Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: ACCORD Hospice, Paisley

Service Provider: ACCORD Hospice

21–22 July 2021

NHS SCOTLAND

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Contents

1 Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 8–9 August 2017

Recommendation

The service should ensure that a recognised wound grading tool is used to grade pressure ulcers.

Action taken

The service now used the Scottish adaptation of the European Pressure Ulcer Advisory Panel tool to grade pressure ulcers. We saw that this tool was in the patient's bedside documentation to promote its use.

Recommendation

The service should ensure correct recording of pressure ulcer development to make certain accurate data is collected.

Action taken

A pressure ulcer safety cross was used to record when pressure ulcers were inherited from another care setting or had developed in the service.

Recommendation

We recommend that the service should review the induction process for all staff to ensure a format that is role specific and records progress throughout the probationary period.

Action taken

This recommendation is reported in Quality Indicator 7.1.

Recommendation

We recommend that the service should develop an audit programme for all patient care information within the electronic care records. This will ensure that all patient care and treatment information is recorded correctly and consistently.

Action taken

We saw a regular programme of audits carried out, including patient care information in the patient care records. This showed good compliance.

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 ACCORD Hospice on Wednesday 21–Thursday 22 July 2021. We spoke with a number of staff, patients and carers during the inspection

The inspection team was made up of three inspectors.

As part of the inspection process, we asked the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Framework and ask the service to tell us what it does well, what improvements could be made and how it intends to make those improvements. The service submitted a comprehensive self-evaluation.

What we found and inspection grades awarded

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

Key quality indicators inspected		
Domain 2 – Impact on people experiencing care, carers and families		
Quality indicator	**Summary findings**	**Grade awarded**
2.1 - People's experience of care and the involvement of carers and families	The service followed its participation strategy in gathering feedback to identify patients' expectations and measure how well they had been met. Improvements were shared with staff and visitors in a variety of ways.	✓✓✓ Exceptional
Domain 5 – Delivery of safe, effective, compassionate and person-centred care		
5.1 - Safe delivery of care	Systems and processes were in place to make sure patients were cared for safely and effectively in a clean and safe environment. All housekeeping staff were trained as cleanliness champions to help make sure all	✓✓ Good

	cleaning processes were in line with standard infection control precautions. The environment and patient equipment were clean. Infection prevention and control policies should be specific to the hospice environment.	
Domain 9 – Quality improvement-focused leadership		
9.4 - Leadership of improvement and change	An excellent leadership and assurance structure was in place. Innovative processes and new strategic plans were in place to improve patient and families' experience of the service. We saw significant evidence of patient and staff participation in the day-to-day running of the hospice.	✓✓✓ Exceptional

The following additional quality indicator was inspected against during this inspection.

Additional quality indicators inspected (ungraded)	
Domain 5 – Delivery of safe, effective, compassionate and person-centred care	
5.2 - Assessment and management of people experiencing care	Patient care records were comprehensive and appropriate risk assessments were completed to inform patient care. We saw evidence of multidisciplinary team members reviewing patient care. The patient care record should be reviewed so that it meets the need of the service while safely and effectively supporting patient care.
Domain 7 – Workforce management and support	
7.1 - Staff recruitment, training and development	Systems and processes were in place to help make sure staff recruitment was safe and effective. Induction and appraisal programmes were in place. Staff were clear about the reporting structures in the service.

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 ACCORD Hospice to take after our inspection

This inspection resulted in two 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

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

We would like to thank all staff at ACCORD 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

The service followed its participation strategy in gathering feedback to identify patients' expectations and measure how well they had been met. Improvements were shared with staff and visitors in a variety of ways.

The service had a participation policy in place. A participation plan mapped patients' experiences and set out how the service gathered feedback through engagement with patients and carers.

The hospice had a patient participation group, a patient focus group and patient representation on the hospice governance groups. We saw evidence in minutes of meetings to demonstrate patients were involved in the interview panel and process for employing the new chief executive officer.

Regular feedback was also sought from patients and families in a variety of ways, such as through:

- art and alternative therapies
- questionnaires and surveys
- suggestion and feedback boxes in the hospice, and
- virtual meetings.

