Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Marie Curie Hospice, Glasgow

Service Provider: Marie Curie

3-4 October 2023

NHS SCOTLAND

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First published November 2023

www.healthcareimprovementscotland.org

Contents

1 Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 21 April 2021

Recommendation

The service should ensure compliance with the guidance in Health Protection Scotland's National Infection Prevention and Control Manual for hand hygiene and the use of personal protective equipment, and Health Protection Scotland's Scottish COVID-19 Community Health and Care Settings Infection Prevention and Control Addendum for the decontamination of the environment and near patient equipment.

Action taken

The service was able to evidence that all staff had completed online infection prevention and control training as part of their induction, or as part of their ongoing training and development. Cleaning schedules contained detailed evidence of areas and patient equipment being cleaned in line with national infection prevention and control guidance.

Recommendation

The service should ensure that, before admission to the hospice, patients and families are made aware of the COVID-19 restrictions in the service and this conversation is documented in each patient care record.

Action taken

We saw that COVID-19 restrictions were discussed and suitable conversations about patients' COVID-19 history and vaccine status were documented in the four patient care records we reviewed.

Recommendation

The service should ensure that the pre-admission COVID-19 screening process is documented in each patient care record prior to admission to the hospice.

Action taken

We saw that the pre-admission COVID-19 screening process was discussed with patients and documented in the four patient care records we reviewed.

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 Marie Curie Hospice - Glasgow on Tuesday 3 and Wednesday 4 October 2023. We spoke with a number of staff, patients and carers during the inspection. We received feedback from 39 staff members through an online survey we had asked the service to issue for us during the inspection.

Based in Glasgow, Marie Curie Hospice is an independent hospital (a hospice providing palliative/end of life care).

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For Marie Curie Hospice - Glasgow, 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 provider had a clear defined vision of 'a better end of life for all'. Based on this vision, key performance indicators for the service focused on the patient experience, staff and clinical care. A clear governance structure was in place with defined lines of reporting and accountability. Senior management carried out daily walkrounds. The wide range of meetings that take place should be reviewed to make sure these are meaningful and relevant to all staff involved.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
A range of processes and procedures helped to ensure the safe delivery of care, including good infection prevention and control practices and a maintenance programme. Processes were in place to ensure that both staff and patients contributed to improving the service. The patient journey was well documented, and staff recruitment and support were in place. A wide range of risk assessments, an audit programme and a Scotland-wide quality improvement plan helped to ensure the service continually improved. An annual duty of candour report should be published.	✓✓ 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. Patient care records were comprehensively completed. Patients and families spoke positively about their experiences, and said they felt fully supported by the service. Staff told us they enjoyed working in the service and felt supported by the senior management team. Information about the patient's power of attorney status should be documented.	✓✓ 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 Marie Curie 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 five recommendations.

Direction	
Requirements	
None	
Recommendation	
a	The service should ensure that the range of meetings held are meaningful to all staff and are managed appropriately (see page 13). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.23

Implementation and delivery	
Requirements	
None	
Recommendations	
b	The service should ensure its complaints policy and procedures contain the correct information and details for patients to be able to contact Healthcare Improvement Scotland at any point of the complaint process (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.20
c	The service should produce and publish an annual duty of candour report (see page 20). 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 ensure all relevant staff contact details are included in the business continuity plan (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	
Requirements	
None	
Recommendation	
e	The service should ensure that information on the patient's power of attorney status is documented in the correct place in the patient care record and is easily accessible for all staff (see page 25). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.15

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

We would like to thank all staff at Marie Curie Hospice - Glasgow 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 provider had a clear defined vision of 'a better end of life for all'. Based on this vision, key performance indicators for the service focused on the patient experience, staff and clinical care. A clear governance structure was in place with defined lines of reporting and accountability. Senior management carried out daily walkrounds. The wide range of meetings that take place should be reviewed to make sure these are meaningful and relevant to all staff involved.

