Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Marie Curie Hospice, Edinburgh

Service Provider: Marie Curie

14-15 November 2023

NHS SCOTLAND

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1 Progress since our last inspection

What the service had done to meet the requirement we made at our last inspection on 6 April 2021

Requirement

The provider must have appropriate procedures for infection prevention and control in place that state clearly what staff are expected to do.

Action taken

Good processes were now in place to ensure the service's infection prevention and control policy was being followed. The policy referred to Health Protection Scotland's *National Infection Prevention and Control Manual*. This included the standard infection control precautions, required staff training, auditing and reporting of processes. Signage displayed around the service reminded staff of infection prevention and control processes. We were told the housekeeping supervisor regularly reviewed processes. Staff we spoke with were knowledgeable about what was required. **This requirement is met.**

What the service had done to meet the recommendations we made at our last inspection on 6 April 2021

Recommendation

The service should ensure that staff follow best practice guidance for the use and cleaning of sessional visors.

Action taken

Although sessional (face) visors were no longer in general use, staff we spoke with were fully aware of the importance of infection prevention and control processes for cleaning equipment.

Recommendation

The service should ensure that patient care records contain details of pre-admission COVID-19 patient screening details consistently in each patient care record.

Action taken

In the five patient care records we reviewed, there was documentation to show that patients' COVID-19 status had been discussed.

Recommendation

The service should ensure consent to share information is consistently recorded in patient care records.

Action taken

The five patient care records we reviewed showed that various aspects of patient consent were obtained. This included consent to share information with the patient's next of kin. However, consent to treatment was not consistently being documented. **A new recommendation has been reported in Domain 7 (Quality control)** (see recommendation (f) on page 27).

Recommendation

The service should ensure that, where applicable, there is evidence that the patient's power of attorney is documented and a copy of the document is stored in the patient care record.

Action taken

Although a power of attorney template was available in patient care records, we found this was not completed in three of the five patient care records we reviewed. **This recommendation is reported in Domain 7 (Quality control)** (see recommendation (g) on page 28).

What the service had done to meet the requirements we made following a complaint investigation on 5 October 2021

Requirement

The service must ensure that all relevant staff receive refresher training in the procedure for the administration of medicines.

Action taken

The hospice pharmacist delivered training at staff inductions sessions, and also had allocated time to discuss and review palliative care staff training needs. Further sessions were delivered as and when identified during staff 1:1 sessions with their line manager, at their annual appraisal or as a result of any drug incidents involving medical or nursing staff.

Requirement

The service must review the current level of competency required for administration of controlled drugs.

Action taken

Controlled drugs are medications that require to be controlled more strictly, such as some types of painkillers. We were told that the staff competency required for the administration of controlled drugs was considered on an individual basis, and was dependent on previous experience. This was discussed at senior nurse meetings as to when an individual would be considered ready to commence training.

Requirement

The service must ensure that all complaints are responded to within 20 working days. Any delay to this timescale should be discussed and agreed with the complainant.

Action taken

We reviewed complaints the service had received from the last year. We noted identified dates for responding to the complainant were documented. We saw that all complaints were responded to within this timeframe and, if there were any extensions required, this was identified at an early stage.

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, Edinburgh, on Tuesday 14 and Wednesday 15 November 2023. We spoke with a number of staff and patients during the inspection. We received feedback from 37 staff through an online survey we had asked the service to issue for us during the inspection.

Based in Edinburgh, 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, Edinburgh, 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 vision and purpose, with a comprehensive 5-year strategic plan and defined objectives. Although the provider had measurable key performance indicators for continuous improvement, key performance indicators should be developed for the service. A governance framework was in place, and structures were clear and well defined. Leadership was visible and supportive, and staff felt valued and supported. Information about 'freedom to speak up' champions should be easily available for staff.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patient experience was regularly assessed and used to continually improve how the service was delivered. A range of processes and procedures helped to ensure the safe delivery of care, including good infection prevention and control practices and a detailed maintenance programme. The patient care journey was well documented. Staff were recruited appropriately, with evidence of staff support and training. 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. Thorough processes were in place to ensure that infection prevention and control processes were readily available to staff and were followed. Patients and families told us they were well supported and felt listened to. Staff told us they enjoyed working for the service and felt supported. A regular audit programme of patient care records should be introduced.	✓✓ 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 eight recommendations.

