Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Ardgowan Hospice, Greenock

Service Provider: Ardgowan Hospice Limited

16-17 May 2023

NHS SCOTLAND

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1 Progress since our last inspection

What the provider had done to meet the requirement we made at our last inspection on 22-23 October 2019

Requirement

The provider must ensure that if a patient has appointed a power of attorney that a copy of the power of attorney document is clearly filed in the patient's notes.

Action taken

Although patient care records we reviewed documented that a power of attorney was in place, the power of attorney document was not filed in the records. **This requirement is not met** and is reported in Quality indicator 5.4 (see requirement 2)**.**

What the service had done to meet the recommendations we made at our last inspection on 22-23 October 2019

Recommendation

The service should update its complaints patient information and policy to make clear that complainants can refer a complaint to Healthcare Improvement Scotland at any stage of the complaints process.

Action taken

The service had now updated its complaints patient information and policy to make clear that complainants can refer a complaint to Healthcare Improvement Scotland at any time.

Recommendation

The service should update its safeguarding and data protection policies.

Action taken

The service had now updated its safeguarding and data protection policies.

Recommendation

The service should develop the current audit programme to ensure key areas of audit are easily identified.

Action taken

We saw the audit programme was now clearly recorded in an electronic format with defined outcomes and an ongoing review programme.

2 A summary of our inspection

The focus of our inspections is to ensure each service is person-centred, safe and well led. Therefore, we only evaluate the service against key quality indicators which apply across all services. However, depending on the scope and nature of the service, we may look at additional quality indicators.

About our inspection

We carried out an unannounced inspection to Ardgowan Hospice on Tuesday 16 and Wednesday 17 May 2023. We spoke with a number of staff, patients and carers during the inspection. We received feedback from 40 staff members through an online survey we had asked the service to issue for us during the inspection.

The inspection team was made up of two inspectors.

As part of the inspection process, we asked the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality 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.

What we found and inspection grades awarded

For Ardgowan Hospice, the following grades have been applied to the key quality indicators inspected.

Key quality indicators inspected		
Domain 2 – Impact on people experiencing care, carers and families		
Quality indicator	**Summary findings**	**Grade awarded**
2.1 - People's experience of care and the involvement of carers and families	Patients were encouraged to provide feedback on their experience to help the service continue to develop and improve. Patients were very positive about the standard of care and support. An easily accessible complaints process was in place. Staff should be trained in duty of candour, managing complaints and informed consent.	✓✓ Good

Key quality indicators inspected (continued)		
Domain 5 – Delivery of safe, effective, compassionate and person-centred care		
Quality indicator	**Summary findings**	**Grade awarded**
5.1 - Safe delivery of care	The environment and patient equipment was clean and well maintained. Processes were in place to ensure the ongoing review of risk, and a clear programme of audits and audit review was also in place. Treatment and storage areas should be reviewed and re-organised. An active risk assessment should be in place for all clinical and non-clinical sinks.	✓ Satisfactory
Domain 9 – Quality improvement-focused leadership		
9.4 - Leadership of improvement and change	There was evidence of positive and visible leadership, and a culture of continuous improvement. Good communication helped to ensure staff were kept informed. Various processes helped to continually evaluate and measure the quality, safety and effectiveness of the service.	✓✓ Good

The following additional quality indicators were inspected against during this inspection.

Additional quality indicators inspected (ungraded)	
Domain 3 – Impact on staff	
Quality indicator	**Summary findings**
3.1 - The involvement of staff in the work of the organisation	Good processes were in place to support staff and encourage them to make suggestions to help improve the service. Benefit and recognition schemes helped reward staff for their contribution to the service.
Domain 5 – Delivery of safe, effective, compassionate and person-centred care	
5.4 – Clinical excellence	The service followed national and local clinical care guidelines. Good processes were in place to ensure

	patients and their families were fully aware of their plan of care, and there was ongoing communication between patients and the multidisciplinary team. A copy of the power of attorney document must be filed in each patient care record, where applicable.
Domain 7 – Workforce management and support	
7.1 - Staff recruitment, training and development	Effective recruitment processes made sure staff were recruited safely. Opportunities for staff learning and development were available. A formal training plan would ensure staff complete role-specific learning.