Clear vision and purpose

The service is part of the Marie Curie charity providing end of life care both in hospice settings and in the community. Marie Curie has a clearly defined vision of 'A better end of life for all'. This vision helps to identify aims and objectives and measurable key performance indicators to monitor both the performance of the wider charity and also each of its services.

The main aims of the provider, the Marie Curie charity, were to:

- lead in shaping the end of life care system
- end financial insecurity at the end of life, and
- end inequalities in access to end of life care.

The provider's key performance indicators were focused on its reach into the community over the next 5 years and included:

- increasing the number of people cared for
- growing the reach of information and support services, and
- increasing the influence of its research and policy.

The service's key performance indicators mirrored those of the provider. These were focused on patient feedback, staff training, complaints and aspects of clinical care, for example adverse events and targeted questions about the patient care experience while in the hospice.

The service also housed the community outreach support team for Scotland and was directly involved in supporting and working with the outreach staff across Scotland.

The service was currently preparing to present an exhibition to the Scottish Parliament. Research was carried out by the University of Glasgow and Marie Curie exploring the barriers to dying at home for people experiencing poverty. The service was invested in reaching out to people with a palliative care need that was not being fully or partially met as they were remote from specialised care either through custodial sentence or societal isolation. This exhibition was about raising awareness of people dying in prisons or alone in the community without the benefit of dedicated palliative care professionals or end of life expertise.

An annual report was produced by the provider which was available on its website. This detailed the charity's achievements in the past year, and its aims and objectives for the coming year. The provider had produced a 5-year strategic plan which focused on equity and inclusion to ensure everyone had access to end of life care and the support they needed. Information about progress against the strategic plan was included in the annual reports.

The service produced reports every 3 months to monitor outcomes and inform short- and longer-term actions to be taken forward. There was a focus on continued improvement with progress on performance against key performance indicators shared with staff.

What needs to improve

As both the service and provider had a clear vision and purpose, it would be beneficial if this was more prominently displayed to the public and patients when they were in the hospice. We will follow this up at the next inspection.

- No requirements.
- No recommendations.

Leadership and culture

The service had inpatient and outpatient facilities, and was also the hub for community nursing support across the whole of Scotland. The hub was regulated by the Care Inspectorate.

The service had a highly skilled staffing resource covering medical consultants, doctors, palliative care nurses, physiotherapists, occupational therapists, pharmacists, social worker, counsellor, chaplain roles and complementary therapists. These various staff groups helped to ensure all patient needs were met.

Some medical staff were on rotation from the NHS to gain experience and share knowledge in palliative care. There was strong and positive relationship between the service and the local NHS board.

There was a clear governance structure and defined lines of reporting and accountability. Senior managers were visible on a daily basis and carried out daily walkrounds to understand any pressures or challenges staff were experiencing.

The service held a wide range of meetings covering all aspects of the service, including:

- health and safety
- financial governance
- partnership working
- safeguarding (public protection), and
- medicines management.

The meetings involved representatives from all staff grades, and there was a clear escalation and reporting process from each of the meetings. This meant that senior management did not have to attend all meetings, but still received appropriate notification of any concerns or required actions.

A meeting escalation chart described how relevant information from the service was filtered to a joint meeting of all Marie Curie services in Scotland, and then to a national corporate board. The service's chief executive officer and medical director attended the national corporate board meetings.

Results from monthly key performance indicators were displayed on a noticeboard on the staff corridor which meant they were easily accessible to all staff members.

Staff were positively engaged in the service's provision of care and proud of being part of the organisation. This was evident from our discussions with staff during the inspection and from the results of our online staff survey:

- 'It is a very friendly and supportive environment and I have been enjoying working here.'
- 'Absolutely recommend the organisation.'
- 'I feel my role is rewarding, I can see the difference I make to clients and their loved ones and this is motivating to me.'

What needs to improve

The wide range of regular meetings held could be challenging to a small staffing group to make each meeting meaningful and worthwhile. Consideration could be given to merging some of the meetings where there was a common theme, for example a clinical meeting could include discussions on tissue viability, falls and medicines management rather than hold these as separate meetings (recommendation a).

