Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Rachel House Children's Hospice, Kinross

Service Provider: Children's Hospices Across Scotland

16–17 October 2023

This report is embargoed until 10.00am on Monday 11 December 2023

NHS SCOTLAND

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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 27 October 2020

Recommendation

The service should follow the guidance in Health Protection Scotland's National Infection Prevention and Control Manual for the recommended product for cleaning sanitary fittings.

Action taken

We saw that an appropriate chlorine-based cleaning product was now being used for cleaning sanitary fittings.

Recommendation

The service should ensure COVID-19 pre-assessments are recorded consistently in patient care records.

Action taken

From the four patient care records we reviewed, we saw that discussions with families addressing aspects of care before a child's admission were fully documented. This included an assessment of COVID-19, such as asking about any recent symptoms in the family.

Recommendation

The service should ensure all families have adequate COVID-19 guidance and information before admission and during the discharge process.

Action taken

From the four patient care records we reviewed, we saw that guidance and information about COVID-19 symptoms were provided to families before a child's admission and during the discharge process, where applicable.

2 A summary of our inspection

Background

Healthcare Improvement Scotland is the regulator of independent healthcare services in Scotland. As a part of this role, we undertake risk-based and intelligence-led inspections of independent healthcare services.

Our focus

The focus of our inspections is to ensure each service is person-centred, safe and well led. We evaluate the service against the National Health Services (Scotland) Act 1978 and regulations or orders made under the Act, its conditions of registration and Healthcare Improvement Scotland's Quality Assurance Framework. We ask questions about the provider's direction, its processes for the implementation and delivery of the service, and its results.

About our inspection

We carried out an unannounced inspection to Rachel House Children's Hospice on Monday 16 and Tuesday 17 October 2023. We spoke with a number of staff and families during the inspection. We received feedback from 50 staff through an online survey we had asked the service to issue to staff on the day of the inspection.

Based in Kinross, Rachel House is an independent hospital (a hospice providing palliative care/end of life care).

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For Rachel House Children's Hospice, the following grades have been applied.

Direction	*How clear is the service's vision and purpose and how supportive is its leadership and culture?*
Summary findings	**Grade awarded**
The service's strategic plan set out clear definitions and ambitions to support children and families in the hospice, in hospital and at home. Key performance indicators helped to measure how the service performed and continued to improve. A wide range of meetings was held to support all aspects of delivering person-centred care for children and families. Staff told us senior management were visible and approachable.	✓✓✓ Exceptional
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
The service was very focused on ensuring children and families were included in ongoing improvements in the service, and feedback was constantly sought and reviewed. The service also worked closely with hospitals across Scotland to deliver palliative care to children. A range of policies and standard operating procedures helped to support safe, person-centred care. Key staff roles had been developed to support the needs of children. An audit programme and quality strategy, as well as good risk management systems, helped to ensure the safe delivery of care. Incident investigations must be fully completed, and include lessons learned or actions to be taken. Relevant information from incidents should be fully documented in patient care records.	✓✓ Good
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The environment was clean and in a good state of repair. We saw a lot of fun activities taking place with children. Families told us they really appreciated the staff and how they felt fully supported by the service. Staff told us they enjoyed working in the service. Consent to treatment should always be obtained.	✓✓ Good

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

Further information about the Quality Assurance Framework can also be found on our website at: https://www.healthcareimprovementscotland.org/scrutiny/the_quality_assurance_system.aspx

What action we expect Children's Hospices Across Scotland to take after our inspection

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.
- **Recommendation:** A recommendation is a statement which sets out what a service should do in order to align with relevant standards and guidance.

This inspection resulted in one requirement and three recommendations.

Implementation and delivery	
Requirement	
1	The provider must ensure that incident investigations are fully completed, including documenting any resulting lessons learned or actions to be taken (see page 18). Timescale – immediate *Regulation 13(2)(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

Implementation and delivery (continued)	
Recommendation	
a	The service should ensure that an incident investigation process and learning outcomes are always fully documented in the relevant patient care record (see page 18). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Results	
Requirements	
None	
Recommendations	
b	The service should ensure it obtains consent for treatment for every child on admission (see page 23). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
c	The service should ensure a process of yearly checks are completed on all staff who have individual insurance policies (see page 23). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

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

Children's Hospices Across Scotland, the provider, must address the requirement and make the necessary improvements as a matter of priority.

