Unannounced Focused Inspection Report: Independent Healthcare

Service: St. Andrew’s Hospice, Airdrie
Service Provider: St. Andrew’s Hospice

15 March 2021
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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 April 2018

Recommendation
*We recommend that the service should respond to issues identified in the staff survey in a timely manner.*

Action taken
The service had documented actions taken to address issues identified in the staff survey. The actions had appropriate timeframes, responsibilities and ongoing actions noted.

Recommendation
*We recommend that the service should ensure that planned team and ward meetings are held regularly.*

Action taken
We saw evidence that regular meetings had been held.

Recommendation
*We recommend that the service should develop the cleaning schedules in line with current guidance.*

Action taken
Cleaning schedules had been developed and implemented for the patient bed space, hospice environment and equipment.
2 A summary of our inspection

We carried out an unannounced inspection to St. Andrew’s hospice on Monday 15 March 2021. The purpose of the inspection was to make sure the service was delivering care safely to patients, in light of the COVID-19 pandemic. We reviewed the service’s infection prevention and control policies and procedures, and spoke with a number of staff during the inspection.

The inspection team was made up of three inspectors.

As part of this inspection, we did not request a self-evaluation from the service.

What we found and inspection grades awarded

For St. Andrew’s Hospice, the following grades have been applied to the key quality indicators inspected.

<table>
<thead>
<tr>
<th>Key quality indicators inspected</th>
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<tbody>
<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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<tr>
<td>Cleaning procedures followed current national guidance and appropriate assurance systems were in place to minimise the risk of COVID-19 transmission. Good supplies of personal protective equipment (PPE) were available. Clinical waste should be disposed of and stored correctly. Staff should not travel to work in uniform.</td>
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<td>✔️ Good</td>
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| **Domain 9 – Quality improvement-focused leadership** |
| 9.4 - Leadership of improvement and change |
| Good leadership and assurance structures were in place for leading and supporting staff and patients safely through the current COVID-19 pandemic. The risks from COVID-19 had been considered and actions had been taken to minimise the risk of transmission. |
| ✔️ Good |

The following additional quality indicator was inspected against during this inspection.
Additional quality indicators inspected (ungraded)

<table>
<thead>
<tr>
<th>Domain 5 – Delivery of safe, effective, compassionate and person-centred care</th>
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<tbody>
<tr>
<td>5.2 - Assessment and management of people experiencing care</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](http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/ihc_inspection_guidance/inspection_methodology.aspx)

**What action we expect St. Andrew’s Hospice to take after our inspection**

This inspection resulted in four recommendations. See Appendix 1 for a full list of the 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)

St Andrew’s 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 St Andrew’s Hospice for their assistance during the inspection.
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

Cleaning procedures followed current national guidance and appropriate assurance systems minimised the risk of COVID-19 transmission. Good supplies of personal protective equipment (PPE) were available. Clinical waste should be disposed of and stored correctly. Staff should not travel to work in uniform.

The service had developed comprehensive policies and procedures which described the control measures the service was taking to minimise the risks of COVID-19 transmission. This included policies and standard operating procedures in line with Health Protection Scotland’s national infection prevention and control manual.

Enhanced control measures had been put in pace to minimise the risk of COVID-19 transmission. These included:

- signage in key areas with reminders of expectations in relation to distancing, hand hygiene and sanitation of work spaces
- increased cleaning of the environment, patient equipment and frequently touched surfaces such as door handles
- alcohol-based hand rub available at appropriate points throughout the hospice
- personal protective equipment available, such as face masks, aprons and gloves for patient, staff and visitors’ use
- COVID-19 screening of all patients and essential visitors
- dedicated staff allocated to work in each ward to minimise cross-over, and
- restricted visitor access to the building.
Patients were cared for using either a red or green pathway. If a patient had either suspected or confirmed COVID-19 infection, they were cared for using the red (high-risk) pathway which required the use of enhanced PPE. The green pathway was used where patients did not have a suspected or confirmed COVID-19 infection. Staff reviewed the status of patients every day, with the update visible on the signage on each door. Since January 2021, this process had been adapted using the Health Protection Scotland COVID-19 guidance addendum using high, medium and low risk patient pathways and colour-coding patients red, amber and green.

During our inspection, all patients were cared for in separate rooms. Multiple-bedded bay areas had been reconfigured to accommodate only one patient in each area so every patient had access to their own bathroom facilities. Communal areas were closed off, including the sitting room, tranquility room and shop. We saw that all patients had signage placed on their door to remind staff and visitors of the appropriate PPE to be worn when entering the room. Where appropriate, new admissions to the hospice were tested for COVID-19 inside 24 hours of arrival. Newly-admitted patients were then nursed in isolation until the test result was returned as negative.