- No requirements.

Recommendation a

- The service should ensure that the range of meetings held are meaningful to all staff and are managed appropriately.

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

A range of processes and procedures helped to ensure the safe delivery of care, including good infection prevention and control practices and a maintenance programme. Processes were in place to ensure that both staff and patients contributed to improving the service. The patient journey was well documented, and staff recruitment and support were in place. A wide range of risk assessments, an audit programme and a Scotland-wide quality improvement plan helped to ensure the service continually improved. An annual duty of candour report should be published.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The provider is a well-known national charity providing palliative care within hospices across the country. The services available were fully highlighted on its website, in public spaces and on television. The service had its own informative website with information on:

- inpatient care
- day therapies, and
- support for families and carers.

In the 3-monthly reports, we saw examples of 'You said, We did' where the service had acted on feedback received. For example, volunteers had stated that concerns were being shared with them from patients or families and they were unaware how to escalate these appropriately. As a result, training had been given and support for volunteers was now available to help them to manage any concern shared with them in their volunteering role.

We also saw action taken for patients highlighting they were unable to access a back door on the ward as it was locked during the night and was not always reopened early the next morning to allow access to the roof top garden. The door opening process had been changed to ensure there was earlier access. When redecorating areas in the service, we were told that patients and families were involved in the colour and soft fabric choices.

Feedback ‘speech bubbles’ were displayed throughout the service with comments from patients and carers of their experience of using the hospice. Under each feedback comment, the service had either acknowledged the compliment or provided information on the subject of the comment. Minutes of a recent experience of care meeting had documented there had been good feedback received from patients and carers on the information in these speech bubbles. These were typically complimentary comments about the staff and service.

A number of patient information leaflets were available at reception, in the day service and the inpatient service. We were told that the provider was currently rebranding and leaflets had still to be updated. The service’s current strategic plan was available in the public areas, including in the day services.

Notices were displayed in the ward to let patients and carers know that beloved pets were allowed to visit by arrangement.

The provider had an employee assistance programme which allowed staff to access help with a range of personal issues, for example counselling, legal support and stress management. This information was displayed throughout the service with contact details available.

External NHS services were also available for staff to contact should they require mental health support. We saw that staff were encouraged to access support within the service, for example through clinical supervision. This allowed staff to speak either on a one-to-one basis or in a group about their experiences and to be supported to manage any difficulties.

Staff information boards displayed information on, for example audit results, patient feedback and staff training. We were told these boards were regularly reviewed and updated.

The service had developed a mobile phone app for staff which included information about the hospice, guidance on processes and who to contact in the service. This included guidance on what to do on admission and for discharge planning. This was available to all new medical staff who told us it was invaluable.

We saw that the service had carried out a staff survey in February 2023. An action plan had been developed and had recently been sent to all staff. We saw monthly ward meeting agendas and minutes and saw that staff had an opportunity to invite someone from another department to talk about their role, encouraging an open door approach.

What needs to improve

It was noted that not all staff wore name badges. This would be helpful to patients, carers and visitors as a way of building relationships. We will follow this up at the next inspection.

- No requirements.
- No recommendations.

Quality improvement

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

The service fully understood Healthcare Improvement Scotland's notification process and the need to inform Healthcare Improvement Scotland of certain events or incidents occurring in the service. A process of recording and investigating incidents and accidents was in place.

There was a range of up-to-date policies in place, including:

- safeguarding children and adults at risk
- harassment and management, and
- duty of candour.

Effective processes and procedures ensured the environment was safe with appropriate infection prevention and control processes in place. These were carried out in line with the service's infection prevention and control policy. This policy took account of national infection prevention and control guidance.

The majority of linen, including sheets and towels, was laundered by an external service. The onsite laundry catered for small items of linen from the therapy rooms and, occasionally, would launder patients' clothing if required. This laundry was transported in appropriate containers. Containers for soiled linen were also readily available. Staff told us these items were washed at temperatures in line with national guidance. The laundry had a separate entry and exit system, was clean and tidy and was stocked with appropriate personal protective equipment, such as disposable aprons and gloves.

