Unannounced Inspection Report: Independent Healthcare

Service: Kilbryde Hospice, East Kilbride
Service Provider: Kilbryde Hospice

18–19 June 2019
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Improvement Scotland Equality and Diversity Advisor on 0141 225 6999 or email
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Healthcare Improvement Scotland Unannounced Inspection Report
Kilbryde Hospice, 18–19 June 2019
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1 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 three 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 Kilbryde Hospice on Tuesday 18 and Wednesday 19 June 2019. We spoke with a number of staff, patients, families and carers during the inspection. This was our first inspection to this service.

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For Kilbryde Hospice, the following grades have been applied to three key quality indicators.

<table>
<thead>
<tr>
<th>Key quality indicators inspected</th>
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<tr>
<td><strong>Domain 2 – Impact on people experiencing care, carers and families</strong></td>
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<tr>
<td><strong>Quality indicator</strong></td>
</tr>
<tr>
<td>2.1 - People’s experience of care and the involvement of carers and families</td>
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<tr>
<td><strong>Domain 5 – Delivery of safe, effective, compassionate and person-centred care</strong></td>
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<tr>
<td>5.1 - Safe delivery of care</td>
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### Key quality indicators inspected (continued)

<table>
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<th>Domain 9 – Quality improvement-focused leadership</th>
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<td><strong>9.4 - Leadership of improvement and change</strong></td>
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The following additional quality indicators were inspected against during this inspection.

### Additional quality indicators inspected (ungraded)

<table>
<thead>
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<th>Domain 4 – Impact on community</th>
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<td><strong>4.1 - The organisation’s success in working with and engaging the local community</strong></td>
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<tr>
<th>Domain 5 – Delivery of safe, effective, compassionate and person-centred care</th>
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<tr>
<td><strong>5.2 - Assessment and management of people experiencing care</strong></td>
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<th>Domain 7 – Workforce management and support</th>
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<tr>
<td><strong>7.1 - Staff recruitment, training and development</strong></td>
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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

**What action we expect Kilbryde Hospice to take after our inspection**

This inspection resulted in one requirement (see Appendix 1). 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.

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

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

We would like to thank all staff at Kilbryde Hospice for their assistance during the inspection.
## 2 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 felt cared for and supported by staff who were compassionate and sensitive to their needs. Feedback from patients and visitors was gathered in a number of ways.

We saw staff were supportive and compassionate when caring for patients. Each staff member introduced themselves and asked the patient what they could do for them at that time. Staff asked about meal preferences and were sensitive to the needs of the individual. Patients we spoke with about their care said they were treated with privacy, dignity and respect. Other comments included:

- ‘Excellent care – nothing is a bother to them.’
- ‘I could not ask for anything better – everyone is so kind.’

The service carried out a visitor survey from January to March 2019. Although the sample was small, comments received by friends and families who visited patients were positive. Results showed that families felt patients were cared for with dignity and respect and care was individualised.

Patients, families and carers were provided with information about the service using a variety of formats, such as leaflets on admission, information boards, television screens and information stands.

The service’s participation policy described how patients, families and carers could be involved in the service and give feedback on all aspects of clinical and non-clinical care. This could be done in a variety of ways, including attendance at governance meetings and providing direct feedback that would be used to...
evaluate and develop the hospice. The service developed a ‘you said, we did’ approach in response to feedback received. We were told the service was considering including patients and families on interview panels. Feedback was also reviewed from Care Opinion (a website where anyone can leave feedback about their experience of health and social care). Feedback received was responded to regularly by the clinical services manager, or an appropriate member of the team.

Any concerns raised by patients, families and carers would follow the service’s complaints process if necessary. A leaflet detailing how to make a complaint was given to both the patient and their families at the time of admission. We were told all complaints and incidents were reported through the relevant governance committee, the senior management team and the board. We saw a good example of how a complaint was dealt with following a complicated discharge of one patient. The situation was reviewed by staff, and the senior nurse discussed the learning with their team. This led to a positive outcome for the patient and family.

We saw evidence of participation by patients, families and carers in the Kilbryde Voice (the service’s participation group). This group meets every 3 months and reports back to the clinical governance group and board of directors. As a direct result of discussion at this group, new patients are now met by a member of staff at the front door on admission and escorted to the inpatient unit.

We saw feedback was positive from patients who attended the day service. All respondents were happy with the quality of care they received. Most said their quality of life had improved and they felt less socially isolated since they started to attend the day service.

