Healthcare Improvement Scotland | Inspections and reviews To drive improvement

Unannounced Focused Inspection Report: Independent Healthcare

Service: St. Margaret of Scotland Hospice, Clydebank

Service Provider: St. Margaret of Scotland Hospice

9 April 2026

NHS SCOTLAND

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1 Progress since our last inspection

What the provider had done to meet the requirement we made at our last inspection on 9-10 July 2024

Requirement

The provider must ensure sustainable staffing and workforce resources for the care being delivered.

Action taken

The hospice had expanded its medical team since the July 2024 inspection to include a wide range of qualified doctors, including consultants providing sessions for the hospice's inpatient and community services. Many of these doctors were on a specialty register as part of the General Medical Council (GMC) register, including doctors specifically qualified in palliative medicine. **This requirement is met.**

What the service had done to meet the recommendations we made at our last inspection on 9-10 July 2024

Recommendation

The service should develop formal methods to support patients, carers or family members to participate in groups or discussions about improving the service to ensure that their opinions and experiences are considered.

Action taken

Patient feedback was gathered through Care Opinion (a website where people can anonymously share their experiences of health and care services). Care Opinion information cards were available throughout the inpatient ward and were also contained in the patient admission pack. The provider was using this method as a comprehensive way to understand the opinions and experiences of patients and their families. Information from this could then feed into service development. The provider had chosen this approach due to the challenges it faced obtaining the level of engagement needed from patients and families to offer focus groups.

Recommendation

The service should ensure patient outcomes from the use of treating patients using peripherally inserted central catheters (PICCs) in a hospice are identified and shared with the wider palliative care community.

Action taken

The hospice clinical team had continued to collate data on the use of peripherally inserted central catheters (PICC) lines for its patients. These thin flexible tubes are inserted into the upper arm to allow for more easy and comfortable access to intravenous (IV) fluids. The data had recently been presented in poster form at three national/regional palliative care conferences. We were told that the hospice team was in the process of developing a paper for publication in medical journals in relation to this work.

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 focused inspection to St. Margaret of Scotland Hospice on Thursday 9 April 2026. The purpose of the inspection was to focus on patient admissions, response times to patient referral requests, the quality and safety of care, and the views of both patients and staff about the hospice. We spoke with a number of staff, patients and family members during the inspection. We received feedback from 27 staff members through an online survey we had asked the hospice to issue for us during the inspection. We received feedback from one family member through our online patient and family survey as a result of posters displayed during the inspection.

Based in Clydebank, St. Margaret of Scotland Hospice is an independent hospital (a hospice providing palliative care/end of life care).

The inspection team was made up of four inspectors and a subject matter expert in palliative medicine.

What we found and inspection grades awarded

For St. Margaret of Scotland 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**
Staff across the multidisciplinary team described a supportive, compassionate leadership culture, with strong peer support and confidence to raise concerns or share learning with managers and senior leaders. New medical staff reported feeling welcomed and well supported. To address recent issues with patient admissions and communication with the local NHS board, an operational liaison forum had been set up and a desk-top review of recent patient admissions had been arranged. It is anticipated that this will help to improve the future patient admission process.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patient feedback was now being routinely gathered through Care Opinion, with a future review of this method planned. Effective systems were in place, such as incident reporting and medicines management, to help ensure safe, well co-ordinated and patient-centred care. The hospice was actively involved in sharing information about the use of controlled drugs with other external hospice services.	✓✓ Good
Results	*How well has the service demonstrated that it provides safe, person-centred care*
The hospice had a calm, well-managed environment, despite major refurbishment work taking place. Effective infection control measures ensured no disruption to patient care. Patients and families reported feeling safe, supported and listened to, and actively involved in care decisions. Patients were also very complimentary about the quality of care they received. Care delivery was person-centred and dignified, with evidence of comprehensive and thorough documentation and multidisciplinary working. We saw evidence that staff were safely recruited.	✓✓ 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: [Guidance for independent healthcare service providers – Healthcare Improvement Scotland]

Further information about the Quality Assurance Framework can also be found on our website at: [The quality assurance system and framework – Healthcare Improvement Scotland]

What action we expect St. Margaret of Scotland Hospice 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 no requirements and no recommendations.

We would like to thank all staff at St. Margaret of Scotland 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

Staff across the multidisciplinary team described a supportive, compassionate leadership culture, with strong peer support and confidence to raise concerns or share learning with managers and senior leaders. New medical staff reported feeling welcomed and well supported. To address recent issues with patient admissions and communication with the local NHS board, an operational liaison forum had been set up and a desk-top review of recent patient admissions had been arranged. It is anticipated that this will help to improve the future patient admission process.

Leadership and culture

Various members of the multidisciplinary team told us they felt supported within their peer groups. They also felt able to approach managers and senior leaders with any concerns or to have a discussion which may enhance the individual's learning. Staff told us there was a caring and compassionate approach throughout the leadership team.

At the time of the inspection, medical staff we spoke with had been on rotation for 1 week at the hospice. They described feeling well supported and having built good working relationships.