A maintenance and servicing programme/log was in place for reporting any maintenance and repair jobs. Daily checks carried out were recorded on the facilities online system. This system identified schedules of checks for maintenance staff to carry out every day, 3 months or 6 months as appropriate. This included fire, gas and planned maintenance.

External contractors carried out water and planned preventative maintenance checks. Maintenance issues not able to be dealt with by the in-house team were escalated to the service's dedicated contractor.

Fire drills and out-of-hours fire drills were carried out on a regular basis. A recent drill had highlighted that some staff in the inpatient area were not familiar with the fire panel codes. The facilities team addressed this issue immediately, providing new information at each fire exit sign which correlated with the information on the fire panel in the inpatient area. We saw that fire safety training was being carried out for staff during our inspection.

Monthly facilities management meetings took place which included shared learning, sharing of policies and good practice. Health and safety walkrounds were carried out every month by the facilities manager and the health and safety committee, with results uploaded to the facilities online system.

A thorough process was in place to ensure safe medicines management, including ordering, prescribing and administering all medicines. The pharmacy team consisted of a pharmacist, who was based on site 4 days each week, a clinical technician who was responsible for medicines reconciliation and non-stock medications, and a pharmacy support worker who was responsible for stock control and non-stock items. All members of the pharmacy team were employed directly by NHS Greater Glasgow and Clyde.

Medicine expiry dates, medicine prescription charts, discharge prescriptions and controlled drug orders were all part of the daily and weekly checks carried out by the pharmacy team. Controlled drugs are medications that require to be controlled more strictly, such as some types of painkillers.

The service had an up-to-date duty of candour policy. Healthcare Improvement Scotland had been notified of two incidents in the last 12 months where duty of candour had been triggered. Staff we spoke with were aware of the processes and procedures for duty of candour, and told us they had attended and completed training for this.

The complaints policy detailed processes and procedures to follow in the event of a complaint or concern being raised. We noted a number of complaints and notes of concern had been raised within the previous 12 months. These had been reviewed and managed in line with the service's complaints policy and procedures. No outstanding issues were noted.

Patient care records were held electronically on a password-protected secure system. There was a detailed process of communication and assessment from the point of the patient's referral to the service from the community team to admission to the inpatient service and throughout their stay. Patients' COVID assessments were carried out before admission and discussions about the patient's COVID vaccine history and any recent COVID symptoms were documented.

Various members of the multidisciplinary team inputted into the patient care records, for example physiotherapists and the social work team. Discussions could be documented about the patients' preferred place of care and death. A treatment plan was available for highlighting what the patient would wish should their condition deteriorate and a 'do not attempt cardiopulmonary resuscitation' (DNACPR) document was available to be included in discussions and was completed where applicable. This relates to the emergency treatment given when a patient's heart stops or they stop breathing.

A number of assessments and care plans were completed on admission, including:

- moving and handling
- nutrition and mouth (oral) assessment
- pain assessment
- falls risk, and
- skin care.

An electronic hand-held scan device was used that assessed potentially vulnerable pressure areas of patients' skin to determine the risk of pressure sores developing, for example the heels. This then ensured the correct care could be carried out and the correct pressure-relieving mattress used. This process was repeated throughout a patient's stay and the results of this would be documented in the patient care records.

The provider was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights) to ensure safe processes were in place when storing confidential patient information.

Safe recruitment processes were in place. The human resources function was carried out through the provider's central team. Appropriate background checks were carried out, including an ID check, references and immunisation history. Employees had up-to-date Disclosure Scotland Protecting Vulnerable Group (PVG) checks in place.

A number of doctors that worked in the service were employed by NHS Greater Glasgow and Clyde. An 'honorary contract' was in place which allowed them to also work in the service. We saw a checklist completed before they started working that ensured their pre-employment checks were available to the service. The service also had an agreement with the NHS board to be informed of any changes that may occur to the individual's status. A number of checks were also carried out by the service on an individual's first day of working, for example their ID.