We would like to thank all staff at Rachel House Children's Hospice for their assistance during the inspection.

3 What we found during our inspection

Key Focus Area: Direction

Domain 1: Clear vision and purpose	Domain 2: Leadership and culture
How clear is the service's vision and purpose and how supportive is its leadership and culture?	

Our findings

The service's strategic plan set out clear definitions and ambitions to support children and families in the hospice, in hospital and at home. Key performance indicators helped to measure how the service performed and continued to improve. A wide range of meetings was held to support all aspects of delivering person-centred care for children and families. Staff told us senior management were visible and approachable.

Clear vision and purpose

The service is part of the Children's Hospices Across Scotland (CHAS) charity providing essential care for children who have life-limiting conditions, including end of life care. The service provides inpatient and outpatient care, care at home and a care support service for children in hospital. Rachel House has a clear vision of supporting families through difficult times knowing their child's condition may deteriorate. It provides a compassionate, person-centred approach to and for families during and after their child's life.

This vision supported the service's aims and objectives which included new core values of:

- helping all family members to make the most of the time they spend together
- encouraging children and families to help the service to provide high standards of person centred care
- providing a loving environment that promotes dignity and inclusion, and
- helping children to learn through play and to achieve their goals.

The service's aims, objectives and core values informed its service delivery and performance indicators using key measures for:

- admissions
- number of nights children remained in the hospice
- occupancy percentages
- use of the rainbow room (room used for children who have died), and
- CHAS at Home team, including home visits.

The service's strategic plan 2020-2024 included key priorities, for example:

- how the hospice recovered from the COVID 19 pandemic in order to re-open beds to increase respite care
- increasing support to families while children were in hospital across Scotland, and
- increasing services being delivered in family homes and the community.

The service produced a Board report every 3 months. This report was developed by the chief executive with input from the senior leadership team and relevant managers, and was shared with the Board Trustees. Information from these reports was also included in the service's annual report detailing updates on key elements such as progress against the key priorities detailed in the service's strategic plan.

- No requirements.
- No recommendations.

Leadership and culture

The service had a highly skilled staffing resource which consisted of children's specialist palliative care consultants, medical staff, advanced nurse practitioners, paediatric palliative care nurses, physiotherapists, pharmacists, activity staff, chaplain and a newly appointed social worker. This staff group ensured all aspects of the child and families' needs were being met.

We saw evidence that the new strategic plan for 2024-2028 was being developed with the service engaging with many more families than ever before. This gave them the opportunity to tell their own stories and say what was important to them. We were told the service's new family involvement lead had been instrumental in increasing engagement with children through art and storytelling.

The service's governance structure included a number of clinical and care governance groups. These included:

- board of directors
- clinical and care governance committee
- care services governance group
- care services operational governance group, and
- corporate governance.

We saw that various groups and processes informed these governance groups, such as risk management, child and family feedback, and staff training and education.

These meetings included representatives from all grades of staff. Key information from these meetings was circulated to all staff using a variety of methods, such as team meetings and newsletters.

Daily meetings (huddles) took place between all staff groups, including care at home staff, to discuss planned admissions and discharges, children and their families, planned activities and any other issues identified. These meetings could be attended in person, or staff who were either working from home or working in another area could join remotely.

The service's medical director had been involved in the planning stage for two new palliative care consultants to attend specific paediatric palliative care training in England. This will increase the medical staff expertise ensuring there is a 24-hour service for all children with life-limiting conditions across Scotland.

The service worked collaboratively with other children's hospices across Great Britain and Ireland. This included hosting events, and supporting and encouraging staff to attend events to review service development, family involvement and funding.

We were told the service was planning a significant refurbishment in the coming year and planned to visit children's hospices in England to review how they delivered and continually improved their services. This refurbishment will help the service to deliver an improved experience for children and families and enhance the way care is delivered.