Staff who completed our online staff survey told us:

- 'The leadership is of the highest standard. Always encouraging and supportive in all that we do on a daily basis.'
- 'Excellent leadership within the Hospice from top to bottom.'
- 'I feel my thoughts and suggestions are taken on board.'
- 'The hospice is a wonderful place to work providing excellent care for all patients and providing a wonderful environment for all staff to work.'
- 'It is a great place to work and I feel that my length of service speaks volumes for how this organisation has looked after me.'

- ‘I love that each day I come to work, I work with teams who genuinely provide the best possible care and support within an environment that is cared for.’

The hospice’s leadership team acknowledged that there had been some recent issues with patient admissions and communication with the local NHS board who referred patients to the hospice services. Due to some current refurbishment work taking place, the hospice acknowledged that its ability to admit patients was limited at present and that it was currently operating at 50% of its anticipated capacity once the refurbishment was completed.

Admissions to the hospice, for both the continuing care beds and the palliative care beds, were considered by the multidisciplinary team. Decisions to admit patients were based on the hospice’s admission policy and its ability to care for the individual and the needs of the wider family. The leadership team and staff were clear that access to the hospice was not based on any other factors. A consultant from NHS Greater Glasgow and Clyde worked in the continuing care ward one day a week and also had oversight of admissions to that part of the service.

What needs to improve

To improve the communication and admissions pathway between the hospice and local NHS board, an operational liaison forum had been recently set up that was co-chaired by senior staff from the local NHS board and the hospice. The purpose of the group was to ‘provide leadership support and guidance to the development and implementation of a consistent and effective operational liaison’ between the hospice and the local NHS board. While we saw the forum’s terms of reference, we will follow up on its effectiveness at the next inspection.

We were told that a desk-top review of recent patient admissions was planned where issues about communication and care were identified by both the hospice and the local NHS board. The purpose of the meeting would be to review each of the cases, identify any learning points and share this information with the operational liaison forum to improve the admission process in the future.

- 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

Patient feedback was now being routinely gathered through Care Opinion, with a future review of this method planned. Effective systems were in place, such as incident reporting and medicines management, to help ensure safe, well co-ordinated and patient-centred care. The hospice was actively involved in sharing information about the use of controlled drugs with other external hospice services.

Co-design, co-production *(patients, staff and stakeholder engagement)*
Patient feedback was now being gathered using Care Opinion (a website where people can anonymously share their experiences of health and care services). This website allows patients to describe both positive and negative aspects of their care experience in the public domain, and allows a service to respond to these. Staff we spoke with were familiar with accessing this website. Care Opinion information cards were available at staff nursing stations and we were told these were also contained in the patient admission pack.

The hospice had recently embedded Care Opinion within its governance processes, and patient feedback from this website was included in the chief executive's reports to the hospice Board. This additional feedback supplemented the informal thanks and feedback the hospice regularly received. Care Opinion allows the provider to gather and analyse both positive and negative responses to help monitor how well the hospice is performing. We saw that every 'story' about the hospice on Care Opinion was responded to with an acknowledgement tailored to the individual. At the time of the inspection, we were told that the stories submitted to Care Opinion had all been positive.

We were told that the hospice Board would receive a formal review report about the effectiveness of using Care Opinion as a mechanism for gathering patient feedback once this had been implemented in the hospice for a year.

What needs to improve

Staff told us that the feedback they received from patients and families was always positive in nature and, therefore, it was often a challenge to be able to evidence patient-led improvements. The hospice was hopeful that Care Opinion

would, in time, allow a space for patients and families to express actionable suggestions for improvement. We will follow up on the hospice's use of Care Opinion at the next inspection to understand how this information has been used to inform the continued development of the hospice and how any suggested improvements from patients have been taken forward.

The hospice carried out staff surveys. However, we were told that the last staff survey had a very poor return rate. Currently, a staff survey was under way focused on staff awareness of Care Opinion. The leadership team was working with managers to make sure that staff were aware of the importance of these survey results to the organisation. Once this survey had been completed, a further general staff survey would be conducted. We will follow this up at the next inspection.

- No requirements.
- No recommendations.

Quality improvement

Staff fully understood Healthcare Improvement Scotland's notification process and the need to inform Healthcare Improvement Scotland of certain events or incidents that occurred.

An electronic process was in place for managing and recording incidents and accidents, and staff were aware of how to report any accidents or incidents. We saw that all accidents and incidents we reviewed were fully investigated and had resulted in learning outcomes which had been acted on. For example, we reviewed how a medication incident had been managed and saw that a full review and investigation had taken place, including communication with the patient, family and staff involved, with learning outcomes and actions identified.

Effective processes were in place for managing medicines, including a clear process of reviewing and auditing practice. Ongoing training was in place for all relevant staff, including specific training for new staff. Regular reviews of staff competencies also took place in line with prescribing and administering medicines guidance. We saw that all medicines were stored securely. The hospice had regular input and support from the local NHS pharmacy team.