The day service unit offers patients the opportunity to attend a 12-week programme to help with their diagnosis and offer support. Patients we spoke with had been attending for 11 weeks and found this to be ‘a happy place, not morbid’. They told us:

- ‘We build up friendships because we all go for 12 weeks.’
- ‘First class, staff helpful.’

The service was considering whether using video calling would assist patients who are unable to physically access the programme.

A weekly choir group takes place in the Kilbryde Kafe. Patients from the inpatient unit, day services and visitors can attend this group. A day service
patient said ‘we love to attend this as singing makes us all feel better’. During the inspection, we noted a small concert by Scottish Opera was taking place for patients.

**What needs to improve**

Although the service made sure patients, families and carers could input to the participation group, attendance at the Kilbryde Voice meetings was limited. The service was aware of this and was considering how to ensure full representation by patients, families and carers.

- No requirements.
- No recommendations.

**Domain 4 – Impact on the community**

High performing healthcare organisations have a proactive approach to engaging and working with the local community that inspires public confidence.

**Our findings**

**Quality indicator 4.1 - The organisation’s success in working with and engaging the local community**

Excellent community links had been established and the service had a number of ways of engaging with the community. Volunteers felt well supported by staff and other volunteers.

The service had 162 volunteers. A number of these volunteers worked in the inpatient unit, day services, Kilbryde Kafe and reception. Volunteers were supported to choose a role that fitted their skills. They were encouraged by peer support and managers to continue to identify any development needs.

Feedback from volunteers was gathered using an annual satisfaction survey. Results showed the majority would recommend the service to other people looking to volunteer. A large proportion of the volunteers had been with the service for more than 5 years. Some had gone on to be employed by the service.

Although the volunteer workforce was mostly stable, the service was reviewing how many people stop volunteering and why to ensure it can retain volunteers.
The service had good links with local businesses, primary and secondary schools. Links had also been made with South Lanarkshire College where students had become befriending volunteers.

Representatives from the service attended locality health and social care planning groups to advise on palliative care, encourage joint working and share best practice. Representatives also attended other community carer groups such as The Cancer Care Group. We saw the service was involved with the new Macmillan cancer support project Good Life, Good Death, Good Grief: The Truacanta Project.

The service engaged with local corporate event companies and hosted a Business Breakfast in December 2018 with local businesses. The event was arranged to raise awareness and gain support through recruiting volunteers and fundraising. This will be repeated in July 2019. This event, and others, were communicated using social media, newsletters and flyers distributed around community areas.

The service ensured all patients’ spiritual needs were met. Good links were in place with local churches and a mosque who had engaged in Light a Light on the hospice’s Christmas tree and fundraising.

- No requirements.
- No recommendations.
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

A comprehensive audit and risk management system was in place to identify and mitigate clinical and environmental risks in the service. Action plans were developed and improvements prioritised according to the level of risk. Although the inpatient unit had only been operating since August 2018, the service planned some refurbishments as a result of minor issues in the building.

A lead had been appointed to oversee audit and risk in the service. Committees were responsible for the management of medication, infection prevention and control, and clinical audit and risk. Senior managers supported the committees to minimise risks throughout the service.

The service had an annual health and safety risk management programme in place for the assessment and maintenance of gas, electric, water, fire and equipment. Basic repairs were carried out promptly by the service’s maintenance team. External contracts were in place to mitigate higher level risks such as fire, electric and specialist equipment.

The service carried out a number of audits as part of its annual audit and risk management programme, including infection prevention and control, medicines management and anticipatory care planning. We saw good compliance with hand hygiene and waste management audits. Good systems were in place to record accidents and incidents. All adverse events were dealt with appropriately and any learning was put in place.

A recent medication audit demonstrated occasions when staff had not recorded medications given to patients. As a result of staff training and the
implementation of a ‘second checking system’, the results of recent audits demonstrated vastly improved documentation and outcomes for patients.

Results also highlighted frequent checking and documentation of intravenous medication infusions could be improved. However, reflective practice carried out with nursing staff and increased monitoring of documentation helped remind staff to check medical infusions more frequently.

What needs to improve
The general waste bin in the medication preparation room contained waste that should have been disposed of in the clinical waste bin (requirement 1).

