**Action Plan**

<table>
<thead>
<tr>
<th>Service Name:</th>
<th>St. Margaret of Scotland Hospice, Clydebank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service number:</td>
<td>00059</td>
</tr>
<tr>
<td>Service Provider:</td>
<td>St. Margaret of Scotland Hospice</td>
</tr>
<tr>
<td>Address:</td>
<td>East Barns Street, Clydebank, G81 1EG</td>
</tr>
<tr>
<td>Date Inspection Concluded:</td>
<td>17 August 2022</td>
</tr>
</tbody>
</table>

### Requirements and Recommendations

<table>
<thead>
<tr>
<th>Requirement 1: The provider must ensure that systems are in place to ensure emergency equipment is always in date.</th>
<th>Action Planned</th>
<th>Timescale</th>
<th>Responsible person</th>
</tr>
</thead>
<tbody>
<tr>
<td>As acknowledged in the report – this was actioned immediately. It is worthy of note, the “out of date” equipment was a nasal airway, eye gel, venflons, giving set and a pair of forceps. Following assessment, this equipment was not required and has been removed. Feedback from HIS during the inspection was that this was considered a minor issue.</td>
<td>Completed</td>
<td>Director of Clinical Services</td>
<td></td>
</tr>
</tbody>
</table>

**Recommendation a:** The service should invite patients, carers or family members to participate in groups or discussions about improving the service to ensure that the opinions and experiences of patients, carers and families are considered.

Patients and their families are at the very centre of all that we do and are included and involved in every part of the service. Until recently, we couldn’t even have more than 2 visitors at a time. We had to work within the Scottish Government guidance for COVID. We carried out patient and relative satisfaction reports which included any improvements to the service. We have just come through Covid – where a telephone survey was carried out and the feedback was very positive.

| Ongoing | SMT |
which the inspection team acknowledged. As the
Inspection Team fed back during the inspection,
they witnessed both patients and family members
were regularly invited to complete surveys of their
experience of the hospice and to make suggestions
for improvement. The Inspection Team observed
these were carried out regularly and feedback was
positive. All of the relative and patient satisfaction
audits have consistently been graded as
Exceptional, also the feedback from patients,
relatives and carers which was evidenced in
supporting documentation, and was available for
the inspection.
Furthermore, most of our groups have staff
members who have had relatives who have been
Hospice patients. Those staff members, through
experience, know the standard which is expected
for patients and families and seek to drive the
service delivery and improvement of services to the
highest standard. Staff listen to patients and
relatives during their day-to-day activities and
feedback what they have learned about wishes and
areas which could be improved – we address these
in real-time.
At feedback the inspection team acknowledged
patients and relatives did not give any suggestions
or improvements which could be made. The
Inspection team also acknowledged the Hospice
discusses feedback in groups but made a
suggestion that even though patients and relatives
have not made any recommendations for
improvement, we should advise we have taken on
board their feedback.
The feedback from the inspection team was that evidence provided was positive. The feedback following inspection and narrative in the report in relation to domain 2.1 is contradictory to the awarding of a Satisfactory grade which is “the service is performing at a basic level.” A grade of satisfactory does not represent the innovation, Reshaping, continuation and maintaining quality assurance which was evident during the pandemic. How does this grade correlate with the comments by patients “giving 100%”?

There is a dilemma across the country in getting people to join groups. When people are so unwell it is not appropriate and we cannot simply ‘engineer’ groups. Patients and families cannot be used as a ‘means to an end’ as this would be unethical.

We have created a patient experience film (Summer 2022) which is available to watch:
Link to patient Hospice experience video - https://vimeo.com/759076586
A Patient’s story of their Hospice experience was also included in the Light Up a Life service which was streamed online in November 2021.

It was acknowledged by the Inspection Team on the day that there are no improvements or suggestions from patients/relatives. We also must still consider the safety of patients and relatives in groups in relation to the on-going transmission of Covid. The methodology of feedback gathered in the Hospice.
should be respected. This methodology has been supported by evidence including satisfaction reports, feedback and agreed actions based on any recommendations or suggestions, which have been limited. This methodology has been proven to be effective for this Hospice population.

| Recommendation b: The service should ensure information on its website is accurate and up to date. | The new website was already in development as advised to HIS in July 2022, to allow for up-to-date and accurate information to be shared online. This was included in our quality improvement plan (shared during inspection), and in our self-evaluation submitted to HIS in July 2022. The inspection team noted during feedback the website was under development. | On-going with launch in mid-November and completion by early 2023 | Administrator |

| Recommendation c: The service should develop a whistleblowing policy and support staff to create a whistleblowing champion role. This would ensure that staff have the opportunity and confidence to raise concerns and promote a culture of speaking up. | At feedback it was confirmed there was no area of non-compliance in respect of Whistleblowing. We previously had a Whistleblowing policy in place which was never used. The Hospice principles of Right Time, Right Place, Right Person ensure that anyone can raise any issue at any time – right to the top of the House which has proven to be a much more immediate, effective and robust process. Everyone has the right and opportunity to speak up in the Hospice. We note the recommendation, but as you have stated in your report, there is an Open Door Policy. The Mission Effectiveness programme provides a platform for all staff members to anonymously raise any issue or concern they wish processed through the five Core Values scrutiny process. The Mission report is submitted to the Board of Directors twice a year. We note the report states “staff are expected” to | Ongoing | SMT/All staff |
attend Mandatory training is incorrect. Mandatory training is a legal requirement and continued throughout the pandemic and it is mandatory (not expected) for staff to attend in terms of the law and healthcare regulation.