The hospice engaged with other external hospice services through local intelligence network forums. These forums facilitated the sharing of information, concerns and good practice about the management and use of controlled drugs between healthcare organisations. Controlled drugs are medications that are subject to strict government regulations and require to be controlled more strictly, such as some types of painkillers.

The hospice had recently introduced a new electronic patient care record system which allowed authorised access to NHS documentation. This was a password-protected, secure system and allowed access to information from external professionals, including GPs, and about a patient’s NHS hospital admissions. The hospice is registered with the Information Commissioner’s Office (an independent authority for data protection and privacy rights) to ensure confidential information was safely managed.

A thorough process was in place for documenting patient information, including contact details and next of kin, clinical assessments and treatment plans. A plan about the patient’s wishes was clearly documented for staff in the event that a patient’s condition deteriorated out of hours. This included information about where the patient wanted to be in the last days of their life.

- 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 hospice had a calm, well-managed environment, despite major refurbishment work taking place. Effective infection control measures ensured no disruption to patient care. Patients and families reported feeling safe, supported and listened to, and actively involved in care decisions. Patients were also very complimentary about the quality of care they received. Care delivery was person-centred and dignified, with evidence of comprehensive and thorough documentation and multidisciplinary working. We saw evidence that staff were safely recruited.

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. The hospice was not requested to submit a self-evaluation in advance of this inspection.

The hospice was currently undertaking a full renovation of St Joseph's ward (the palliative inpatient ward). This had reduced its current bed capacity. On the day of inspection, the hospice was calm, quiet, clean, tidy and well organised with a total of 20 patients across both the palliative and continuing care beds.

Although extensive building work was ongoing on site, no work was being carried out in patient areas, and no crossover of waste, equipment or workers was noted in clinical or support areas. Senior managers were able to tell us about the controls and mitigations that had been put in place to protect the rest of the hospice from contamination from the areas undergoing refurbishment and to prevent unauthorised access to these restricted areas. They were also able to discuss the contact they had had with external NHS infection prevention and control advisors. Although the works were extensive, no family members or patients commented to us on any disruption or concerns. One patient commented that the 'place was spotless.'

Staff were observed to be working together respectfully. They appeared to know each other well and understood their own and others' roles. Staff we spoke with were very positive about their experience of working at the hospice and had confidence in the organisation. All felt supported and understood the value of their role and how to influence the future development of the hospice, as well as the difference they made for patients.

As a Catholic run charity, patients were able to attend mass and a Church of Scotland service if they wished. Patients we spoke with described these services as uplifting. Staff were supported to be released from clinical duties to also attend if possible but were never expected to participate in faith-based observances. Staff were also able to discuss supporting multi-faith initiatives for each patient as required.

Patients told us that staff were available at any time for them. While we were in the inpatient ward, we observed staff talking to and spending time with patients who were being cared for in the last days of their life, showing both dignity and respect for them and their families.

We reviewed five patient care records and found these were detailed and comprehensive. A thorough process of assessment and consultation took place, including assessing the patient's capacity to understand information on their admission. Throughout the documentation, we saw examples of the individualised care given, and that patient and family discussions about care and decision making was thoroughly detailed in the patient care records. Entries in the patient care record were dated and signed by appropriately qualified clinical staff. Patients and their families we spoke with told us they felt involved in care decisions and felt listened to.

Daily medical assessments of patients were carried out and we saw that these were fully documented in the patient care records. Multidisciplinary team discussions were also recorded, with clear documentation of any resulting changes made to a patient's treatment plan, and any discussions that took place with patients and their families. Consent to share information with the patient's next of kin and external professionals was available in paper copies of consent forms on the ward.

We reviewed five staff files and found that all the appropriate background and identify checks had been comprehensively completed. All of the staff records were well organised with evidence to support the recruitment processes. We focused on recently appointed members of staff to ensure that safe recruitment practices were being followed. We saw that in each of the files reviewed there was:

- an application form or CV
- a background check, including evidence that the identity of the applicant had been verified
- a check of the professional register, such as the Nursing and Midwifery Council (NMC) register, where appropriate
- evidence of relevant qualifications

- two references
- interview notes and evidence that the person specification for the role was met
- a contract of employment, and
- records of induction training.

Patients and family members who completed our online survey and who we spoke with on the day of inspection told us:

- ‘They got me back on my feet.’
- ‘They look after all of us (as a family) and they are there for us.’
- ‘We have a good laugh and a bit of banter, I feel safe here.’
- ‘I feel listened too, they’ve given me hope.’
- ‘I tell it straight, and if it wasn’t for the care I am getting here, I wouldn’t be here now.’
- ‘The team were fully transparent, they listened intently to any queries we had as a family.’

■ No requirements.

■ No recommendations.

Appendix 1 – About our inspections

Our quality of care approach and the quality assurance 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:
[The quality assurance system and framework – Healthcare Improvement Scotland]

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

Email: his.ihcregulation@nhs.scot

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