

Action Plan

| Service Name: | Marie Curie Hospice – Edinburgh |
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| Service number: | 00046 |
| Service Provider: | Marie Curie |
| Address: | 45 Frogston Road West, Edinburgh, EH10 7DR |
| Date Inspection Concluded: | 14-15 November 2023 |

| Requirements and Recommendations | Action Planned | Timescale | Responsible Person |
|--|--|------------------------|---|
| Recommendation a: The service should develop measurable key performance indicators and a process to measure these (see page 13). | An internal review will take place of Marie Curie's current national KPI's and what scope we must introduce more localised KPI's. We will also work with Scotland North and West to review there local KPI's for consistency. We will also review St Columbas KPI's to ensure consistency with another local Hospice. The plan will be to have local KPI's if possible that mirror St Columbas and Scotland North and West. | 31 st March | Head of Quality and Clinical Practice |

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| Recommendation b: The service should publicise freedom to speak up champions' contact information to make it easy for staff to raise any concerns or queries (see page 15). | We include information on our freedom to speak up champions during our induction process and make it a mandatory part of the induction process. This will overview what a freedom to speak up champion is and who they are. We will also introduce into one to ones with staff, a prompt ensuring people know who the freedom to speak up champions are and how to contact them. | Clinical Support Services Manager | January 31st |
|---|---|--------------------------------------|---------------------------|
| | We will complete a review of the freedom to speak up champions and particularly review how we can boost their profile across the place. We will look at how often our champions meet, how they communicate with each other and the champions from other places. We'll look at how they continue to raise their profile across the place and review how often they are approached for support and guidance. Other best practise across the nation will be reviewed to bring this into our plans. | Head of Quality & Clinical Practice | 15 th February |
| Recommendation c: The service should produce and publish an annual duty of candour report (see page 22). | This report was previously published and the decision moving forward will sit within our SOAP group. A decision will be made within this group on when to publish it, what period is to be published and via what method its to be published. | Head of Operations | 31 st January |
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| Recommendation d: The service should ensure its complaints policy and procedures contain the correct information and details for patients to be able to contact Healthcare Improvement Scotland at any point of the complaints process (see page 22). | Scotland S&E will work with Scotland N&W to work together for a Scotland wide approach. A review will take place of current details and update the accordingly. Due to rebrand, we will work with the rebranding team to ensure any new and updated leaflets etc. will have the new and correct contact details available. | Clinical Support Services Manager | 31 st March |
|---|--|---|---------------------------|
| Recommendation e: The service should ensure policies and standard operating procedures are reviewed and updated as planned (see page 22). | A guidance is currently being developed to ensure all SOP's are created and updated in a consistent manner whether clinical or non-clinical. The guidance will include what information should be considered, who should be involved in SOP development and when a SOP is required (so it doesn't not duplicate with a policy). After development, all SOP's will be reviewed using this new guidance ensuring consistency across all SOP's. | Clinical Support Services Manager/ Head of Quality and Clinical Practice/ Medical Director | 31 st December |

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| Recommendation f : The service should ensure patients' consent to treatment is documented in the patient care records (see page 27). | A review will take place to see what questions we currently ask to capture the consent and if they are fit for purpose. Any required amendments will be made after this review. | Medical Director/ Admin supervisor | 1 st July |
|--|---|---|----------------------|
| | We will then ensure staff training is completed to train staff consistently on consent to treatment capture and is documented correctly. | | |
| | Audit's will then ensure the training has been embedded amongst staff. | | |
| Recommendation g: The service should ensure that information on the patient's power of attorney status is documented in the correct place in the patient care record and is easily accessible for all staff (see | A review will take place to see what questions we currently ask to capture the consent and if they are fit for purpose. Any required amendments will be made after this review. | Clinical Support Services Manager/ Admin supervisor | 31st March |
| page 28). | We will then ensure staff training is completed to train staff consistently on power of attorney capture and is documented correctly. | | |
| | Audit's will then ensure the training has been embedded amongst staff. | | |
| | We will include in MDT a review process which will ensure power of attorney capture is reviewed. | | |

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| Recommendation h: The service should introduce regular audits of patient care records (see page 28). | A review will take place of our current audit requirements/assessment/documentation and see if it's fit for purpose. We will then amend the current documentation to include all aspects of what needs to be audited so it's captured in the same place, on the same documents and is updated and covers all our audit requirements. | Head of Quality and Clinical Practice / Deputy Head of Quality and clinical Governance | 1 st August |
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| Name | Charlotte lindlev | | | |
|-------------|--|------|---------------|--|
| Designation | Head of Operations Scotland South and East | | | |
| Signature | Olis | Date | 05 / 01 /2024 | |

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

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Guidance on completing the action plan.

- **Action Planned**: This must be a relevant to the requirement or recommendation. It must be measurable and focussed with a well-defined description of how the requirement/recommendation will be (or has been) met. Including the tasks and steps required.
- **Timescales:** for some requirements can be immediate. If you identify a requirement/recommendation timescale that you feel needs to be extended, include the reason why.
- Person Responsible: Please do not name individuals or an easily identifiable person. Use Job Titles.
- Please do not name individuals in the document.
- If you have any questions about your inspection, the requirements/recommendations or how to complete this action plan, please contact the lead inspector for your inspection.

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