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 Framework can also be found on our website at: https://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach/quality_framework.aspx

What action we expect Ardgowan Hospice Limited to take after our inspection

This inspection resulted in two requirements and 10 recommendations. Requirements are linked to compliance with the National Health Services (Scotland) Act 1978 and regulations or orders made under the Act, or a condition of registration. See Appendix 1 for a full list of the requirements and recommendations.

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

Ardgowan Hospice Limited, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at Ardgowan Hospice for their assistance during the inspection.

3 What we found during our inspection

Outcomes and impact

This section is where we report on how well the service meets people's needs.

Domain 2 – Impact on people experiencing care, carers and families

High performing healthcare organisations deliver services that meet the needs and expectations of the people who use them.

Our findings

Quality indicator 2.1 - People's experience of care and the involvement of carers and families

Patients were encouraged to provide feedback on their experience to help the service continue to develop and improve. Patients were very positive about the standard of care and support. An easily accessible complaints process was in place. Staff should be trained in duty of candour, managing complaints and informed consent.

The Ardgowan website provided detailed information on what services were offered and how to access them. It also included other information such as 'meet the team', fundraising activities, events and volunteering. The website had recently been updated and made more user friendly. A new information pack had been developed for patients being admitted to the inpatient unit to tell them what to expect during their admission.

The service used a range of ways to gather feedback, such as:

- 'Compliments, Concerns and Complaints' form on the website
- 'Tell Us What You Think' boxes placed around the buildings
- feedback cards for the patient transport service
- surveys for hospitality services
- verbally
- emails, and
- cards and letters.

When a compliments, concerns and complaints form was submitted from the website, the chief executive officer received a notification. We were told this notification was reviewed immediately, in case urgent action was needed. Any

feedback received from the website was automatically added to an electronic feedback log. Any other feedback received from the other methods was manually added to the log. This was discussed at monthly senior management meetings and actions would be taken, if required. Feedback forms included asking if the person providing the feedback wished to be contacted to enable the service to feedback any action taken or to discuss further with them. All feedback we saw was positive.

The Moving Forward programme is for anyone living in the Inverclyde area who is affected by life-limiting illnesses to explore how they can improve their wellbeing and also get practical support around finance. To measure the impact of this service, patients were asked to complete a survey at the start and end of the programme. Patients were also asked to provide feedback at the end of each session to help inform how future sessions could be developed.

Ardgowan Hospice had recently started MYlife, a service offering a calendar of social activities for people with a life-limiting illness and their carers to meet new people. With the support of a service co-ordinator, members made suggestions for social events and were asked for feedback after each event or session. When we attended a MYlife session, members told us that 'any suggestion was considered' and that the co-ordinator was 'brilliant' and 'tireless' in facilitating their suggestions.

An improvement project, 'Improving the Patient Experience', welcomed suggestions from staff and patients. Resulting changes had been made such as:

- patients provided with hand-held tablets to access television, music and library apps
- daily delivery of newspapers
- replaced mattresses, and
- replaced patient room doors for doors with window panels for better visibility.

The project also planned to:

- improve the decor, and
- employ a staff member who would be responsible for engaging with patients throughout their stay to address any non-clinical needs they may have.

Patients we spoke with told us:

- ‘They cannot do enough for me.’
- ‘I thought I’d won the lottery when I got a bed.’
- ‘First class.’

Patients and family members told us they spoke with staff every day and were fully aware of their care plan. They told us all staff were approachable and they felt able to raise concerns.

At the time of inspection, the service had not received any formal complaints. However, a complaints process was in place which was easily accessible to patients, carers and families. A duty of candour policy was also in place (where healthcare organisations have a professional responsibility to be honest with patients when something goes wrong). We were told an updated duty of candour report would shortly be published on the service’s new website.

What needs to improve

There was no evidence that staff had received duty of candour training (recommendation a).

There was no evidence that staff had received training on managing complaints (recommendation b).

There was no evidence that staff had received training on informed consent (recommendation c).

- No requirements.

Recommendation a

- The service should ensure relevant staff are trained in the principles of duty of candour.

Recommendation b

- The service should ensure staff are trained in the management of complaints.