Direction	
Requirements	
None	
Recommendations	
a	The service should develop measurable key performance indicators and a process to measure these (see page 13). Health and Social Care Standards: My support, my life. I experience high quality care and support that is right for me. Statement 1.20

Direction (continued)	
Recommendations	
b	The service should publicise freedom to speak up champions' contact information to make it easy for staff to raise any concerns or queries (see page 15). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.20

Implementation and delivery	
Requirements	
None	
Recommendations	
c	The service should produce and publish an annual duty of candour report (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 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 complaints process (see page 22). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.20
e	The service should ensure policies and standard operating procedures are reviewed and updated as planned (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	
Recommendations	
f	The service should ensure patients' consent to treatment is documented in the patient care records (see page 27). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
g	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 28). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.15 This was previously identified as a recommendation in the April 2021 inspection report for Marie Curie Hospice, Edinburgh.
h	The service should introduce regular audits of patient care records (see page 28). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

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, Edinburgh, 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 vision and purpose, with a comprehensive 5-year strategic plan and defined objectives. Although the provider had measurable key performance indicators for continuous improvement, key performance indicators should be developed for the service. A governance framework was in place, and structures were clear and well defined. Leadership was visible and supportive, and staff felt valued and supported. Information about 'freedom to speak up' champions should be easily available for staff.

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.' The provider's mission over the next 5 years was to 'close the gap in end-of-life care' and clear objectives had been set to achieve this, including:

- transforming direct care and support
- providing more practical information and support, and
- leading in shaping the end-of-life system.

Key performance indicators were set by the provider to help measure success. These were measured every 3 months to help reassure the provider of performance across several areas such as:

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

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. This was available on the service's website. Information about progress against the strategic plan was included in the annual reports.

The service had recently presented to the Scottish Government in a bid for funding for a virtual bed model in the hospice. This would allow two patients requiring palliative care to receive clinical, hands-on care at home, staffed by the multidisciplinary team from the service's inpatient unit. The aim was to attract initial funding for two virtual beds with the hope for this capacity to increase over time.

What needs to improve

Although the provider had an overarching programme of measurable key performance indicators, it was unclear if the service had specific key performance indicators that could be measured at a local level. Setting and measuring key performance indicators at this level would be beneficial to the service and its patients and staff (recommendation a).

- No requirements.

Recommendation a

- The service should develop measurable key performance indicators and a process to measure these.

Leadership and culture

The provider had recently changed its organisational structures, which meant the structure of the leadership team had also changed. The majority of the senior management team were new to post within the last 2 years.

The service had a highly skilled staffing resource covering medical consultants, doctors, palliative care nurses, physiotherapists, occupational therapists, pharmacists, social worker, counsellor, chaplaincy 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 relationships between the service and the local NHS board.

There was a clear governance structure and defined lines of reporting and accountability. The service had an effective leadership structure in place through its senior management team who managed its daily operations. Senior managers were visible on a daily basis and carried out daily walkrounds to understand any pressures or challenges staff were experiencing.

The senior management team had well-defined roles, responsibilities and support arrangements. This helped to provide assurance of safe and consistent patient care and treatment. The service's governance framework detailed all local and regional groups, which included:

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

The specific meetings involved representatives from all staff grades, and there was a clear escalation and reporting process from each of the meetings.

The service's meeting schedule detailed all groups and how often they met. From reviewing a sample of minutes for all these meetings, we saw good representation from all staff groups.

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.

The provider offered a number of leadership programmes to encourage staff empowerment. This included both inhouse and national leadership programmes. At the time of our inspection, four members of staff were enrolled in the leadership programmes.

A 'freedom to speak up' system had been introduced, where staff could speak with a nominated freedom to speak up 'champion' in confidence if they had any concerns.