This information was recorded and reviewed from all service areas, such as day services and family support services.

The clinical nurse specialist service was based in the hospice 'community hub' and was involved in reviewing feedback to help improve the service. Staff gathered feedback from relatives, families and friends individually in the inpatient and outpatient areas. Outcomes of the discussions were shared with

staff through daily team meetings, newsletters and online information such as testimonials.

Traditional outpatient services were no longer available due to the COVID-19 restrictions. Patients could not attend the hospice. After consultation with staff members, inpatients and outpatients, the hospice offered the following services virtually:

- a 6-week activity programme which included light exercises, quizzes, games, group discussions and reiki
- a counselling service for patients and their relatives, and
- access to senior consultant clinicians for symptom and medication reviews.

The service was reviewing its 'traditional' befriending service at the time of our inspection and had decided to move to a 'buddies' service, to include:

- light home-help activities to assist patients in their own homes
- a basic housekeeping service
- neighbourly jobs, and
- a networking service

We observed staff engaging with patients and families. We saw evidence recorded to demonstrate the conversations between multi-agency staff and patients and their families before or on admission to the hospice inpatient unit. Conversations included:

- patient and family expectations, wishes, concerns, aspirations and what the hospice could realistically offer during their stay
- the particular life-limiting condition to the patient and realistic approach to palliative or end-of-life care
- living well until time of death
- preferred place of death
- symptom control, and
- pain control and alternative options to pain relief, such as alternative therapies massages.

Feedback we saw from inpatients and their relatives who had completed the service's survey consistently demonstrated that the services provided at the hospice met each patient's individual needs. Feedback also showed very high levels of confidence in staff and that patients felt treated with dignity and

respect. All patients and relatives we spoke with told us they felt valued, included and had been involved in discussions around care. Comments about their quality of care and experience included:

- 'I am able to be his wife again and not his carer.'
- 'The staff are all angels and every step I take they take it with me.'

The service carried out a patient and visitor survey once every 2 years. Results from the most recent patient and visitor survey reported compassionate care delivered across all services provided. The denominational and cultural services in the local area met the emotional and spiritual needs of patients. These services included:

- bereavement support
- children's support
- pastoral
- social, and
- spiritual.

All feedback was reviewed at 6 weekly staff meetings. From viewing the meeting notes, we saw that consideration was given to how the service could address the needs of these groups. This included:

- Patients accessing complementary services having the same routine and ritual every day.
- Patients helping to design new iron benches that a local steel company donated.

Areas where improvements had been made were visible in the hospice – 'you said we did' information was widely available.

Complaints, concerns and comments were discussed at monthly committee meetings along with actions, outcomes and learning or areas to improve.

The service had not received many complaints. However, information given to patients and their families advised that Healthcare Improvement Scotland can be contacted at any stage of this process.

- 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

Systems and processes were in place to make sure patients were cared for safely and effectively in a clean and safe environment. All housekeeping staff were trained as cleanliness champions to help make sure all cleaning processes were in line with standard infection control precautions. The environment and patient equipment were clean. Infection prevention and control policies should be specific to the hospice environment.

The environment was clean, well maintained and free from clutter. Housekeeping staff were up to date with infection prevention and control training as well as COVID-19 risks and cleaning methods. From completed cleaning checklists, we saw that general cleaning was carried out at least twice a day, in line with the hospice's revised cleaning procedures. We saw that housekeeping staff were using appropriate chlorine-based cleaning products for sanitary fixtures and fittings and colour-coded cleaning equipment. Staff cleaned equipment between each patient use and marked this with a sticker to confirm.

An external company laundered all patient linen off-site to make sure thermal disinfection washing was maintained in line with disinfection requirements.

Appropriate hand hygiene facilities were available and included clinical hand wash basins with hand soap and paper towels. Alcohol-based hand rub dispensers were also available throughout the hospice. We observed good compliance with hand hygiene from staff during our inspection.