Recommendation c

- The service should ensure relevant staff are trained in the process of obtaining informed consent.

Domain 3 – Impact on staff

High performing healthcare organisations value their people and create a culture and an environment that supports them to deliver high quality care.

Our findings

Quality indicator 3.1 - The involvement of staff in the work of the organisation

Good processes were in place to support staff and encourage them to make suggestions to help improve the service. Benefit and recognition schemes helped reward staff for their contribution to the service.

The service's staff communication and engagement policy acknowledged that its staff had an essential contribution to make in the continuous improvement of all the hospice's services and activities. A 'Stop Start Continue' exercise encouraged staff to submit suggestions for things the organisation should stop, things they would like to see start, and those things they think worked well and would like to continue. For example, this had highlighted that staff were involved in numerous committees and meetings, and sometimes felt overwhelmed by these commitments. As a result, a number of meetings had been merged.

Staff were involved in some short-life improvement working groups such as:

- improving patient experience
- Playlist for Life - a pilot for UK Hospices, and
- children and young people's services.

New staff who recently joined the service had been asked to provide feedback on the induction process. They said they would like a more detailed induction to understand all areas of the hospice and the services it provided. We were told that, as a result, a revised induction process would be developed.

Away days and conferences were held for staff which included workshops where staff could contribute on topics such as their aspirations for a new hospice, rebranding of the service, and choosing and developing new core values. Staff had also raised other suggestions such as wanting information on menopause and how to become a more eco-friendly service. As a result, the service held a menopause discussion session and produced a menopause policy. We were told the service was also working towards becoming a 'menopause friendly' accredited employer. An environmental group had been set up and was drafting a 5-year plan to become a more environmentally friendly organisation.

This would then be incorporated to the service's 5-year strategy. We will follow this up at future inspections.

The majority of staff told us they felt able to influence how things were done in the service. Comments included:

- 'Feedback is always encouraged by managers and CEO [chief executive officer].'
- 'We all have opportunity to contribute to how things are done.'

An internal staff intranet website was used for communication with and between staff and volunteers. We saw that the chief executive officer regularly posted videos with service updates and information. Individual chat forums were set up on the website for groups such as volunteers, all staff and the senior management team to help improve communication and engagement.

A staff support policy recognised the stressful environment that palliative care could be and detailed the support mechanisms in place for staff.

To support staff emotionally, we were told reflective sessions were held and staff could access paid counselling sessions. Spiritual care services were available for staff and volunteers.

The people and culture team held a calendar of health and wellbeing events and carried out health promotion activities. For example, there were links to support for stopping smoking on the staff intranet on National No Smoking Day and, during Mental Health Awareness week, a link to a managing anxiety webinar was posted.

To support staff with the rising cost of living, staff were provided with breakfast, lunch and refreshments, and also received a one-off cost of living payment. The service was awarded Living Wage Employer status in September 2022.

Staff and volunteers received long service awards in recognition of their contributions to the service. Staff could nominate each other for a monthly 'care award' linked to the service's new core values of CARE (compassion, appreciation, respect and equality). The winner of the care award received a certificate and a gift voucher.

Social events were organised for staff and volunteers. Birthdays, special occasions or significant dates were acknowledged and celebrated.

We saw evidence on the staff intranet of staff and volunteers being involved in fundraising events in the community such as sponsored races and local fayres.

What needs to improve

While the service encouraged staff and volunteer feedback, there was no method for obtaining structured anonymous feedback that could be evaluated, such as an annual survey (recommendation d).

- No requirements.

Recommendation d

- The service should carry out regular staff and volunteer surveys and share the results. Staff and volunteers should then be involved in developing any resulting action plans.

Service delivery

This section is where we report on how safe the service is.

Domain 5 – Delivery of safe, effective, compassionate and person-centred care

High performing healthcare organisations are focused on safety and learning to take forward improvements, and put in place appropriate controls to manage risks. They provide care that is respectful and responsive to people's individual needs, preferences and values delivered through appropriate clinical and operational planning, processes and procedures.

Our findings

Quality indicator 5.1 - Safe delivery of care

The environment and patient equipment was clean and well maintained. Processes were in place to ensure the ongoing review of risk, and a clear programme of audits and audit review was also in place. Treatment and storage areas should be reviewed and re-organised. An active risk assessment should be in place for all clinical and non-clinical sinks.