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:

- 'I have a fantastic line manager who is very supportive.'
- 'Leadership team work hard to engage and involve teams where they can.'
- '… I chose to come here and work due to the positive leadership team who are very professional.'

What needs to improve

Although 'freedom to speak up' champions were in place, not all staff knew who they were (recommendation b).

- No requirements.

Recommendation b

- The service should publicise freedom to speak up champions' contact information to make it easy for staff to raise any concerns or queries.

Key Focus Area: Implementation and delivery

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

Our findings

Patient experience was regularly assessed and used to continually improve how the service was delivered. A range of processes and procedures helped to ensure the safe delivery of care, including good infection prevention and control practices and a detailed maintenance programme. The patient care journey was well documented. Staff were recruited appropriately, with evidence of staff support and training. 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 and in the community across the country. Information on services available were fully highlighted on the provider's website, in public spaces and on television. The hospice had its own informative website with information on:

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

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 actively sought feedback from patients and families about their experience of treatment and care, and used this information to continually improve the way the service was delivered. We could see that patient feedback was collected in a number of ways, including:

- using a QR code displayed in the service
- compliments/concerns section on the website
- listening sessions in the service, and
- team of volunteers collecting inpatient feedback.

Feedback was analysed every month and results were shared at 'experience of patient care meetings' and other senior management meetings. We looked at a selection of patient feedback, which showed high levels of patient satisfaction, especially in patient care and with individual staff members. Patient feedback and improvements made were shared with the public through the service's website and its published annual report.

The service was revamping its day services into 'The Wellness Service'. This was as a result of feedback from patients and staff after COVID-19. The service was producing a timetable of services available to its patients, which would be a mix of in person activities and video meetings. The timetable was run by healthcare and complementary therapists and included classes for:

- light exercise
- fatigue, pain and breathlessness
- music, and
- photography.

Patients were able to be referred into these services by direct referral. However, the aim over the coming year was to allow patients to self-refer to the wellness service and to book classes online independently.

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 mental health services were also available for staff to contact should they require support.

A staff arts therapy session had recently been set up, and staff were being supported to attend.

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.

- 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:

- infection prevention and control
- medicine management
- medical emergencies
- health and safety
- safeguarding (public protection), 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. Laundry was transported in appropriate containers. We saw a log which advised of the correct temperatures being used by staff each time the washing machines were used. Staff were able to demonstrate they were aware of the correct temperature for washing items, as described in national infection prevention and control guidelines for hospices. The laundry 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. This included gas, boiler, air units, electrics and planned maintenance. Hospice lifts were serviced every 2 months by an external contractor. Daily checks carried out were recorded on the facilities online system. This included daily water flushing regimes carried out by housekeeping staff. This system identified schedules of checks for maintenance staff to carry out every day, 3 months or 6 months as appropriate.

Staff reporting maintenance issues were able to access the electronic system at any time to see what stage the issue they had reported was at.

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.

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 covered two hospices within the South East of Scotland, and a pharmacy technician who was responsible for medicines reconciliation and non-stock medications, stock control and non-stock items. Both members of the pharmacy team were employed directly by NHS Lothian.

The service has recently changed the process for ordering drugs and changed where patient medication was obtained from. However, we were told both suppliers would continue to be used to ensure a contingency plan was in place. This will ensure patients will receive their prescribed medication at all times.

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.

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

The pharmacist attended managed network meetings within NHS Lothian which included all hospices within the South East of Scotland. These meetings took place every 3 months and included reviewing policies and guidelines to ensure consistency across services.

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.

The service had an up-to-date duty of candour policy. Healthcare Improvement Scotland had been notified of a number of 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.

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.

Each day, staff recorded information about patients in a series of assessments and care plans, for example:

- skin care
- nutritional assessment
- pain assessment, and
- risk of falls.

The multidisciplinary team met weekly to discuss the progress and plans for each patient. This was recorded in the patient care records. This was an opportunity for staff to discuss aspects of support the patient and their family may require and to assess the patient's condition.