Reported scores from HIS’ anonymous online survey completed on the day of inspection (47 responses). With this level of positive response, how can leadership be graded as Good? This equates to one negative response and as this was an anonymous and open link, it could have been completed by anyone. It is well known that in any organisation, there will be at least 10% of staff who will never be satisfied.

1. There is positive leadership at the highest level in this organisation
   1. Yes – 97.8%
   2. No

2. A positive culture is visible where I work
   1. Yes – 97.8%
   2. No

3. I am able to influence how things are done in this organisation
   1. Yes – 84.7%
   2. No
4. My concerns are taken seriously by my line manager
   1. Yes – 95.7%
   2. No

5. I would recommend this organisation as a good place to work
   1. Yes – 93%
   2. No

One Inspector said they would not get these results in their own organisation.

The inspection team reported the feedback on the staff survey results and noted the many positive comments:

- patient care – everybody talked about care being exemplary, best possible care and family support – everybody said that
- a good 68 people talked about encouraging professional development
- a place of excellence was mentioned on two or three entries
- care of families was mentioned a number of times
- staff support was a big positive
- MDT working was a positive
- Positive atmosphere in the environment
- Staff approachable
- Feel valued and respected
- Working as one team
- Working as a family
- Holistic working
- Sister Rita constantly available – was a very big positive
- Positive attitude
- Lovely place to work

<table>
<thead>
<tr>
<th>Recommendation d: The service should carry out a staffing review using a recognised safe staffing tool.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Inspection Team acknowledged that recruitment is tricky. This is further corroborated by the fact our draft report was over 4 weeks late and the reason given was a lack of availability of staff as noted by Head of Service Review at HIS. The inspection team noted the Hospice is not alone with recruitment issues. As discussed with the inspection team, staffing levels are reviewed every day by the senior management team and risk assessments are completed based on staffing needs to meet the requirements of the patients on any given day. To date, there has never been a staffing tool for Specialist Palliative Care. The closest tab from the Nursing Midwifery Workforce Planning Team has related to paediatrics. Please share a validated tool which can be used in this current climate. At no point did the team visiting congratulate the Hospice on surviving throughout the pandemic and ‘never dropping the ball’. We never closed to new referrals. However, we were restricted in terms of shared rooms. We never had to close any ward. The CEO and SMT immediately transformed their roles and methods of working to become completely clinically focussed and patient/family</td>
</tr>
<tr>
<td>Continuous</td>
</tr>
<tr>
<td>Recommendation e:</td>
</tr>
</tbody>
</table>
rationale for investigation. For example, without obtaining blood, how would we identify a circumstance of reversible hypercalcaemia or anaemia when there is evidence-based protocols in place to guide decision making. HIS have minimised the impact of dehydration in the elderly and the increased risk of earlier death and longer hospital stays in those who are admitted to hospital not hydrated compared to those who are admitted in a hydrated condition. When recently visiting the Hospice, the PICC team advised they would come to the Hospice for any of our patients. They advised the Hospice team knows what they are doing and look after the PICC lines beautifully. When asked about any criteria for insertion of a PICC line, the team advised that if cannulation was required more than three times, PICC could be considered appropriate. These are the experts in this field and there is absolutely no doubt they would ever insert a PICC line if it was thought to be inappropriate.

**Recommendation f:** The service should review patient care records and how information is displayed on the electronic record keeping system and improve how clinical care and pastoral care information is documented. Unfortunately the Inspection Team tasked with reviewing patient records had never used Crosscare previously and therefore it was a lack of knowledge and expertise as to how to filter information appropriately. Our recommendation to you is to make sure all inspectors reviewing patient records are competent in the use of the relevant electronic patient record. We acknowledge it is best to avoid duplication of information, however we also acknowledge, in terms of documentation, the more information the better.

| On-going | Director of Clinical Services and SMT |
you have, the better. And as is regularly noted in the Hospice, ‘if it is not written down, it is not done’ as would be important in a Court of Law. The electronic records have a particular design which cannot be customized; therefore, the display of information cannot be adapted. The Inspection Team noted the level of detail and documentation, is very high. The Inspection Team looked through a few of the patient records and found the level of documentation is extremely good and high. Furthermore, it is not sufficient to say “In most cases, we saw discussions about power of attorney, and about treatment escalation plans should a patient’s condition deteriorate. In relevant patient care records reviewed, a do not attempt to resuscitate form (DNACPR) was discussed and completed.” HIS need to give a % of cases as they have made a nebulous statement – “most cases” is not very scientific. The PoA audit was also reviewed at the inspection. The philosophy of treatment escalation plans is embedded in Hospice communication and decision-making processes, however, these are referred to as goals of care conversations and these are continually reviewed and aligned to patient wishes.

**Recommendation g:** The service should ensure a process is in place to contribute to and obtain appraisals for any staff members working under practicing privileges from their respective NHS employer.

We have one member of staff with practicing privileges who has worked at the Hospice for 20+ years. All staff, whether employed or with practising privileges, are appraised and we are involved in all nurses and doctors’ revalidation processes. In fact, the Hospice’s policy on
practicing privileges mirrors exactly the guidance provided by HIS (IHC Practising Privileges Checklist for Clinics – October 2020). We acknowledge the information which was shared informally by the Inspection Team during the inspection regarding the opportunity to contribute to/obtain information from the respective NHS employer however this feedback was not given as a formal recommendation on the day. We would refer to Form 4 guidance on NES.

In signing this form, you are confirming that you have the authority to complete it on behalf of the service provider.

<table>
<thead>
<tr>
<th>Name</th>
<th>Sister Rita Dawson MBE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designation</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>Signature</td>
<td>Sister Rita Dawson MBE</td>
</tr>
<tr>
<td>Date</td>
<td>31 / 10 /2022</td>
</tr>
</tbody>
</table>