Unannounced Inspection Report: Independent Healthcare

Service: Ayrshire Hospice, Ayr
Service Provider: Ayrshire Hospice

5–6 June 2019
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www.healthcareimprovementscotland.org
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1 Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 18–19 May 2016

Recommendation
We recommend that the service should ensure clinical hand wash sinks are installed as part of the ongoing refurbishment plan in patient bedrooms.

Action taken
Some clinical hand wash sinks had been replaced and the hospice planned to refurbish the inpatient unit. This recommendation is met.

Recommendation
We recommend that the service should develop and implement a robust audit plan that includes specific, measurable action plans.

Action taken
Some audits were inconsistently completed and action plans not always detailed enough. This recommendation is not met (see recommendation b).
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 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 Ayrshire Hospice on Wednesday 5 and Thursday 6 June 2019. We spoke with a number of staff, patients and carers during the inspection. The inspection team was made up of three inspectors and an observer.

What we found and inspection grades awarded

For Ayrshire 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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<tbody>
<tr>
<td><strong>Domain 2 – Impact on people experiencing care, carers and families</strong></td>
</tr>
<tr>
<td>Quality indicator</td>
</tr>
<tr>
<td>2.1 - People’s experience of care and the involvement of carers and families</td>
</tr>
<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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</table>
The following additional quality indicators were inspected against during this inspection.

### Domain 4 – Impact on community

<table>
<thead>
<tr>
<th>Quality indicator</th>
<th>Summary findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 - The organisation’s success in working with and engaging the local community</td>
<td>The service engaged with the wider community through a drop-in cafe, youth focus groups and fundraising and awareness events.</td>
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### Domain 5 – Delivery of safe, effective, compassionate and person-centred care

<table>
<thead>
<tr>
<th>Quality indicator</th>
<th>Summary findings</th>
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<tbody>
<tr>
<td>5.2 - Assessment and management of people experiencing care</td>
<td>Good systems were in place to record how patients’ needs and expectations were met. An integrated palliative outcome scale also gave patients more opportunities to share their concerns about their care or let staff know about any extra support they required.</td>
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### Domain 7 – Workforce management and support

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>7.1 - Staff recruitment, training and development</td>
<td>Good recruitment procedures were in place and staff completed an induction package available to them. Training and development opportunities were accessible and yearly appraisals were carried out. Staff we spoke with enjoyed working at the service and were a highly motivated group.</td>
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</tbody>
</table>

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 Ayrshire Hospice to take after our inspection

This inspection two recommendations. The 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](http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/find_a_provider_or_service.aspx)

Ayrshire Hospice, the provider, must make the necessary improvements as a matter of priority.

We would like to thank all staff at Ayrshire 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 and their families told us they looked forward to attending the service because they received individualised care that met their needs, wishes and they felt supported and valued.

Patients and families were involved in developing care plans and the patients we spoke with said they felt very involved in planning their care. The service involved patients and families in discharge planning to help make sure patients’ needs were met at home. Patients were encouraged to manage their own illness as far as possible, helping to maintain their independence. The service ran workshops where patients could choose from a variety of topics, such as running their own finances to help increase their confidence. We attended one of these workshops and feedback from patients we spoke with there was excellent.

The service used the integrated palliative care outcome scale (IPOS). This asked patients to reflect on and rate their symptoms and feelings over the previous 3 days. Staff reported the feedback from the IPOS questionnaire had helped improve the way they met patient needs. This allowed medication to be adjusted to maximize effect and reduce side effects. Symptom control was targeted to reduce those that caused the individual the most distress. Patients we spoke with all said they felt they and their family were included in their care planning and were given choices.

Patients we spoke with said they felt respected, listened to and that they could offer staff feedback. For example, access to oxygen masks had been improved after one patient’s feedback. They felt staff had enough time to meet their care needs, they could ask for things and staff responded quickly and pleasantly. For example, we saw one nurse styling a patient’s hair to satisfy their personal
need. We also saw a variety of different ways that patients could feedback, such as:

- an online ‘care opinion’ platform
- paper feedback questionnaires, and
- suggestion boxes.

We saw that staff were friendly, professional and engaging with patients. All patients and carers we spoke with were happy with the service they received and their comments included: Patients and relatives we spoke with told us:

- ‘I couldn’t wait to get back in here.’
- ‘Different from hospital, relaxed, more like home ... can even bring the dog in.’

The service’s comments, concerns and complaints policy and procedure, along with the patient information leaflet, was readily available on its website. The complaints procedure provided feedback to the complainant in writing of the findings and actions taken as a result of the complaint. We tracked one complaint and saw that staff acted in line with the policy.

- 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**

The service engaged with the wider community through a drop-in cafe, youth focus groups and fundraising and awareness events.

Senior management described how the service’s profile was raised in the wider community to encourage the community to become involved and support fundraising.
The service had a strategic plan for 2018–21 which identified an aim to increase education for its community partners. We visited the service’s community cafe which was open to patients and the public and could be used for public events. Staff told us that some prospective patients had visited the cafe with their families to see the service in a relaxed way and help them decide whether to use the hospice services.