We noted the service implemented suitable measures to minimise the spread of infection. However, results from the standard infection control precautions audits (such as hand hygiene, use of personal protective equipment and waste management) should be compared against previous results to allow for more refined assessment of risk and areas of improvement. The service agreed to review how it audited standard infection control precautions.

The service was aware that the paintwork needed to be refreshed and this was planned to be completed soon. We also saw evidence of dirty paintwork and light sockets on arrival. We highlighted this to a member of staff on arrival and it was resolved.

Requirement 1 – Timescale: immediately

■ The provider must ensure all waste is disposed of in the correct bins. This will help to minimise risks associated with wrongly disposed and collection of waste in the hospice.

■ No recommendations.
Quality indicator 5.2 - Assessment and management of people experiencing care

The service proactively communicated with patients to make sure they, and where necessary families and carers, were involved in planning of their care. Care plans were centred on patients’ needs and preferences. Patients were kept up to date of any changes in their care or treatment.

Staff worked in partnership with people delivering care in the community and other acute care settings. This ensured patients and families were supported by the right people in the most appropriate environment. Patients living at home were occasionally seen by the service’s care at home team before admission. Information gathered during home visits allowed the service to make sure plans were in place to meet the patient’s needs as soon as possible.

The service had developed a new patient admission checklist to ensure patients, or their family, were asked about any support required at home or in the hospice. A number of assessment tools were used to provide a framework for the management of risk to patients.

Staff communicated well with each other and met regularly to discuss patient care and treatment, share any concerns or discuss care plans for each patient.

Most patient care notes were hand written. The service was planning to move towards an electronic system in the future. All staff involved in patient care recorded information in the same care record. This meant all staff were able to see all the information about each patient in the same set of care records.

We reviewed five patient care records and found core care plans were in place that provided up-to-date information about how patients’ needs were met. All patients had specific care plans that provided information about any specialist care and treatment where necessary.

Staff identified what was most important to the patient in terms of meeting their needs using an integrated palliative care outcome scale (IPOS). Standard operating procedures were in place to provide staff with additional guidance about aspects of care and treatment and management of risk in the hospice. For example, remote prescribing and catheter care.

We noted that information about anticipatory care planning was also recorded in the patient care records to anticipate any significant changes in a person’s
health and care needs. It would describe actions that should be taken to manage the anticipated problem in the best way. We spoke with the lead consultant who told us how the staff worked in partnership with NHS Lanarkshire to address current and future anticipatory care for patients.

Through care planning and good communication, the service was keen to ensure patients’ wishes about their preferred place of care and death were met. Staff audited patient care records to identify whether patients’ wishes had been recorded before death and were then met after death. Early results showed patients were being asked more consistently about their preferences. The service had implemented procedures to ensure patients understood consent and information sharing processes.

- No requirements.
- No recommendations.

**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 systems and processes were in place to safely recruit staff and volunteers. Patients were supported by a stable, skilled and experienced staff group. Staff received good opportunities for training, and personal development plans included a rolling programme of planned learning.

Safe and effective systems were in place for the recruitment of staff and volunteers. Job specifications and standardised interview questions were used to make sure staff employed had the right skills and experience for each role. In the seven staff files we reviewed, pre-employment checks were carried out in line with the service’s recruitment policy. Staff did not begin work in the service until references, professional registration for healthcare professionals, and Disclosure Scotland checks were completed. All staff had to complete a pre-employment health questionnaire as part of their application.

Recruitment to the inpatient unit was managed on a phased basis depending on patient admissions. All staff received a 2-week induction programme before starting in the unit, followed by a period of supervised practice once in post. We
saw that staffing was stable, absence levels were low and the service had no vacant posts. Flexible bank staff provided cover for holidays and sickness. Bank staff were also used to provide the core team with additional support to care for patients admitted with complex care needs or when patients were approaching end of life and needed extra care.

The service provided a separately staffed day care service. A care at home support team also visited patients with life limiting illnesses in their own homes. We saw good joined-up working across all the clinical services delivered. Multidisciplinary meetings were attended by key staff involved in patients’ care and treatment. This helped to ensure the service maintained continuity of care for all its patients.

Staff we spoke with demonstrated good knowledge and understanding of their role. They told us they received regular opportunities for ongoing training and development. Individual learning needs were identified and staff had a period of shadowing to ensure safe practice and competency in their role.