Personal protective equipment (PPE) was appropriately stored close to where patient care was delivered. We saw good staff compliance with the use of this equipment, including face masks, nitrile gloves and aprons. Fluid-resistant surgical face masks were also readily available. During the inspection there

continued to be restricted access to the building for visitors due to the COVID-19 pandemic. PPE was readily available for staff and visitors to wear as appropriate.

Changing facilities were available on-site, with shower and toilet facilities. Staff uniforms were laundered on-site and stored appropriately.

We saw a comprehensive risk register in place which included COVID-19. The risk management team met every 3 months before the board meeting. Risks were discussed at the meetings and risk reviews allocated to staff throughout the hospice. Members of the risk management team included a wide range of staff from the senior management team to volunteers. Senior management reviewed accidents and incidents and compared these to other hospices. The learning from these was shared with all teams in the hospice.

Risk assessment reports were available to all staff. For example, we saw a risk assessment being completed for re-introducing volunteers to the service. Volunteer services were put on hold during the COVID-19 lockdown and Health Protection Scotland's COVID-19 age-risk assessment would be completed before reinstating the service.

We saw evidence of a comprehensive audit programme which prioritised infection prevention and control, as well as medicines management. Monthly audits of hand hygiene and PPE use showed good compliance. We saw audits carried out on anticipatory care planning and documentation of patients' power of attorney. We saw regular audits carried out on the single nurse drug administration. This is a process that allows a nurse to administer certain medicines that in the past would have required two nurses to carry out.

Medicine incidents meetings were held every 3 months as part of the risk management group. This allowed for feedback on incident investigation outcomes and learning to all clinical staff.

During the pandemic lockdown, the hospice experienced a small outbreak of COVID-19 among inpatient staff and patients. We saw evidence of a de-briefing document shared with all staff following the outbreak which included an action plan and lessons learned.

The hospice had created its own local infection prevention and control policy for staff, which included staff responsibilities and main safe guards for prevention of infection. A folder was also available that included the infection prevention and control standard operating procedures, based on NHS Greater Glasgow and Clyde policies. These documents were available to staff in the inpatient unit and online. Staff we spoke with knew where to find information. When asked staff

knew the 10 standard infection control precautions and the different dilution rates of chlorine-based cleaning products and when they were required.

The service's inpatient unit consisted of eight single en-suite rooms. Each room comprised of a specialist beds to manage pressure areas, an in built hoist and facilities for families to stay. Each room had access to the outside patio. All these measures ensured a safe environment for patients, families and staff.

Patients and families commented on this facility. Comments included:

- 'I can even get outside into the sunshine in my bed.'
- 'Being able to get outside is just wonderful.'

Oxygen and suction apparatus were portable and readily available in the event of an emergency situation. This apparatus was checked regularly to make sure it was in working order.

What needs to improve

The folder with the infection prevention and control standard operating procedures from NHS Greater Glasgow and Clyde included information that was not applicable to the hospice environment (recommendation a).

- No requirements.

Recommendation a

- The service should ensure that the hospice infection prevention and control policies relate specifically to the hospice.

Our findings

Quality indicator 5.2 - Assessment and management of people experiencing care

Patient care records were comprehensive and appropriate risk assessments were completed to inform patient care. We saw evidence of multidisciplinary team members reviewing patient care. The patient care record should be reviewed so that it meets the need of the service while safely and effectively supporting patient care.

With the exception of those kept in the patient's bedside folder, patient care records were in electronic format. Patient information, such as their next of kin contact details were recorded consistently entries were legible. Consent to

discuss their care with their next of kin or other health professional was recorded in the patient care records we reviewed. The electronic patient care records were password-protected and each member of staff had their own individual log in.

Patients had a number of risk assessments carried out, including a Waterlow and Pressure Ulcer Daily Risk Assessment (PUDRA) for pressure area care and canard risk assessment for falls. We saw that, where appropriate the majority were carried out on admission. We saw that after completion of the risk assessments, a patient care plan was generated with a date for when the care plan was to be reviewed. Risk assessments had been repeated and care plans reviewed.