Some volunteers, called business ambassadors, delivered speeches to community groups to help promote the service and these encouraged groups to support the service. For example, one of the groups raised money to provide a bowling green and golf putting in the garden for patients and their families.

Volunteers with dogs from the local community provided ‘Therapets’. These visits helped patients to have experiences which they may have had at home. Patients and staff told us they looked forward to their visits.

The service’s community pharmacy project provided expert knowledge and training to community pharmacists to improve understanding of current palliative care. A network of pharmacists had been established to keep the continuity for inpatients and patients in the community accessing the service.

**What needs to improve**

The service had identified some issues with its community engagement, including the cafe not accessed as well as it could be. The service continued to look for other innovative ways to engage with the community and planned to form a consultation focus group of people unconnected to the service. We will follow this up at future inspections.

- 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

The environment was clean and tidy throughout the service inpatient and day care unit. The senior management team and hospice board was aware that the service needed refurbishment to make sure the accommodation met the changing needs of patients, visitors and staff.

The service had a corporate risk register for non-clinical risks as well as an operational risk register to inform its safe care management framework. Staff were allocated responsibility for certain risks identified. For example, the maintenance team made sure equipment was safe and repairs were carried out.

Patients and visitors told us they felt safe and secure in the hospice environment. Good processes were in place and, along with the infection control champion, this helped make sure staff worked in line with Health Protection Scotland’s National Infection Prevention and Control Manual and standard infection control precautions such as hand hygiene and linen management. All standard infection control precautions were audited in line with a yearly programme. Results of the inpatient unit audits of standard infection control precautions were reviewed every 3 months. Improvement actions were taken to address issues and audit results were shared with the quality assurance department and at monthly clinical effectiveness meetings. This helped make sure risks associated with the spread of infection were minimised.

The service followed an appropriate medicines management policy. Patients met with staff to discuss medications they were taking before admission to the hospice and any possible changes during their stay and at discharge. As part of a community project, the service had also started a ‘Just in Case’ medication process to help make sure patients had their medication at home in the event of...
deterioration. All medical and nursing staff also attended medicines management training every year.

We saw that accidents and incidents were recorded. Learning was implemented from adverse events to help minimise future risks. We tracked a falls incident that had been recorded and saw that staff followed the service’s procedures. The incident was recorded in detail and improvement lessons were learned.

We spoke with staff about their roles and responsibilities in safeguarding and raising concerns. We saw that the adults at risk and child protection policies had recently been updated to reflect current national guidance.

A patient and families support team based in the service included a social worker to support families, visitors and staff in the protection of vulnerable people. A charge nurse would liaise with an external social work team for advice if the social worker was not available.

**What needs to improve**

The hospice did not use chlorine-releasing detergent to clean sanitary fittings or wash hand basins in line with national guidance (recommendation a).

We saw examples where audits were inconsistently completed and reasons for changes in audit frequency were not always documented. Some action plans we saw also did not have sufficient detail to address all issues identified (recommendation b).

While staff had completed online child and adult protection training, they had not completed ‘Getting it Right for Every Child’ (GIRFEC) training. However, the service’s education development plan stated that all care-delivering staff would complete this and face-to-face training before the end of 2019. We will follow this up at future inspections.

**Recommendation a**

- The service should ensure that in line with national guidance, appropriate cleaning products are used for the cleaning of all sanitary fittings, including sinks.

**Recommendation b**

- The service should review its audit programme to ensure consistency of reporting, actioning of any issues identified and appropriate frequency of auditing taking place.
**Our findings**

**Quality indicator 5.2 - Assessment and management of people experiencing care**

Good systems were in place to record how patients’ needs and expectations were met. An integrated palliative outcome scale also gave patients more opportunities to share their concerns about their care or let staff know about any extra support they required.

Before admission to the service, patients were seen in their own home or an appropriate setting. This helped to make sure their needs were identified early and care plans were put in place to meet the patients’ needs. A specialist or the hospice charge nurse visited patients with more complex needs.

Once admitted to the service, nursing and medical staff recorded more information in patients’ electronic and written care plans. We reviewed five electronic patients’ care records and five written care records. We found documentation was legible, accurate and up to date in all patient care records. Each patient had core care plans which described how the patients’ needs were met. Staff also recorded how extra health and social care needs were met. For example, we saw care plans for managing pressure ulcers, oral hygiene and anxiety.

We saw good communication in the service. Staff delivering care met twice a day to discuss patients’ care. Staff were also given a written summary of how each patient’s needs were met and any planned interventions for that day. This helped to remind staff of any tasks they had to complete during their shift. An afternoon huddle was used as a short meeting for clinical staff to share information about any increased risk associated with patient care. The information shared at the huddles allowed designated staff to quickly plan any interventions.

Staff were proactive when the patient’s condition was deteriorating, and met with patients and families to discuss arrangements for end-of-life care.

Anticipatory care planning helps to meet patients’ and families’ current and longer terms needs and wishes. The service told us it was in the early stages of implementing Healthcare Improvement Scotland’s anticipatory care planning tool for patients who wish to discuss and plan anticipatory care. We saw some good examples of anticipatory care planning in the service, such as the ‘Just in
Case’ medication home support and an audit of how well patient care record documentation was completed. The audits showed good compliance.