Patients were asked to complete a recognised tool that allowed them to express how they felt, how their quality of life had been impacted and their overall wellbeing. This was completed weekly or when the patient's situation had changed. Patients and families were also encouraged to complete an anticipatory care plan called 'What matters to me'. This allowed them to highlight to staff who and what was important to them. Both these documents gave staff a thorough insight into the patient's overall wellbeing and were referred to during the multidisciplinary team meetings.

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 the NHS. An 'honorary contract' was in place which allowed them to also work in the service. Consent to share information was obtained from the individual and a checklist was completed as part of the recruitment process. The checklist ensured their pre-employment checks were available to the service. The service 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 work, for example their ID.

Both general/corporate and role-specific inductions took place. The service had developed a new framework for carrying out appraisals that allowed the individual to score their capabilities. This led to discussions with their line manager and the development of professional objectives. These were stored electronically and could be updated at any time. Staff met with their manager regularly and the objectives were reviewed.

Volunteers worked in the service to provide support with, for example serving meals and drinks to patients, gardening and maintenance of groundwork. All volunteers had enhanced disclosure checks completed through Disclosure Scotland. They also completed an induction progamme which included all mandatory training relevant to their roles. There was an ongoing recruitment drive to expand the number of volunteers working in the service.

All non-clinical staff were managed by the service's support manager. This was a relatively new role in the service, and the manager worked closely with the clinical services manager.

Mandatory training was completed by all staff every year and was role specific. The provider had a central team of clinical educators. As part of that team, a local Scottish-wide team of clinical educators had developed role-specific training for staff, for example training in mental health first aid and physical first aid, and managing seizures. Most training was carried out online.

A number of the senior nursing staff were currently carrying out external training on a course that highlighted and acknowledged the skilled role of nurses caring for people who are dying. The learning from this will be implemented into the nursing team's skill set.

The service used specific workforce software to proactively manage its staffing compliment to help make sure that an appropriate skill mix and safe number of staffing was always provided.

What needs to improve

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

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

Although the majority of policies and standard operating procedures were in date and had been reviewed in line with the service's annual plan, we saw a few were outstanding and were out of date, such as the standard operating procedures on the use of medical gas, for example oxygen (recommendation e).

Although the service displayed its Healthcare Improvement Scotland certificate in the staff corridor, this should be displayed in a public area where it can be seen by patients and families, for example in the reception area. We will follow this up at the next inspection.

- No requirements.

Recommendation c

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

Recommendation d

- 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 complaints process.

Recommendation e

- The service should ensure policies and standard operating procedures are reviewed and updated as planned.

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. The maintenance team also carried out a monthly thermal flush checking for any evidence of pseudomonas (a water-based infection) as part of its risk management. 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 and benchmarked against the national Hospice UK programme, highlighting areas of good practice and also of any training needs identified.

An extensive clinical audit programme included audits on infection prevention and control, medicines management, nutrition and the environment. It also included audits on care of the dying patient, intravenous drug and fluid therapy, anticipatory prescribing of medication, tissue viability to establish patients who may have or are at risk of skin problems, duty of candour, safeguarding and falls. The last two audits carried out had detailed information on patients' nutritional needs and falls prevention. Audit meetings took place every 2 months where all audit results and reports were discussed and reviewed against the national Hospice UK audit programme. If actions were identified,

a 2-month timeframe was set with an action plan to address any issues. A responsible person was also identified who would be expected to provide progress reports to these meetings.

The provider had recently delivered a national training audit workshop for staff who were then tasked with completing an audit relevant to their area of work in their local service. Results of this audit were then reported to the central quality team.

A non-clinical audit programme included audits of the fire risk assessment, water safety, food hygiene and medical gases.

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.

A business continuity plan described what steps would be taken to protect patient care if an unexpected event happened, such as power failure or a major incident. An arrangement was in place with another service in the provider's wider organisation in case evacuation of patients became necessary.

The service 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.

- No requirements.
- No recommendations.