We saw that the environment was in a good state of repair and equipment was maintained. We inspected a number of items of patient equipment, including toilets, commodes and beds, and found they were all clean and in good condition. Each item had a sticker attached highlighting when it had been cleaned. A checklist in each patient room was completed, highlighting areas that had been cleaned before a patient was admitted.

We spoke with housekeeping staff and saw that appropriate processes were in place for cleaning, including using appropriate colour-coded equipment, for example mop heads and buckets. We saw that sanitary equipment was appropriately cleaned with chlorine-based products. Cleaning schedules were available and fully completed. We saw that adequate numbers of housekeeping staff were on duty throughout the day to ensure all cleaning tasks were achieved.

The service laundered small items of linen on site, for example towels and patient clothing. We were told larger items of laundry were laundered at an external NHS laundry company. The service had recently purchased a new washing machine and the housekeeping manager confirmed that specific items were being laundered at appropriate temperatures in line with current guidance. In the laundry area, information posters were displayed to remind staff of the correct laundry processes. We were told all staff kept up to date with online infection control training.

Processes were in place to ensure safe medicine management. A pharmacist and pharmacy technician attended the service twice a week to ensure safe processes were being maintained. A thorough process was in place for ordering, prescribing and administering all medicines. We noted the medicine management policy was currently being reviewed.

New staff were supported in the administration of medicines. When appropriate, experienced staff were encouraged to train further in single nurse drug administration. This allowed staff to administer drugs that would previously have relied on two staff members to administer and meant that patients could receive pain relief more quickly. We were told that staff carried out annual training on single nurse drug administration, medicine calculation tests and the use of syringe pumps. The pharmacist had a programme of meetings with each individual nurse to ensure their knowledge of medicines was current.

We saw a process of reporting incidents and near misses. A paper document was initially completed by the staff involved detailing what had occurred and actions taken and an investigation was then completed by the ward manager. Any learning and outcomes were transferred onto an electronic system and reported at clinical governance meetings. These were also discussed at monthly reflective medicine management meetings, attended by all clinical staff. Following an incident, staff involved also completed a reflective document to ensure they had taken any learning from the incident. We were told the service would be upgrading the reporting process by using a new electronic system to report incidents and accidents. We will follow this up at the next inspection.

We saw up-to-date policies which included:

- risk management
- medicines incident
- infection control, and
- incident and near miss reporting.

All policies were accessible to staff on the staff intranet.

A thorough process of risk management was in place, which included both corporate and clinical risk registers. These contained appropriate risk assessments, including infection control, medicine management and workforce planning. These were reviewed at a formal monthly meeting with associated action plans developed. Both risk registers were on an electronic system which was currently being upgraded.

The service carried out a wide range of audits to ensure the quality and safety of the care and treatment patients received was maintained. These included audits on:

- trips and falls
- prescribing of medicines
- patient referrals, and
- patient care records.

There was an active programme of reviewing audits with actions to be taken logged. Outcomes from audits were discussed at the quality and clinical effectiveness group which met every 3 months.

We saw thorough servicing and maintenance processes in place for all aspects of the service, including gas, electrical checks and water safety checks. These were carried out either inhouse by the maintenance manager and caretaker team or by external contractors. All compliance certificates were stored on a new electronic system. We were told that a new electronic reporting system had been introduced which allowed any staff member to report maintenance issues. We were told this had resulted in repairs being dealt with more quickly.

A recent fire risk assessment had been carried out. We were told fire doors had recently been replaced in the building and, on the day of inspection, a fire safety company was checking the fire alarm system. A staff fire evacuation plan was in place with a staged evacuation carried out every 3 months. We were told the service aimed to increase this to monthly to ensure all staff became more familiar with the fire alarm system.

Closed circuit television (CCTV) security was in place in the main building and the Ardgowan Access Centre. This was maintained by the service's maintenance team with nurses setting the alarm panel at night. Staff had access to panic alarms at various points in the building should this be needed. The maintenance manager and caretaker team were available out of hours on a weekly rota.