A person-centred approach for visiting had been adopted, with the individual views and needs of each patient central to any decisions. We were told that patients were allowed two visits a week, pre-booked in advance, from one designated visitor (or two from the same household). Visiting for each patient was reviewed daily, and increased if the patient’s clinical condition changed positively. Any visitors who wished to stay with the patient overnight must stay in the patient’s bedroom and use their en-suite facilities. For patients approaching the end of life, families were supported to remain with their relative.

Staff controlled access to the hospice and a designated PPE station had been set up at the main entrance. We were told that before entering the hospice reception area, visitors must sanitise their hands and put on a face mask. Visitors who arrived wearing fabric face coverings were asked to change to fluid-resistant face masks while in the clinical area. Visitors were provided with written information about the current visiting arrangements prior to admission and written guidance at the time of admission. All visitors were screened for symptoms of COVID-19 before each visit. Information about COVID-19 risks, symptoms and control measures was displayed throughout the service.

Measures had been put in place to help promote social distancing for staff. This included repurposing some areas to create additional staff changing areas and to increase office space. We also saw that some areas had signage to indicate the number of staff that could be in that area at one time. The service co-
ordinated staff break times to allow social distancing in staff dining areas. During meal breaks, we saw staff appropriately socially distancing and cleaning their environment before leaving the table.

Good hand hygiene facilities were in place. Clinical hand wash basins complied with current national guidance, hand soap and paper towels were available and alcohol-based hand rub dispensers had been provided. We saw that monthly hand hygiene audits were carried out to check and encourage good staff compliance with hand hygiene practice.

The care environment and patient equipment were clean and well maintained. We spoke with a wide variety of staff on duty who were able to describe the appropriate cleaning materials and dilution rates for chlorine-releasing disinfectant and detergent. We saw up-to-date cleaning schedules easily accessible to all staff. Housekeeping staff told us they had enough time and equipment to complete cleaning tasks and systems were in place to escalate any incomplete cleaning tasks. Nursing staff completed daily and weekly assurance checks of the cleanliness of the patient bed space, hospice environment and equipment.

During the COVID-19 pandemic, we were told that supplies of PPE had remained stable and was monitored to make sure enough was in stock. PPE dispensers were available in the hospice to make sure staff and visitors had quick and easy access to PPE.

We were told that weekly COVID-19 testing was carried out on staff and any with symptoms were immediately required to go home and isolate. We were also told of a vaccination programme for front line staff. The majority of staff had been vaccinated, with the remaining staff scheduled for their vaccinations.

Clean linen was being stored in a dedicated linen cupboard. All used linen was managed effectively and safely. Staff laundered their uniforms at home, at the highest temperature suitable for the fabric.

Aerosol-generating procedures present a risk of cross-infection to the environment, due to the fine spray of air or water they generate. Patients requiring aerosol-generating procedures were deemed high risk. Staff explained to us the processes in place to care and treat the patients who required aerosol-generating procedures, including the correct use of PPE.

The service used an electronic system for staff to report incidents or areas of concern in the environment. We were told that issues were quickly addressed. Weekly water flushing was carried out for the control of Legionella.
All staff had easy access to the electronic Health Protection Scotland national Infection Prevention and Control Manual this sat alongside the hospice’s own detailed standard operating procedures with regard to COVID-19 and other infectious diseases.

We saw that all staff had completed NHS Education for Scotland (NES) infection prevention and control training online, this addressed all aspects of the standard infection control precautions. Training was also available for the use of personal protective equipment. Staff completed refresher modules in infection prevention and control. We were told that the organisation also provided COVID-19 lunch and learn sessions for staff over the last 12 months.

What needs to improve
PPE stations has been set up throughout the hospice. However, no waste bins were available at the PPE stations for the disposal of used PPE (recommendation a).

Clinical waste was not stored securely in external waste containers as the containers could not be locked (recommendation b).

We were told that staff could wear their uniform if travelling directly to work in their own personal car. However, current national guidance advises that where changing facilities are available, staff should change into their uniform at work (recommendation c).

- No requirements.

Recommendation a
- The service should ensure that waste bins are provided at all PPE stations for the disposal of PPE.

Recommendation b
- The service should ensure that clinical waste is stored safely and securely in locked external waste containers.