Both general/corporate and role-specific inductions took place. Appraisals were carried out by the individual's manager and included setting personal development objectives. Appraisals were documented electronically and access to this information was restricted to the individual and their manager.

A standard operating procedure for safe staffing in the inpatient unit included optimal staffing numbers and staff-to-patient ratios.

The service had set up a workforce training working group allowing staff to meet and highlight options for further training, for example anticipatory care planning, bereavement and communication. This also allowed staff to talk about any issues that stopped them from embarking on further training. Terms of reference were in place for this group and minutes were kept.

All staff had to undergo regular mandatory training. This resulted in post-training assessments, certificates of completion and merit awards. A training session for clinical staff was held each week which included aspects of care, such as symptom management or medicines management issues. Staff had the opportunity to attend external conferences with financial support available to allow them to complete these. We were told that a clinical team was about to undergo training in effective communication for healthcare professionals.

We were told the pharmacist delivered medicines training to hospice and district nursing staff, and offered advice and information to clinicians working in NHS Greater Glasgow and Clyde who were seeking medicines information and support for their hospital and community patients.

What needs to improve

Contact details for Healthcare Improvement Scotland were incorrect on the service's complaints policy and procedures (recommendation b).

The service had not produced and published a recent annual duty of candour report (recommendation c).

Alongside the yearly appraisal process, we were told that staff had regular one-to-one meetings with their managers and that a document was being developed to document these. We will follow this up at the next inspection.

- No requirements.

Recommendation b

- The service should ensure its complaints policy and procedures contain the correct information and details for patients to be able to contact Healthcare Improvement Scotland at any point of the complaint process.

Recommendation c

- The service should produce and publish an annual duty of candour report.

Planning for quality

The service carried out a wide range of clinical and non-clinical risk assessments, for example:

- moving and handling risk assessments for specific groups of staff
- lone working
- inpatient services, and
- environment.

Each risk assessment detailed any risks identified to staff and patients, and included a risk rating status, staff delegated to take forward any actions, dates of completion and dates of next review.

Health and safety and fire risk assessments were carried out every year by the health and safety manager. Areas of concern or identified issues were automatically recorded onto the facilities online system with identified actions to be taken and dates for completion. Asset registers for all equipment used in the service were also completed by the facilities manager and stored on this system.

Clinical and non-clinical risk assessments and risk logs were stored electronically which meant that all managers could access them. They were then automatically alerted if the risk was within their remit or department.

Accidents and incidents, including ‘near misses’, were also documented and recorded on this system. These were reviewed by the appropriate head of service and/or manager who would take forward any actions. This information was added to the agendas for appropriate meetings and discussed with other hospices in the UK, highlighting areas of good practice and also of any training needs identified.

The clinical audit programme included audits on infection prevention and control, medicines management, nutrition and the environment.

A non-clinical audit programme included audits of the fire risk assessment, water safety, food hygiene and medical gases. Others audits took place such as information security and display screen equipment.

We saw the most recent nutrition audit had identified some areas of concern and how these were then addressed. The report generated from this was reviewed by the deputy head of quality and governance, with people then assigned responsibility for taking forward actions. This information was discussed in national and regional audit meetings.

We saw high compliance rates from the audits we reviewed on inspection.

The service worked in line with the Marie Curie Scotland annual review document, which acted as the quality improvement plan. This detailed planned new ways of working and improved efficiencies for the service. This included planned improvements for experience of care, electronic prescribing, clinical leadership, communication skills and clinical documentation. We saw evidence that this review document was continually reviewed.

The pharmacist attended the service’s weekly medical staff meeting. This meeting discussed any medicine incidents and any identified learning needs. Controlled drug audits were carried out every 3 months which now included drugs which were found to be ‘desirable’, such as strong painkillers. Monthly audits took place of patient prescriptions and medicines reconciliation to ensure safe prescribing practices took place. Results from audits were then reported to senior managers.