Patients spoke positively about the environment where they had access to a small café area, the sanctuary (a quiet enclosed room), the conservatory and the garden. One patient told us:

- 'The garden is lovely. I often come out here.'

What needs to improve

Some areas of the service were in need of refurbishment. We noted a number of wash hand basins were in need of upgrading, for example to replace the plug grill or sealant around the taps. There was also a non-compliant clinical sink in the inpatient unit with staff using patient wash hand basins when required. A risk assessment had been in place to ensure the clinical sink was appropriately cleaned and maintained. However, this had recently been archived in the electronic risk register. The risk assessment should be re-introduced into the active risk register for all sinks in the patient and clinical areas. This should also be reviewed regularly on the environmental walkrounds carried out by the senior management team (requirement 1).

Areas in the main hospice building needed to be decluttered. This included the treatment room in the inpatient unit where items of electrical equipment were also stored, for example infusion pumps. We found a storage room next to the laundry included some single-use clinical equipment, various items of patient equipment and patient belongings. Storage throughout the hospice should be reviewed and re-organised to maintain a clean and safe environment (recommendation e).

We saw that expiry date checks were carried out on emergency medicines boxes in the pharmacy. However, the checks were documented on a small post-it note attached to each box. A more formal checklist should be introduced which is signed and dated appropriately to show that these checks have taken place (recommendation f).

With a recent change in the senior management team and as part of a re-structuring of the service, a number of systems and processes were being introduced to improve efficiency of communication and reporting. For example, some new electronic processes and management systems were being introduced. We will follow this up at future inspections.

Requirement 1 – Timescale: immediate

- The provider must ensure there is an active risk assessment addressing all clinical and non-clinical sinks in the inpatient unit. As the clinical sink does not comply with national guidance about sanitary fittings in healthcare premises, this should be replaced at the next refurbishment.

Recommendation e

- The service should review storage facilities throughout the hospice and ensure treatment and storage rooms are being used for the correct purpose.

Recommendation f

- The service should develop a more formal document to record checks on expiry dates of emergency medicine and equipment.

Our findings

Quality indicator 5.4 – Clinical excellence

The service followed national and local clinical care guidelines. Good processes were in place to ensure patients and their families were fully aware of their plan of care, and there was ongoing communication between patients and the multidisciplinary team. A copy of the power of attorney document must be filed in each patient care record, where applicable.

We spoke with a number of staff from both the medical and nursing teams. They felt supported by the organisation and the senior management team. For example, staff from the nursing team told us they had recently suggested changes to how patients in the community were reviewed which the service's senior management team had supported.

The service had online links with experienced consultants in palliative medicine in a hospice in England, who participated online with the service's multidisciplinary team meetings and supported clinical decision making.

The service followed appropriate clinical care guidelines in line with national guidance. We saw a weekly programme of learning for the medical team. These sessions encouraged staff to present specific topics. The clinical team also carried out clinical review meetings which included a monthly review of recent deaths, including unexpected deaths and cases where symptom management had been challenging. Staff we spoke with felt these sessions were very beneficial, and outcomes and learning were always identified.

We attended a daily staff handover in the inpatient unit. This is where staff provide patient information to the wider multidisciplinary team. This included any incidents that had occurred overnight, changes to patients' conditions, planned admissions and discharges.

All staff we spoke with in the inpatient unit felt that the current programme of service review and change was a positive and much needed one.

We reviewed four patient care records. The records consisted of both electronic and paper documents. Each patient had paper copies of assessment tools available to allow staff to complete them more readily. These patient files were stored securely in the staff office. The electronic information was password protected and included daily care plans, multidisciplinary team input, medical ward rounds and patient care plans. The service was registered with the Information Commissioner's Office (an independent authority for data and privacy rights) to make sure it handled confidential patient information safely and securely.

In all patient care records reviewed, we saw that patient details were thoroughly recorded, including patients' GP contact details and next of kin details. In most cases, we saw that power of attorney had been discussed and a treatment escalation plan had been documented. This ensured a patient's wishes were known by all staff in the event the patient's condition deteriorated. A 'do not attempt cardiopulmonary resuscitation' (DNACPR) document was correctly completed in each patient care record reviewed. This related to the emergency treatment given when a patient's heart stops or they stop breathing.