Recommendation c
- The service should ensure that current national guidance is adhered to and staff should not travel to work in uniform.
Quality indicator 5.2 - Assessment and management of people experiencing care

COVID-19 information, including screening was clearly documented throughout each patient care record. This included test results, re-testing dates and the need for isolation if required. All sections of the patient care records should be completed and relevant information recorded.

Patients were tested for COVID-19 on admission to the hospice and then every 4 days after admission. Patients were required to isolate for 14 days after their admission in single en-suite rooms. We saw evidence that patient who were required to attend the local hospital for any investigations or follow-up procedures, remained in isolation on their return.

The five patient care records we reviewed were comprehensive and covered all aspects of patient care this included conversations with the patient and family with regard to the COVID-19 restrictions in place in the hospice. Patient care records contained information on infection prevention and control risks, assessment and COVID-19 care plans. We found essential nursing and medical assessments were thoroughly completed from the time of the patient’s admission to the hospice. This included assessments for nutrition, pressure ulcers and pain. Where relevant, we also saw anticipatory care documentation including the patient’s preferred place of care and preferred place of death. This included detailed, significant conversations with patients and their families over a period of time.

What needs to improve
A combined section in the patient care records was included to record patients’ consent to treatment and to share information with the next of kin. However, this was not completed in any of the five patient care records we viewed during our inspection. We discussed this with the service at the time (recommendation d).

- No requirements.

Recommendation d
- The service should ensure consent to share information with next of kin and or relatives and consent to treatment is recorded consistently in all patient care records.
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

Good leadership and assurance structures were in place for leading and supporting staff and patients safely through the current COVID-19 pandemic. The risks from COVID-19 had been considered and actions had been taken to minimise the risk of transmission.

The hospice had responded rapidly at the beginning of the government lockdown and had formed a COVID-19 committee. The committee included members of the senior management team as well as heads of department and members of the infection prevention and control committee. Outcomes from the COVID-19 committee were discussed at the integrated governance committee meetings carried out every 2 months.

From March 2020, the COVID-19 committee met daily and at the time of our inspection this had been reduced to a weekly meeting. From agendas for the committee meetings, we saw that each member was given an action and we were told that actions would usually be completed on the same day.

The infection prevention and control committee met every 2 months and was part of the weekly COVID-19 committee meetings. The infection prevention and control link nurse chaired the committee, which was made up of:

- chief executive officer
- housekeeping
- medical doctor
- Quality and governance manager, and
- ward manager.
We saw evidence that all staff were risk-assessed for COVID-19 in one-to-one discussions. Staff members then completed a Scottish Government-recommended COVID-19 age risk assessment. This risk assessment guided staff about where the service should place them.

The service had two electronic risk registers: a corporate register and a clinical register. These detailed all the high-level risks for the service and a brief summary of ongoing actions taken to reduce the risks. These included risks around the pandemic. Both registers were updated regularly.

The service recognised that some staff had to car-share to be able to travel to and from work and we saw a policy and process in place for this, to help make sure staff practice was safe. We saw that the service kept a secure record of all staff COVID-19 activity, including their dates of testing, vaccinations and if they required to car share.

We saw detailed regular informative letters to all furloughed staff throughout the pandemic, ensuring they continued to be updated in the changes being made by the organisation. Visitors also received regular letters giving updates about the visiting process during lockdown.

The staff were regularly emailed updates or given updates through a closed social media site. However, the service knew that some staff may require further support with updates and so line managers did this with staff who needed it. Staff were invited to attend reflective sessions that the hospice head of pastoral care carried out twice a month. This was an opportunity to support staff members who may be struggling during the pandemic.

We were told of positive changes in practice that had developed during lockdown. For example, nurses had been trained to administer certain medicines individually where previously this had involved two members of staff. This was found to be more beneficial to the patients and had proven to be a safer process of administering such medicines, with less incidents of error being made. We were told that the hospice had developed some staff members into ‘digital champions’ who could support patients when using digital appliances to keep in touch with their family and friends.

The hospice had developed a good working relationship with NHS Lanarkshire public health consultant. This gave senior managers direct access to consistent public health expertise and advice during the pandemic

- 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.

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<thead>
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<tbody>
<tr>
<td><strong>Requirement</strong></td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td><strong>Recommendations</strong></td>
</tr>
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**Domain 5 – Delivery of safe, effective, compassionate and person-centred care (continued)**

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<th>d</th>
<th>The service should ensure consent to share information with next of kin and or relatives and consent to treatment is recorded consistently in all patient care records (see page 11).</th>
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Health and Social Care Standards: My support, my life. I am fully involved in all decisions about my care and support. Statement 2.14
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.

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
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