The service did not have a separate anticipatory care document. However, patient care records had entries for anticipatory care, such as do-not-attempt-cardiopulmonary-resuscitation (DNACPR) decisions and the patient's preferred place of care and death. Staff were able to locate this information in the patient care record. One patient care record we reviewed had appointed a power of attorney. We saw that an electronic copy of the power-of-attorney document had been attached to the patient care record to make sure staff were aware of it.

We were told that staff were kept up to date on patient care through daily ward rounds and at commencement of shifts. We attended the morning hospice huddle where inpatients, possible admissions and patients in the community were discussed. We saw that staff from different specialties, such as community nurses and physiotherapists were involved in the huddle so that the patient received the appropriate input.

We saw that patients were reviewed each day on a ward round, and this was recorded in the electronic patient care record. We also saw that nursing entries were made each day and covered various aspects of the patient's activities of daily living. Clear medical management plans were recorded in the patient care record and anticipatory medications were prescribed. While the service had decided not to use a formal pain assessment chart, we saw regular entries in the patient care records where the patient's pain was considered.

Patient care record entries showed that the multidisciplinary team reviewed and made inputs to care where appropriate. Patients could also receive input from community dieticians if required. Discussions with families were also recorded.

Some paper documents were still used, such as the patient's drug prescription charts and a pressure area care intervention chart. These documents were kept

outside the patient rooms so that care could be recorded after being delivered. SSKIN charts were well completed. Other patient documentation, such as consultation letters and DNACPR forms were kept in a filing cupboard in the duty room.

The service's audit programme included a patient care records audit report published in February 2021 and showed good staff compliance. All staff had access to this report.

What needs to improve

The service had identified that some parts of the electronic system could be difficult to use and had a process to allow them to review and improve its ease of use. We were also told that other electronic care record systems were being considered to replace the existing system.

The service used the electronic record for wound care. However, it was considering introducing a paper-based version that staff felt was clearer. 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

Systems and processes were in place to help make sure staff recruitment was safe and effective. Induction and appraisal programmes were in place. Staff were clear about the reporting structures in the service.

We reviewed six staff files which were in paper form and generally well organized. We saw evidence of effective recruitment in the majority of the files, any gaps in the staff files were highlighted at the time of the inspection. Recruitments checks included:

- obtaining references
- checking the protecting vulnerable groups (PVG) status of the applicant, and
- checking where appropriate the staff members' professional registration.

The service contracted a third party to obtain PVG checks and we saw a system in place to record the PVG information. Staff files had a checklist to help make sure that appropriate recruitment checks had been carried out.

All staff employed had an induction to the service, including an introduction to key members of staff in the service, statutory and mandatory training and role-specific training. The staff member kept the document so they could update it with their progress. We were told that new staff were allocated a mentor, the length of the mentorship changed based on the skills, knowledge and experience of the new member of staff.

The hospice's own staff delivered most of the training in-house. We were told that a study day to update staff on pressure ulcer care had been organised for clinical staff. This topic had been added to the yearly mandatory training programme.

We saw that appraisals had been carried out for all inpatient staff for the previous year, and that planning for 2021 appraisals had started.

Staff we spoke with were clear about their roles and the reporting structures in the service.

What needs to improve

The service carried out the appropriate checks and had a written agreement with staff who worked under practicing privileges. However, the service did not have a policy to guide the process. We were told that the senior management team had been given a draft policy to approve. We will follow this up at future inspections.

We discussed with the service how the staff files could be further improved. The service told us that it was investigating an electronic system to improve the management of staff files. 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

An excellent leadership and assurance structure was in place. Innovative processes and new strategic plans were in place to improve patient and families' experience of the service. We saw significant evidence of patient and staff participation in the day-to-day running of the hospice.

We saw evidence of regular monthly senior management meetings. These meetings were held daily during the COVID-19 lockdown. Management recognised the high anxiety that staff experienced and made sure they had regular updates, including online video-conferencing to staff working from home.

At the time of our inspection, we saw from minutes that the senior management team met monthly and actions were agreed to address issues discussed. For example, we saw actions agreed to react to changing COVID-19 guidance and update strategic plans. A board meeting was held every 3 months and was informed by feedback from:

- finance meetings
- governance meetings
- risk management meetings, and
- senior management meetings.