Before patients were admitted, detailed assessments were carried out by the hospice community nurse specialists. This included documenting the patient's wishes about preferred place of care and of death. Conversations with the patient and family were documented ensuring the patient fully understood the reasons for admission to the hospice.

Following admission, a range of care plans and assessments were carried out, including:

- pain assessment
- mobility
- assessment of skin, and
- food and nutrition.

Consent to treatment and to share information with other healthcare professionals was fully completed in all patient care records we reviewed.

We saw daily reviews of patients by the multidisciplinary team took place. This included physiotherapy and social work teams. These were part of the patient's ongoing review, and addressed any concerns from the patient and the family supporting them. A weekly multidisciplinary team meeting also took place which included discussion about the patient's progress. This was documented in the patient care records.

One patient care record we reviewed showed that appropriate processes and documentation were completed when a patient fell. This included a medical and nursing review, and a period of assessing the patient's vital signs. We saw that a risk assessment was completed and adaptions made to the environment to reduce the risk of this happening again.

What needs to improve

The power of attorney status of each patient was documented in each patient care record we reviewed. However, no copy of the power of attorney document was available in the patient care records. This had been identified as a requirement at the previous inspection in October 2019 (requirement 2).

From the patient care records we reviewed, we saw that patients' ability to make decisions was assessed and documented on admission. However, no formal assessment tool was used to evidence this (recommendation g).

Anticipatory care planning is when discussions take place with patients about what matters to them and what their wishes would be in the event their condition deteriorated. We saw that these conversations were documented on the electronic patient care records. However, the title of the document was not specific to anticipatory care planning. This should be titled correctly to make sure the document is more readily accessible to all appropriate staff. This would also encourage awareness of the importance of the need for anticipatory care planning. We will follow this up at the next inspection.

Requirement 2 – Timescale: immediate

- The provider must ensure that a copy of the power of attorney document is filed in the patient care records.

Recommendation g

- The service should ensure a recognised assessment tool is used when assessing patients' ability to understand information and make decisions.

Domain 7 – Workforce management and support

High performing healthcare organisations have a proactive approach to workforce planning and management, and value their people supporting them to deliver safe and high quality care.

Our findings

Quality indicator 7.1 - Staff recruitment, training and development

Effective recruitment processes made sure staff were recruited safely. Opportunities for staff learning and development were available. A formal training plan would ensure staff complete role-specific learning.

We reviewed five staff files of employed staff and those working in the service under a practicing privileges agreement (staff not employed directly by the provider but given permission to work in the service). We found all were well organised and included evidence of effective recruitment. The service used a database to hold staffing information and documents. Recruitment checks included:

- obtaining references
- checking the Protecting Vulnerable Groups (PVG) status of the applicant
- checking staff members' professional registration, where appropriate, and
- checking professional indemnity insurance for staff with practicing privileges agreement.

A system was in place to make sure an annual check of staff's registration with their professional body took place to ensure they were still registered to practice.

Staff completed a corporate induction programme and were then given an induction for the area they worked in. As part of the induction programme, mandatory online training was to be completed. This included modules such as health and safety, infection prevention and control, and adult support and protection.

Staff had opportunities to develop through learning and the opportunity to change roles. All staff were invited to attend weekly lunchtime learning sessions on a range of topics such as trans people in palliative care, pain management, seizures and menopause. Posters on staff noticeboards highlighted the next clinical review meeting. These were classed as 'a safe space to reflect on practice, identify learning points, enhance quality of care and improve patient

safety.' The monthly meetings, which were open to all staff and were well attended by medical and nursing staff, were a combination of education and reflection. We saw that learning points were documented and actions resulting from the meetings were assigned to staff members. Attendees were sent a feedback form following the meeting and we saw evidence these forms were evaluated. We also saw that the chief executive officer had posted information on the staff intranet about an external event 'No-one grieves alone' inviting staff to attend.

Staff had opportunities to develop through learning and changing roles. For example, an administrative staff member had become a wellbeing support worker, and a member of the counselling team had been offered the spiritual care lead role.