Information on off license and off-label drugs was included in the medication management policy and local standard operating procedures.

What needs to improve

While the service had a business continuity plan with detailed appendices for specific threats to business continuity, we noted that a number of senior staff contacts details were missing (recommendation d).

- No requirements.

Recommendation d

- The service should ensure all relevant staff contact details are included in the business continuity plan.

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. Patient care records were comprehensively completed. Patients and families spoke positively about their experiences, and said they felt fully supported by the service. Staff told us they enjoyed working in the service and felt supported by the senior management team. Information about the patient's power of attorney status should be documented.

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 tidy throughout the service, and the building was in a good state of repair. Equipment in the inpatient unit had 'clean' stickers attached to show the date and time the item was cleaned and by whom. We saw an extensive range of cleaning products, including appropriate chlorine-based cleaning solutions for sanitary fittings and disposable colour-coded mop heads, in line with national infection prevention and control guidance.

Staff were knowledgeable and able to demonstrate what infection prevention and control training they had completed. All patient bedrooms had cleaning schedules which detailed daily, weekly, monthly, 3-monthly, 6-monthly and annual cleaning required. We found these were completed and up to date. Staff were also able to document any comments and advise or alert the domestic supervisor of any issues. These schedules were reviewed by the domestic supervisor every week and uploaded to the facilities online system. We saw adequate numbers of domestic staff on duty. Staff were assigned and responsible for cleaning identified areas throughout the service.

Personal protective equipment was readily available throughout the service with additional stock located outside each patient room in the inpatient area.

A health, safety, welfare and environment inspection had recently been carried out by colleagues from the provider organisation. We saw evidence of good outcomes from this with small areas highlighted for change, for example changing to LED lighting.

We reviewed four patient care records and saw patient details were well documented. This included:

- personal contact details
- next of kin contact details
- GP details, and
- consent to share information.

From the day of admission, each patient had a thorough medical and nursing assessment documented. This included an assessment of the patient's condition, past medical history and what medicines they were currently taking.

We attended a multidisciplinary team meeting and saw all aspects of the patient's care was discussed, including any family bereavement support that may be required. During the meeting, there was a time of reflection on the patients who had died in the previous week allowing staff to talk about their experiences. Throughout the patient's journey, we saw that staff would use a recognised performance assessment tool to assess and compare the patient's condition throughout their illness. This allowed a consistent assessment to be made. We saw this assessment was discussed at the meeting and allowed staff to agree on the patient's condition and discuss if their needs were changing.

We reviewed six staff files and saw recruitment was fully completed in most cases.

Staff we spoke with told us they felt supported in their role. They said the senior management team was visible and approachable. Staff who completed our online survey told us:

- 'There are sometimes challenges but on the whole everyone is working towards the same outcomes.'
- 'I feel I have been given the opportunity to have a voice.'
- 'The leadership focus on achieving what is best for our patients and their families.'
- 'From senior level to line management there is a professional and positive drive to ensure excellence.'

Patients and families we spoke with told us:

- ‘We had 51 extended days with each other to live life.’
- ‘This place is perfect.’
- ‘We felt reassured my mum was safe and well looked after.’

What needs to improve

Of the four patient care records we reviewed, we saw that patients’ power of attorney status was discussed. However, a specific area in the electronic records was not being consistently completed to highlight the individual’s power of attorney status. This should be completed every time for each patient (recommendation e).

Staff recruitment information was stored in the human resources electronic system. We found one staff file had not been transferred onto the electronic system but were told this was about to take place. We will follow this up at the next inspection.

- No requirements.

Recommendation e

- The service should ensure that information on the patient’s power of attorney status is documented in the correct place in the patient care record and is easily accessible for all staff.

Appendix 1 – About our inspections

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

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

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

Before inspections

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

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

Before

During inspections

We use inspection tools to help us assess the service.

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

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

During

After inspections

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

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

We check progress against the improvement action plan.

After

More information about our approach can be found on our website: 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
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