The service ensured staff had the correct skills and knowledge to deliver high quality patient care and support. Staff told us weekly educational sessions delivered by the lead consultant for palliative care were very informative. This helped raise their awareness and enhanced their skills and knowledge in practice. Staff files we read included a record of:

- completed mandatory, refresher and specialist training
- performance management meetings that took place twice a year, and
- a personal development plan to address ongoing learning needs.

NHS specialist medical staff, physiotherapists and occupational therapists supported the service under a practicing privileges arrangement (staff not employed directly by the provider but given permission to work in the service). The clinical services manager was responsible for appraisals and day-to-day management in association with the respective line managers.

The service had an effective monitoring and tracking system in place to manage absence, training attendance, Disclosure Scotland checks and revalidation checks for nursing staff.
What needs to improve

Staff who held supervisory roles had time built into their work schedule to support and supervise staff and trainees. Currently, staff could arrange a meeting with their line manager in person or by telephone or email once a week. While staff told us they could seek support from a manager at any time, a more formal approach to staff supervision should be introduced. This would ensure all staff working in the service had planned individual time with their line manager on a regular basis to inform performance reviews and annual appraisals.

- No requirements.
- No recommendations.
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

A continuous cycle of improvement was embedded in the service. Action plans were used to promote improvement. We saw a comprehensive record of completed improvement initiatives. The senior management team and board members worked collaboratively with all stakeholders to drive improvement.

The service had a clear management structure with well-defined roles and responsibilities. The senior management team led on service change and improvement and proactively developed their leadership skills. The service had invested in an online training resource that included six leadership modules. Some senior managers also attended formal leadership training.

We saw that senior leaders adopted a shared approach to quality improvement with key stakeholders that included staff, patients, carers, and health and social care partners.

Staff told us senior managers were visible and approachable. Results from staff surveys completed last year and earlier this year were positive. The majority of respondents said the service was a good place to work and they had opportunities to develop in their role. We saw that staff were encouraged to share their ideas for improvement at meetings, team briefs or by emailing the chief executive officer directly.

The chief executive officer published a staff update every 3 months that welcomed new employees, recognised staff achievements and updated them on any service developments. Two social events had been organised by senior managers and board members to reward staff for their hard work and commitment following the opening of the inpatient unit.
The service recorded and discussed feedback from patients, families, complaints and adverse events in order to promote service change. Following feedback from one patient’s experience, all patients were now discharged in the afternoon. This helped make sure patients had everything they needed at home to self-manage their condition.

The service supported staff to undertake research. Complementary therapists had a case study published last year in an international journal. It showed how aromatherapy had improved a palliative care patient’s quality of life. We also saw the service’s care at home team had compiled case studies that demonstrated how complementary therapies had helped alleviate distress and support pain management for some patients living at home.

Good governance structures were in place to ensure the service delivered high quality, safe, person-centred care. The chief executive officer presented monthly business updates to the board with support from other senior managers. We saw that safety and quality of care was regularly discussed at board meetings. Specialist committees and operational groups were established to drive service improvement. We saw that board members were actively involved in some of these groups.

The service had developed some positive initiatives to support service improvement, such as the following.

- An electronic database to store staff records, share information and monitor compliance with training, development and any revalidation requirements.
- Recruitment of a data analyst to support and strengthen measurement of data collected and compare outcomes.
- Specialist rehabilitation staff had implemented the Hospice UK model of rehabilitative palliative care. This promotes independence by setting goals with patients to help them self-manage their condition in preparation for discharge home.

The service was represented by senior managers and staff at palliative care forums and conferences. It was also a member of several national organisations including the Scottish Partnership for Palliative Care, the National Association for Hospice at Home and Hospice UK. This helped the service keep up to date with new developments and deliver best practice. Locally, we saw good partnership working with GPs, community nurses and social work services. This ensured continuity of care was maintained for inpatients and patients cared for at home. The service had also started to network with other hospices. Some
staff were members of the Scottish hospice working groups where ideas and common problems were shared.

**What needs to improve**
Currently, there was no representation from patients, families or carers on the service’s board. Senior managers told us they planned to develop two levels of its governance structure. One would include a smaller strategic board of directors and a separate operational board would include representations of patient, families and carers. We will follow this up at a future inspection.

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

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**Timescale** – immediately

*Regulation 3a (iii)*

*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

<table>
<thead>
<tr>
<th>Recommendations</th>
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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.

**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.

**After inspections**

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

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

We check progress against the improvement action plan.

More information about our approach can be found on our website: [www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.aspx](http://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: hcis.ihcregulation@nhs.net