The service had recently updated its consent to treatment policy to include guidance on sharing of information. All patient care records we reviewed confirmed that staff were following the policy.

What needs to improve
The afternoon huddle did not include non-clinical staff, such as housekeeping staff. We discussed with senior staff that having a representative from other areas could help make all teams aware of any potential risk. We will follow this up at future inspections.

■ 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

Good recruitment procedures were in place and staff had induction packages available to them. Training and development opportunities were accessible and yearly appraisals were carried out. Staff we spoke with enjoyed working at the service and were a highly motivated group.

Recruitment and induction policies were in place. The four staff files and one volunteer file we reviewed were well-organised and all appropriate recruitment checks had been completed. New members of staff and volunteers completed mandatory induction, worked through a service induction package and had a role-specific induction. The service had recently introduced a volunteer handbook and was developing a staff handbook.

The service had a dedicated education department with practice educators. Clinical and non-clinical staff completed yearly mandatory training face to face and online such as health and safety. Other mandatory training could be role-specific, such as medicine management. Management staff monitored
compliance with mandatory training. A wide range of other training days were offered and included communication and leadership training.

Quality improvement was one topic on the staff 2018 training day. This aimed to increase awareness and involvement of staff in quality improvement. In areas where gaps or of learning had been found as a result of audits or investigations, the service had begun to introduce ‘tool box talks’ for staff to improve their knowledge and skills in specific areas. This should help to ensure that all staff had the skills and knowledge to carry out their role.

Staff had yearly appraisals which focused on performance and development. The service had recently reviewed and re-launched professional supervision for all clinical staff to allow them to reflect and learn from specific professional issues.

The service facilitated many education days through partnership working for non-hospice staff to attend and worked closely with the local council, care homes and the NHS to help provide some training.

Staff we spoke with told us about the service’s education process and said they found their work environment to be very supportive. They told us they were given enough education and training to do the job and were clear about their roles and responsibilities. Patients we spoke with were very complimentary of staff. For example, one patient told us:

• ‘I couldn’t ask for anymore, they do everything. I look forward to coming here.’

What needs to improve
The service had a plan for education. However the new head of clinical governance and practice development told us they planned to develop an overall learning and development strategy. We will follow this up at future inspections.

■ 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

Staff told us that leadership was visible and approachable. We saw good governance structures. Staff felt involved in helping to improve the services delivered by the hospice. Plans are being developed for refurbishment of the inpatient unit.

A clear governance structure was in place and a number of groups met and fed into it. From group minutes, we saw that complaints, patient feedback, audits and incidents were discussed. Improvement actions were also noted in minutes with responsible persons decided. Staff told us that communication was good and they felt their voices were heard.

The service had developed a strategic plan for the future which focused on service improvement. Staff could contribute to change and improvement in the service in a variety of ways, including:

- meetings
- performance reviews, and
- surveys.

The service had reviewed its performance in several areas, such as clinical services. From that review, it had changed its approach to make sure it had a firmer focus on community services so patients could stay at home if they wanted to. It had developed improvement strategies in partnership with staff, such as its ‘People Strategy’, which had reinforced that staff could also join subgroups where they could take a lead role in looking at different parts of the service such as falls management. Staff told us these focused pieces of work provided responsibility, development and an opportunity to improve patients’ care and outcomes. Staff told us that leadership was visible and senior staff
were approachable. One staff member told us, ‘it is nice the chief executive knows you by name.’

The service benchmarked its performance against other hospices across the UK on key safety and activity information, including:

- falls
- medication incidents, and
- pressure ulcers.

Data collected from audits was used to identify trends and areas for improvement. The service used an improvement model to drive improvement. We saw examples of how this was being used to do that with the introduction of the new slide sheet.

To maintain a clear approach to anticipatory care planning across Ayrshire & Arran, one of the hospice doctors is working in partnership with NHS Ayrshire & Arran to assess and develop a suitable framework and assessment tool that could be used by all health and care practitioners when working with people and their carers in the community. This would help people to make informed choices about how and where they want to be treated and supported in the future and ensure that all those involved in the care of the patient are working together to achieve the best outcome for the patient.

**What needs to improve**

The service planned to refurbish the inpatient unit and looked to put in place appropriate measures for maintaining patients’ continuity of care and minimise service disruption during the process. This would include finding a suitable location to provide its inpatient service from, as well as considering budgetary constraints. 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 5 – Delivery of safe, effective, compassionate and person-centred care

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<th>Requirements</th>
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<tr>
<td>None</td>
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<table>
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<tr>
<th>Recommendations</th>
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| a The service should ensure that in line with national guidance, appropriate cleaning products are used for the cleaning of all sanitary fittings, including sinks (see page 13).  

Health and Social Care Standards: My support, my life. I experience a high quality environment if the organisation provides the premises. Statement 5.17 |
| b The service should create an audit system that is consistent and offers assurance, is sustainable and leads to improvements (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 |
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

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
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: comments.his@nhs.net