We saw that annual appraisals took place and were documented. Before their appraisal, staff completed a performance review self-assessment to help them prepare what they would like to discuss. The appraisals helped to assess and evaluate staff performance, identify training and support needs, and included topics for discussion such as:

- reviewing the job description
- reviewing previous performance objectives and agreeing new objectives
- planning for the future
- health and wellbeing issues, and
- revalidation.

Appraisal documentation had recently been updated to align with the service's new core values of CARE (compassion, appreciation, respect and equality). The human resources department monitored appraisals including training objectives so that group training could be organised if a particular theme or trend was identified.

What needs to improve

The service was aware that the Protecting Vulnerable Groups (PVG) status of staff should be rechecked regularly. However, no system was in place to highlight when this would be due for each employee or to evidence that it had been carried out (recommendation h).

We saw a list of clinical online training modules that staff in the inpatient unit were required to complete. However, we were not provided with evidence of compliance rates of completion of the training modules. We were told there was no overarching training programme indicating the mandatory training and

ongoing training for the different staff roles in the service. This had already been identified by the service and a new learning and development officer post had been approved. They would be responsible for the development and governance of staff learning and development. A similar issue was also highlighted by some staff in our survey:

- 'A clear training programme for all staff.'
- 'Training in specialist palliative care being compulsory for those delivering care.' (recommendation i).

We were told regular one-to-one meetings took place between staff and their line manager. However, there was no consistent method of documenting the meetings (recommendation j).

- No requirements.

Recommendation h

- The service should introduce a system of routinely rechecking the Protecting Vulnerable Groups (PVG) status of staff appointed to work in the service.

Recommendation i

- The service should develop a formal training programme and monitor staff compliance with the completion of mandatory training.

Recommendation j

- The service should develop and implement a template to record one-to-one meetings held between staff and their line manager. This would help to contribute to the staff personal development and review process.

Vision and leadership

This section is where we report on how well the service is led.

Domain 9 – Quality improvement-focused leadership

High performing healthcare organisations are focused on quality improvement. The leaders and managers in the organisation drive the delivery of high quality, safe, person-centred care by supporting and promoting an open and fair culture of continuous learning and improvement.

Our findings

Quality indicator 9.4 - Leadership of improvement and change

There was evidence of positive and visible leadership, and a culture of continuous improvement. Good communication helped to ensure staff were kept informed. Various processes helped to continually evaluate and measure the quality, safety and effectiveness of the service.

At the time of the inspection, the service was in a period or reorganisation and service redesign. This included a newly appointed chief executive officer. However, despite these changes, almost 91% of staff who responded to our survey said there was positive leadership at the highest level. Comments included:

- 'Honest and transparent leadership through videos/posts on… [the staff intranet].'
- 'There are some excellent traits of positive leadership within the organisation.'

A staff member we spoke with said 'it feels safe… to be innovative and make improvements'.

We saw the chief executive officer was visible to staff through their involvement in meetings, conversations between the chief executive officer and staff we saw during our inspection, and posts and videos on the staff intranet.

There was evidence of a culture of continuous improvement in the organisation. An 'improvement record' spreadsheet documented suggestions made by staff. We saw evidence of these suggestions being discussed and considered at management meetings and some suggestions being implemented as a result. For example, a discharge letter sent to patients' GPs was going to be reviewed following a staff suggestion. This action had a named person responsible and a

timeline for completion. Following another suggestion from staff, digital hand-held tablets were provided for each bed space. This gave patients access to entertainment facilities such as television, music and e-books. If suggestions could not be accommodated, reasons were documented on the improvement record spreadsheet.

For longer-term organisational-wide improvements, we saw a 5-year draft strategy. At the time of the inspection, the strategy was in the consultation stage for staff, volunteers and the public to comment on before being finalised. The strategy included the future approach of the service, objectives and implementation plans.

Three sub-committees helped to provide governance and oversight of feedback, improvements, audits and action plans. The sub-committees were:

- people, culture and engagement
- financial risk and resource, and
- care governance and performance.

Each senior manager submitted a monthly report to their allocated sub-committee. For example, we saw that a summary report of feedback from patients, volunteers, staff, carers and visitors was collated into a compliments, concerns and complaints report and discussed at the care governance and performance sub-committee meeting.

