or complaint. Audits results were entered onto the electronic reporting system.

Infection prevention and control audits included hand hygiene and the use of personal protective equipment (disposable aprons and gloves). We saw evidence of a number of audits completed over the last year. If an audit scored below 90%, it was reaudited the following month. We were told that, over the winter period, the frequency of auditing respiratory and cough etiquette would be increased. We were told that staff members involved in infection prevention and control audits from both Robin House and Rachel House had recently started to hold regular in-person meetings to share experiences and identify any actions to take forward, as required.

The maintenance team was responsible for the day-to-day management of the building and its specialist equipment. Any incidents were recorded through the hospice's electronic reporting system. This was immediately sent to the maintenance team who could also access the information on an app on their mobile phone. Staff were also able to telephone the maintenance team to advise of any issues identified, allowing for a quick response.

Guidance was available for staff on what to do in the event any issues arose out of hours, for example a power cut, fire or problems with water. This information was kept in the clinical areas for all staff to review.

We saw evidence of a recent external health and safety audit which included workplace risk assessments and action plans with risk levels and priority levels identified. A health and safety report was generated every 3 months which was discussed at clinical care and governance meetings.

Staff were able to access all policies, procedures and minutes of meetings on the hospice's intranet system. The business continuity plan could be accessed on the hospice's website for staff, children and their families, and the public to view.

What needs to improve

We saw that not all completed audits had been entered onto the electronic reporting system and so information was not easily accessible by all staff (recommendation b).

Although we saw evidence of non-clinical audits being carried out, there was no specific audit programme for these highlighting when these audits should or would be carried out (recommendation c).

The hospice was currently developing a quality strategy and many quality improvement initiatives were taking place. However, we found that the previous quality improvement plan was no longer being kept up to date. This meant that the hospice could not demonstrate progress against current quality improvement activities. We discussed this with the senior managers who assured us the quality improvement plan would be re-introduced (recommendation d).

- No requirements.

Recommendation b

- The service should ensure that all audits are fully documented and entered onto the electronic reporting system.

Recommendation c

- The service should ensure that regular non-clinical audits are included in the existing audit programme.

Recommendation d

- The service should re-introduce its quality improvement plan to formalise and direct the way it drives and measures improvement.

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 environment was clean and in a good state of repair. A refurbishment and re-decoration of the environment was planned. Patient care records were comprehensive. Families told us they really valued the support from the hospice and its staff. Staff told us they enjoyed working in the hospice.

A review of infection prevention and control procedures must be carried out to ensure all staff are following national guidance for clinical waste and water safety.

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.

Although the environment was very clean, the decoration appeared tired. We were told plans were under way to redecorate and brighten the appearance of the hospice. Corridors and rooms were free from clutter. We saw appropriate cleaning solutions were used, including chlorine-based products for sanitary fixtures and fittings, and disposable colour-coded mop heads. This is in line with national infection prevention and control guidance. Staff told us they had enough equipment to carry out all duties. When a room had been cleaned, a sign outside the room showed that it was ready for use. The housekeeper told us there was good communication between them and the ward staff. Equipment was visibly clean. We saw 'I am clean' stickers used as a visual aid to show that routine cleaning of equipment had taken place. If staff were unable to clean the equipment at that time, an 'I need to be cleaned' sticker would be used to indicate the equipment was still to be cleaned.

Good systems and processes were in place to ensure the care environment and equipment was safe. These included environmental and specialist equipment risk assessments, and maintenance programmes to ensure any repairs were logged and carried out in a timely manner.

Linen was laundered inhouse. The laundry room was in good condition and appeared very clean. Appropriate systems were in place to manage clean and dirty linen and clothes.

Personal protective equipment, including disposable gloves and aprons, was stored appropriately and was readily available throughout the hospice.

We reviewed four patient care records and saw a thorough process of documentation in place. All records reviewed included the appropriate contact details of the family, GP and other healthcare professionals. Before admission, staff were made aware of any changes to the child that may have occurred at home. Consent to treatment and consent to share information with external healthcare professionals was documented on each admission.

At the time of our inspection, the children staying in the hospice were there for a period of respite. All aspects of their care and current routine medicines were documented. Throughout the patient care records reviewed, we saw documented evidence of regular conversations with the family. We saw that each child had an emergency care plan completed, which highlighted the appropriate actions to take in the event of a deterioration in their condition. We saw all members of the multidisciplinary team contributed to the patient care records.

During the inspection, we attended an information handover meeting which involved members of the multidisciplinary team. All staff members contributed to the discussions about each child currently staying in the hospice.

We reviewed five staff files and saw relevant background checks were fully completed. All staff were directly employed by the organisation.

Staff told us they were proud of the work they did to support children and families. Responses to our online survey showed that a number of them felt supported by their team colleagues and would recommend working for the organisation. Comments included:

- ‘I believe we put any issues aside when giving care and always give the best possible care to families.’
- ‘We genuinely care for each other and are an amazing team.’
- ‘Despite the low morale amongst the various teams, I love my job here. We are definitely team players… .’
- ‘The work we do with our children and families is a unique and privileged position to be in.’

Families that we spoke with told us:

- '… a saviour.'
- 'They are a home from home.'
- 'Just amazing.'
- '… so thorough, can't do enough.'
- 'There aren't enough facilities for families like us and I'm so grateful we have this.'

What needs to improve

During the inspection, we found some issues relating to non-compliance with infection prevention and control practice and procedure. For example, we found that clinical waste was not being stored securely in a locked area or container while awaiting uplift. In addition, although we were told infrequently used water outlets were being flushed twice a week, not all of these checks were being recorded (requirement 1).

We were told a new housekeeper lead had just been appointed. We saw that they were completing cleanliness spot checks but were not involved in audits at present. We were told this was something they were looking at as part of developing the role. We will follow this up at future inspections.

We received mixed comments from staff we spoke with during the inspection. The online survey also showed similar staff opinions. While some staff told us the senior management team was supportive and approachable, some told us they were not. Staff told us that they enjoyed their jobs and received a lot of support from within their own teams, but that morale was low. We fed this back to the senior management team, and they spoke about ways of exploring this further with staff. We will follow this up at future inspections.

Requirement 1 – Timescale: immediate

- The provider must ensure that all staff follow national infection prevention and control guidance for the safe management of clinical waste and ensure that all infrequently used water outlets are flushed and appropriate records kept in line with current national guidance.

- No recommendations.

Appendix 1 – About our inspections

Our quality assurance system and the quality assurance framework allow us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this system to check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. Inspections may be announced or unannounced.

We follow a number of stages to inspect independent healthcare services.

Before inspections

Independent healthcare services submit an annual return and self-evaluation to us.

We review this information and produce a service risk assessment to determine the risk level of the service. This helps us to decide the focus and frequency of inspection.

Before

During inspections

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.

During

After inspections

We publish reports for services and people experiencing care, carers and families based on what we find during inspections. Independent healthcare services use our reports to make improvements and find out what other services are doing well. Our reports are available on our website at: **www.healthcareimprovementscotland.org**

We require independent healthcare services to develop and then update an improvement action plan to address the requirements and recommendations we make.

We check progress against the improvement action plan.

After

More information about our approach can be found on our website: [The quality assurance system and framework – Healthcare Improvement Scotland]

Complaints

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Email: his.ihcregulation@nhs.scot

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
or email his.contactpublicinvolvement@nhs.scot

Healthcare Improvement Scotland

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