Key Focus Area: Results

Domain 6: Relationships	Domain 7: Quality control
How well has the service demonstrated that it provides safe, person-centred care?	

Our findings

The environment was clean and in a good state of repair. Thorough processes were in place to ensure that infection prevention and control processes were readily available to staff and were followed. Patients and families told us they were well supported and felt listened to. Staff told us they enjoyed working for the service and felt supported. A regular audit programme of patient care records should be introduced.

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

The environment 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. Additional information on cleaning products was available for all staff to view in the sluice areas, including information on correct dilution of chlorine-based solutions for cleaning up different bodily fluids. Staff we spoke with told us this was extremely helpful and easy to read and understand. All patient bedrooms had cleaning schedules which detailed daily, weekly, monthly, 3-monthly, 6-monthly and annual cleaning required. We saw completed, signed and up-to-date cleaning schedules for all areas in the service. Staff were also able to document any comments and advise or alert the housekeeping supervisor of any issues. These schedules were reviewed by the housekeeping supervisor every week and uploaded to the facilities online system. We saw adequate numbers of domestic staff on duty and noted that the service had recently recruited a further member of staff who

will take up post in January 2024. Staff were assigned to, 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.

We noted a health and safety environment inspection was being carried out by an external company during our inspection.

We reviewed five patient care records and found that appropriate patient information was recorded. This included:

- patient's contact details
- GP and next of contact details, and
- consent to share information with the next of kin.

In each patient care record we reviewed, we saw that a thorough process of assessment was documented by all staff. This included assessment of the patient's condition, nutritional intake and mobility issues. The service used a recognised performance assessment tool to assess and compare the patient's condition throughout their illness. This was reviewed and discussed regularly as a team and demonstrated a consistency in the patient assessment.

We attended a multidisciplinary team meeting and saw that all aspects were considered for each patient, for example their physical and emotional condition, discharge planning and family support. All staff attending the meeting contributed to the discussions.

We reviewed five staff files and saw that a recruitment process had been completed. We also reviewed the induction process and the new appraisal process in a number of staff files.

Staff we spoke with told us they enjoyed their job and felt supported. Staff who completed our online survey told us:

- 'The clinical work and patient contact is rewarding.'
- 'I feel proud to be able to say I work with Marie Curie.'
- 'I think Marie Curie is a good organisastion to work for, obviously there is always room for improvement.'
- 'Some really inspirational staff, in nursing, caring AHP and medical teams.'

Patients and families we spoke with told us:

- ‘I couldn’t fault them.’
- ‘She feels safe here.’
- ‘The staff are second to none.’

What needs to improve

In all the patient care records we reviewed, we saw that consent to treatment was not obtained (recommendation f).

Of the five patient care records we reviewed, we saw that patients’ power of attorney status was not always documented. A specific area in the electronic patient care record was not being consistently completed to highlight the individual’s power of attorney status. Staff should be aware of the patient’s power of attorney status (recommendation g).

A number of templates in the electronic patient care record were not being consistently completed, for example:

- the consent template
- power of attorney, and
- the patient information and equality form.

A process of regularly auditing patient care records should be developed to ensure all necessary information is captured every time (recommendation h).

Staff recruitment information was stored in the human resources electronic system. We found that a number of staff files had not been transferred onto the electronic system but were told this was due to take place. We will follow this up at the next inspection.

- No requirements.

Recommendation f

- The service should ensure patients’ consent to treatment is documented in the patient care records.

Recommendation g

- 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.

Recommendation h

- The service should introduce regular audits of patient care records.

Appendix 1 – About our inspections

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

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

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

Before inspections

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

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

Before

During inspections

We use inspection tools to help us assess the service.

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

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

During

After inspections

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

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

We check progress against the improvement action plan.

After

More information about our approach can be found on our website: https://www.healthcareimprovementscotland.org/scrutiny/the_quality_assurance_system.aspx

Complaints

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

Our contact details are:

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

Telephone: 0131 623 4300

Email: his.ihcregulation@nhs.scot

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

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