After every Board or sub-committee meeting, the responsible senior managers shared an overview of the meeting on the staff intranet. We saw that senior managers and senior workers (team leaders) held meetings every 2 months and all actions were recorded on an action tracker.

The service carried out benchmarking in line with Hospice UK standards which allowed comparison with similar-sized hospices. Key performance indicators were used to evaluate the service. However, it had been identified that the current system did not allow for easy year-on-year comparison or identification of trends about patient satisfaction and outcomes. Therefore, new key performance indicators were drafted for each part of the service and were awaiting approval by the Board at the time of the inspection.

The chief executive officer told us how relationships with other hospices and GPs were being improved by developing support mechanisms such as out-of-hours medical cover. The service had also recently launched a helpline manned by the service's medical and advanced nurse practitioner team for GPs and other health and social care professionals to call for advice and support, or to make referrals.

In 2022, the hospice appointed an advanced nurse practitioner and a trainee advanced nurse practitioner who worked between the inpatient unit and the community. We were told the advanced nurse practitioners had introduced a palliative care education programme with care home staff, as well as working directly with patients in the community.

What needs to improve

Some responses to our staff survey suggested there could be an improvement in nursing leadership. Comments included:

- 'Gap in the management structure within the IPU.'
- '… there needs to be more support in nursing throughout the IPU as there is a direct leader required.'
- 'I feel that there is a distinct need for nursing leadership.'

This had already been identified by the service and actions had been taken to develop roles in the inpatient and community nursing services to improve leadership. We will follow this up at future inspections.

- No requirements.
- No recommendations.

Appendix 1 – Requirements and recommendations

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 at the discretion of Healthcare Improvement Scotland.
- **Recommendation:** A recommendation is a statement that sets out actions the service should take to improve or develop the quality of the service but where failure to do so will not directly result in enforcement.

Domain 2 – Impact on people experiencing care, carers and families	
Requirements	
None	
Recommendations	
a	The service should ensure relevant staff are trained in the principles of duty of candour (see page 10). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.4
b	The service should ensure staff are trained in the management of complaints (see page 10). 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 ensure relevant staff are trained in the process of obtaining informed consent (see page 10). Health and Social Care Standards: My support, my life. I experience high quality care and support that is right for me. Statement 1.18

Domain 3 – Impact on staff	
Requirements	
None	
Recommendation	
d	The service should carry out regular staff and volunteer surveys and share the results. Staff and volunteers should then be involved in developing any resulting action plans (see page 13). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Domain 5 – Delivery of safe, effective, compassionate and person-centred care	
Requirements	
1	The provider must ensure there is an active risk assessment addressing all clinical and non-clinical sinks in the inpatient unit. As the clinical sink does not comply with national guidance about sanitary fittings in healthcare premises, this should be replaced at the next refurbishment (see page 17). Timescale – immediate *Regulation 3(d)(i)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
2	The provider must ensure that a copy of the power of attorney document is filed in the patient care records (see page 20). Timescale – immediate *Regulation 3(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011* This was previously identified as a requirement in the October 2019 inspection report for Ardgowan Hospice.

Domain 5 – Delivery of safe, effective, compassionate and person-centred care (continued)	
Recommendations	
e	The service should review storage facilities throughout the hospice and ensure treatment and storage rooms are being used for the correct purpose (see page 18). Health and Social Care Standards: My support, my life. I experience a high quality environment if the organisation provides the premises. Statement 5.22
f	The service should develop a more formal document to record checks on expiry dates of emergency medicine and equipment (see page 18). 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 a recognised assessment tool is used when assessing patients' ability to understand information and make decisions (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11

Domain 7 – Workforce management and support	
Requirements	
None	
Recommendations	
h	The service should introduce a system of routinely rechecking the Protecting Vulnerable Groups (PVG) status of staff appointed to work in the service (see page 23). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.24
i	The service should develop a formal training programme and monitor staff compliance with the completion of mandatory training (see page 23). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14

Domain 7 – Workforce management and support (continued)	
Recommendations	
j	The service should develop and implement a template to record one-to-one meetings held between staff and their line manager. This would help to contribute to the staff personal development and review process (see page 23). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14

Appendix 2 – About our inspections

Our quality of care approach and the quality framework allows us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this approach 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: www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.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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