Staff were encouraged to participate in the development of the service. Staff told us in the online survey:

- ‘The organisation takes time to have frequent development sessions with staff from all levels.’
- ‘As employees we are able to give opinions and put ideas forward.’

Staff we spoke with told us they felt supported in their role. They said the senior management team was always visible and approachable. Staff who completed our online survey told us:

- ‘There are always members of the senior leadership team around during the day. They are very approachable and there if you need help or advice.’
- ‘The senior leadership team are a visible presence within the organisation and will chat to all staff.’

- No requirements.
- No recommendations.

Key Focus Area: Implementation and delivery

Domain 3: Co-design, co-production	Domain 4: Quality improvement	Domain 5: Planning for quality
How well does the service engage with its stakeholders and manage/improve its performance?		

Our findings

The service was very focused on ensuring children and families were included in ongoing improvements in the service, and feedback was constantly sought and reviewed. The service also worked closely with hospitals across Scotland to deliver palliative care to children. A range of policies and standard operating procedures helped to support safe, person-centred care. Key staff roles had been developed to support the needs of children. An audit programme and quality strategy, as well as good risk management systems, helped to ensure the safe delivery of care.

Incident investigations must be fully completed, and include lessons learned or actions to be taken. Relevant information from incidents should be fully documented in patient care records.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The service was very focused on ensuring children and families were included in ongoing improvements in the service. For example, a new family involvement lead role had been developed who was responsible for raising the voices of children and their families. The service was proactively ensuring that their opinions and views were heard and would be included in the development of the new strategic plan. This had involved families from the moment of diagnosis and referral to the point of post-bereavement support.

Throughout the service, we saw evidence of children and families being asked about their opinion and experiences. This included completing small postcards and posting these in boxes throughout the service. We saw comments were then displayed in the inpatient unit as 'leaves' on a tree. Feedback from children and families was gathered by the quality team and fed back to staff. For example, several children had suggested the building of a swimming pool in the future. We were told that feedback such as this would be used as a point of reference when developing architectural plans for future refurbishments.

Children and families had been involved in interview panels to recruit senior staff, and then provided the new recruits with tasks to complete. For example, when a play assistant was recruited, a child was nominated to show them round the service and then to participate in play activities with them.

The service used the 'Care Opinion' website to source feedback from the general public as well as people who used the service. Responses posted on this website were visible for anyone to view.

Information leaflets were readily available both at reception and throughout the service. These included information on music therapy and 'enabling' holidays which supported families to have holidays with wheelchair users. Families were also supported with energy efficiency measures at home, helping to keep electricity bills manageable.

Information was available for staff on staff noticeboards about accessing counselling services from an external company. There was also information for staff on managing workplace wellbeing and relaxation.

Both families and staff had access to free meals in the service. Staff were also paid for their lunch break.

The service was currently working with the University of Strathclyde on a research project funded by the UK Arts and Humanities Research Council. Staff will work with children's siblings to help understand their perspectives on wellbeing and care.

The provider had developed a 'Diana Children's Nurse' role who worked with NHS staff in children's hospitals across Scotland. They helped to provide palliative care to children and families, and supported staff by delivering training and education. This is a good example of effective partnership working.

- No requirements.
- No recommendations.

Quality improvement

We saw that the service clearly displayed its Healthcare Improvement Scotland registration certificate and was providing care in line with its agreed conditions of registration.

The service manager knew how and when to submit notifications to Healthcare Improvement Scotland, for example to report changes to the service or adverse events and incidents. We saw that several notifications had been submitted, as appropriate.

We noted that the service had recently produced a report reflecting on an adverse event and lessons learned for a child who was known to the service who was admitted to hospital and subsequently died. This report was shared with the NHS board.

The service had an extensive range of policies and standard operating procedures to support safe, person-centred care. This included:

- child protection
- health and safety
- infection control
- resuscitation, and
- medicines management.

We noted that all key policies had been reviewed within stated timeframes, and clear dates for their next review were identified. There was also a comprehensive list of procedures and guidelines specific to the service, including:

- confirmation of death
- complementary therapy
- anticipatory care guidelines, and
- oral hygiene guidelines.