We were told that informal meetings were also held every day between the manager and the chief executive

We were informed of the plans to update and change services as part of the re-mobilisation strategy as COVID-19 restrictions ease. The service had changed practice during the lockdown to ensure patients and staff remained safe. Some of these aspects of change were found to be preferable for some and will

continued to be used and developed further. The national lottery donated some funding for the changes.

We were told the plan to adapt services came from speaking with patients and families who contributed their opinions and ideas for improvement.

The hospice's original strategic plan had to be put on hold due to the pandemic, as a result the hospice has created a 12-month strategy to allow safe passage out of lockdown. Some key projects planned to be delivered include:

- developing a volunteering strategy
- delivering a new, community model of care
- extending the service's bereavement network
- a staff wellbeing and communication plan, and
- embedding a new website and intranet to support external and internal communications.

Results from a staff survey carried out every 2 years were published in a variety of formats, such as newsletters, in minutes and staff noticeboards. Staff morale, culture, training, development and 'wishes' were considered. The staff survey was scheduled to take place later in 2021.

We were told of the staff forum which had taken place every 6 weeks since the COVID-19 lockdown. This involves a representative from every team. All staff contribute to the agenda. We saw evidence of minutes taken. Although this forum may include members of the senior management team, the main aim is to involve all other staff allowing for regular ongoing communication. Examples of subjects discussed included pension advice, senior management updates, and staff coaching sessions. We saw evidence of the forum evaluation and staff felt this was a positive development in staff communication and is likely to continue.

The service told us it was considering the introduction of '360 degree feedback' This is a process of gathering individual employee feedback from colleagues and peers to inform the staff appraisal process.

We spoke with staff from the education department and saw a yearly programme of education and training for all staff that included statutory and mandatory training. We were told of the annual medicine management updates for all registered nurses. This was four sessions carried out through video-conferencing from the hospice and included staff from five other hospices within NHS Greater Glasgow and Clyde. The programme was delivered five

times over 10 months. Feedback from staff involved showed positive learning outcomes.

The hospice also delivered resilience support and training to external services using video-conferencing. This included support to local care homes and the local intensive care unit during the COVID-19 pandemic. The hospice planned to develop an ongoing regular programme of support and learning to external services using the video-conference format.

The hospice had trained all housekeeping staff to be cleanliness champions, providing an excellent resource on infection prevention and control for all staff to access. The hospice was supporting a registered nurse in training in advanced nursing in palliative care.

The hospice was involved in Hospice UK benchmarking, which allows it to be compared with other hospices of a similar size in, for example:

- bed occupancy
- falls
- incidents, and
- patient safety.

This was discussed at board level and showed that the service compared similarly to others. This provided assurance to the service and was used to inform ongoing learning.

The senior management team and board had given all staff a recognition award from the hospice during the COVID-19 lockdown. The team of volunteers enjoyed an online afternoon tea as a 'thank you' from the board. Staff we spoke with felt the senior management team regularly updated and supported them. Staff also commented that they enjoyed working for the service and felt the senior management team was always visible and approachable.

What needs to improve

While the senior management team met monthly to discuss issues on guidance or strategy and improvements to the service had been made, formal action plans were not created (recommendation b).

- No requirements.

Recommendation b

- The service should develop improvement action plans to address issues identified. These should document the person delegated to complete the action and timeframes for completion.

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	
Requirements	
	None
Recommendation	
a	The service should ensure that the hospice infection prevention and control policies relate specifically to the hospice (see page 13). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11

Domain 9 – Quality improvement-focused leadership	
Requirements	
	None
Recommendation	
b	The service should develop improvement action plans to address issues identified. These should document the person delegated to complete the action and timeframes for completion (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

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.

Before

During inspections

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.

During

After inspections

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

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

We check progress against the improvement action plan.

After

More information about our approach can be found on our website: www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.aspx

Complaints

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Telephone: 0131 623 4300

Email: his.ihcregulation@nhs.scot

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or email his.contactpublicinvolvement@nhs.scot

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