The service had a duty of candour policy (where healthcare organisations have a professional responsibility to be honest with people when something goes wrong). We saw that the service had published a duty of candour report on its website within the last year, and copies were also available in the service. We noted that the service had not experienced any incidents that required it to follow the duty of candour process.

The service's complaints policy included information that Healthcare Improvement Scotland could be contacted at any stage of the complaints process. We reviewed one complaint from a child's parent about the standard of care and communication. We saw that the service followed its policy and changed its processes to make sure that bereaved families would not be contacted unless by prior agreement.

The housekeeping staff rota clearly identified the different responsibilities for each staff member on a daily basis. The team meet at the start of every shift to go over their duties for the day. If there were staff shortages, the rota clearly highlighted which tasks were to be prioritised that day.

Throughout the service, there was extensive signage and instructions covering infection prevention and control practices, including:

- hand hygiene
- how to separate different categories of laundry, including contaminated, hazardous or suspected infectious laundry
- waste, and
- cleaning of rooms, equipment and common areas.

We saw that the service was using appropriate cleaning materials, for example chlorine-based products for sinks and baths. There was also clear signage to specify different washing temperatures for washing machines and the sluice.

During the inspection, we saw the hydrotherapy pool water was being tested by the maintenance manager. We saw a schedule for daily cleaning and weekly testing of the pool, and noted this was carried out in line with the manufacturer's instructions.

A thorough system was in place for reporting and following up on any adverse events, incidents and accidents. All incidents were documented, reviewed and signed off through an electronic system. Incidents that had occurred had been appropriately reported to Healthcare Improvement Scotland. We reviewed the process and documentation for two incidents that had occurred in the last year. We saw that appropriate communication took place with hospice management and staff following these incidents.

Patient care records were completed and stored on a secure electronic system which was password protected. There was a thorough process documented throughout the child's admission to the hospice. This included the child's contact details, next of kin and GP details. There was also a contact list of all

external professionals involved in the child's care. The provider was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights).

A significant number of children and families were well known to staff and had been admitted to the service on a number of occasions throughout the years. Therefore, a number of documents remained in place and were reviewed before and during each admission, for example consent to share information and emergency care. These would be updated every year or when the child's condition changed.

Staff were nominated as 'key workers' for specific children and families. The key worker contacted the family before admission to check on any changes to the child's condition, medicines or care needs, for example the use of non-invasive or invasive ventilation, and to discuss aims for the child's admission.

On admission, the child's information was rechecked, including information on emergency care and medicines. Children used their own supply of medicines whilst an inpatient. Aspects of consent were also reviewed and discussed.
A number of documents were stored both on the electronic system and used as a paper copy. The electronic patient care records highlighted specific aspects of daily care, for example sleep and rest, posture and nutrition. This gave staff quick and easy access to specific information. Guidance was available should staff have questions about how to complete the patient care records. We were told there was a process of ensuring all paper copies were scanned into the electronic records. All paper copies were stamped with the date they were scanned.

A process was in place to ensure that suitably qualified staff were recruited safely. All staff files were stored on a password-protected electronic human resources system. Appropriate pre-employment checks were completed, including references and an update of the Disclosure Scotland Protecting Vulnerable Groups (PVG) check. The service had developed a skills and qualification tool for new staff members highlighting training that had been undertaken, for example on the use of oxygen, suction and nebulisers (a machine that changes medicines into a fine mist to allow it to be breathed in). The qualification tool allowed managers to determine the training needs for each individual during their induction period and who to allocate as their 'buddy'. This was a member of staff available to support the new staff member in their role.

The service had developed a classroom style induction programme. This was carried out over a week and involved staff from both Rachel House and Robin House, Balloch. A full programme of training was carried out, including infection

prevention and control, seizure management and an introduction to the service's staff intranet system. Staff were involved in delivering the training sessions and new staff members completed an evaluation of the induction.

The service provided yearly 'safe working days' which allowed staff to update their mandatory training such as infection control, moving and handling, and using syringe drivers. Mandatory training was completed by all staff. Where necessary, additional role-specific training was provided by external trainers, for example high flow oxygen training and ventilation training. The service had various inhouse training programmes, including a leadership development and training programme.

Every 6 weeks, key workers would be allocated an administration day which took them out of the clinical environment and allowed them time to contact families to check in with them, or to take time for their own training. For example, staff could update on documentation, care of intravenous (IV) lines or bereavement care and they also had the opportunity to take part in clinical supervision. This involves staff reflecting on their practice and developing learning from this. Staff we spoke with told us they found these days useful.

What needs to improve

We reviewed the service's investigation of an incident involving the omission of a routine medicine. We saw no evidence of any documented learning outcomes or an action plan from this investigation (requirement 1).

One of the adverse incidents we reviewed was only partially documented in the relevant patient care record (recommendation a).

We were told that, at times, the administration day for key workers was postponed due to staffing issues. Staff we spoke with told us they found the administration days were very useful. We will follow this up at a later date.

Requirement 1 – Timescale: immediate

- The provider must ensure that incident investigations are fully completed, including documenting any resulting lessons learned or actions to be taken.

Recommendation a

- The service should ensure that an incident investigation process and learning outcomes are always fully documented in the relevant patient care record.

Planning for quality

We saw that the service maintained an electronic register of risks and risk assessments that demonstrated all risks identified, their status (high, medium or low risk) and review dates. Examples of risk assessments we saw included:

- spillages
- needlestick injuries
- slips and falls
- clear pathways on stairs and in corridors, and
- cleaning play areas.

We also saw assessments were carried out of any temporary risks identified. For example, a risk assessment had taken place of the laundry room where the outlet pipe for the gas supply to the washing machines did not meet current standards. Appropriate interim measures were being taken until the pipe was repaired.

We saw the service's fire safety policy and noted that a fire inspection and report was produced within the last year. The fire inspections were carried out by an external provider. The policy included evacuation arrangements for different parts of the building. We were told the newly installed fire doors had still to be checked and approved by the fire inspectors. Therefore, the service was in the process of drawing up a temporary evacuation plan as part of a risk assessment.

Maintenance staff kept a record of general fire safety checks, including fire, smoke and heat alarms, and monthly evacuation drills. We were told these tests and drills may be irregularly carried out as there may be children admitted with conditions that made them noise-sensitive. This meant that safety checks would only be carried out when those children were not present.

The service had an extensive clinical and non-clinical audit programme which was included in the service's quality strategy. This covered areas such as patient care records, medicines, equipment maintenance and cleaning. An audit programme was in place, which detailed frequency, dates when audits were carried out and dates for next review.

As well as an internal audit programme, we saw an example of an independent safeguarding audit of the service carried out in October 2022 by the Social Care Institute for Excellence (SCIE). The audit highlighted the commitment from staff in providing the best care to children and families, and recognised their knowledge of safeguarding. The SCIE advised on ensuring that safeguarding is

embedded in all aspects of the service, including governance structures and quality improvement processes. Staff we spoke with told us that experiencing this process had been beneficial.

A dedicated team was responsible for the safe running and maintenance of the technical aspects of the service, including:

- electrical maintenance, including portable appliance testing (PAT) of equipment
- gas maintenance
- water testing (hydrotherapy pool), and
- building security.

Most maintenance was carried out by contractors, and we saw contracts in place for this. Water testing was carried out by one member of the maintenance team, who was currently the only person qualified to do this. We were told other members of the team were in the process of completing the relevant training.

The service's quality strategy included a list of improvements carried out and those that were planned. Improvements included those identified as part of refurbishment plans, as well as those identified as a result of audits, or from input or feedback from families. Examples of recent improvements made included:

- improving communication with families before children were admitted to the service
- attaching soft cushioned barriers to windows in play areas to prevent accidental falls by children, and
- providing laundry facilities for parents.

- No requirements.
- No recommendations.

Key Focus Area: Results

Domain 6: Relationships	Domain 7: Quality control
How well has the service demonstrated that it provides safe, person-centred care?	

Our findings

The environment was clean and in a good state of repair. We saw a lot of fun activities taking place with children. Families told us they really appreciated the staff and how they felt fully supported by the service. Staff told us they enjoyed working in the service. Consent to treatment should always be obtained.

Every year, we ask the service to submit an annual return. This gives us essential information about the service such as composition, activities, incidents and accidents, and staffing details. The service submitted an annual return, as requested. As part of the inspection process, we ask the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Assurance 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.

From an extensive tour of the building, we saw that all areas were clean. The service used an extensive variety of equipment, some used specifically for moving children, for example:

- adjustable baths
- adjustable beds in children's rooms, and
- lifting hoists for baths and beds.

We saw that equipment used through the service was clean and well-maintained. Cleaning staff we spoke with demonstrated their knowledge of national infection prevention and control standards, such as using appropriate cleaning materials for baths and sinks. Sinks and taps in children's rooms met current standards. Kitchen staff were responsible for cleaning the kitchen area. All cleaning and maintenance was documented and signed by the staff responsible.

We saw personal protective equipment, such face masks, aprons and gloves throughout the service and in children's rooms. The service had recently updated its COVID 19 policy to reflect current guidance.

Throughout the service, we saw children's art work on the walls, children going out on excursions, families enjoying meals together and children enjoying the play activities taking place in the inpatient unit. We saw evidence of good fun and good interactions between families and staff. Parents also had the opportunity to take part in complementary therapies, for example massage or reiki.

We reviewed four patient care records and saw a thorough process of documentation in place. All records reviewed included the appropriate contact details of the family, GP and other healthcare professionals. Before admission, staff had been made aware of changes that may have occurred at home (for example, in medication doses) or of specific treatments (such as tube feeding). From the day of admission, each child had a thorough medical and nursing assessment documented. This included an assessment of their condition, all aspects of their care and current routine medicines. Throughout the patient care records reviewed, we saw documented evidence of regular conversations with the family. We saw that each child had an emergency care plan completed, which highlighted the appropriate actions to take in the event of a deterioration in their condition. We saw all members of the multidisciplinary team contributed to the patient care records.

During the inspection, we attended a handover of information meeting which involved some members of the multidisciplinary team. All staff members contributed to the discussions about each child currently in the service.

We reviewed five staff files and saw relevant background checks were fully completed. Most staff were employed by the organisation. One member of staff had an 'honorary contract' which allowed them to work in the service while also working for an NHS board. We saw that all relevant recruitment checks were carried out fully for this staff member.

Staff we spoke with told us they enjoyed working in the service and felt supported in their team. Staff who completed our online survey told us:

- 'The team work well together, supporting different areas when needed.'
- 'As part of a team I can influence good practice within my team.'
- 'Staffing levels can be an issue at times due to a variety of reasons however the staff are flexible to meet the needs of the service.'

Families we spoke with told us:

- ‘This is the only place we feel (our child) is safe.’
- ‘I’m not sure they (Rachel house staff) realise how wonderful they are.’
- ‘Staying at the hospice, they (staff) take care of medicines and meals so we can be parents again.’
- ‘They are always open to suggestions and improvements. For example, before we attend the hospice, they contact us to ask if there has been any changes to medications, as this caused confusion before.’

What needs to improve

While a consent form was completed and signed by parents, this only referred to the sharing of information with external services. This should also include consent to treatment (recommendation b).

When we reviewed staff files, we found that one member of staff’s individual insurance policy had not been checked in 2 years (recommendation c).

- No requirements.

Recommendation b

- The service should ensure it obtains consent for treatment for every child on admission.

Recommendation c

- The service should ensure a process of yearly checks are completed on all staff who have individual insurance policies.

Appendix 1 – About our inspections

Our quality assurance system and the quality assurance framework allow us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this system 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: https://www.healthcareimprovementscotland.org/scrutiny/the_quality_assurance_system.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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Healthcare Improvement Scotland

Edinburgh Office	Glasgow Office
Gyle Square	Delta House
1 South Gyle Crescent	50 West Nile Street
Edinburgh	Glasgow
EH12 9EB	G1 2NP
0131 623 4300	0141 225 6999

www.healthcareimprovementscotland.org