The Regulation and Quality Improvement Authority

Inspection Report

31 March 2022 and 19 May 2022

Marie Curie Hospice
Marie Curie Nursing Service

Type of Service: Independent Hospital (IH) – Adult Hospice
Address: 1a Kensington Road, Belfast, BT5 6NF
Tel No: 028 9088 2000

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/ The Independent Health Care Regulations (Northern Ireland) 2005 and the Minimum Care Standards for Independent Healthcare Establishments (July 2014)

1.0 Service information

Organisation/Registered Provider: Marie Curie **Responsible Individual:** Mrs Paula Heneghan	**Registered Manager:** Miss Jo Browne **Date registered:** Application submitted, registration pending
Person in charge at the time of inspection: Mrs Paula Heneghan	**Number of registered places:** 18 inpatients Day Hospice Belfast - 15 Day Hospice Newtownards - 15 Day Hospice Downpatrick -15
Categories of care: Independent Hospital (IH) – Adult Hospice	

Brief description of how the service operates:
Marie Curie Hospice is a registered independent hospital providing in-patient hospice services for up to 18 adults with life-limiting, life-threatening illnesses and palliative care needs. As a direct result of the COVID-19 pandemic the inpatient beds have been temporarily reduced to 14. This registration also includes day hospice services for adults with life-limiting, life-threatening illnesses and palliative care. Previously the day hospices operated from three sites, based in the Marie Curie Belfast site, at the Ards Community Hospital, Newtownards and at the Downe Hospital, Downpatrick. However as a result of the COVID-19 pandemic the day hospice services in the Ards Community Hospital and the Downe Hospital sites had been temporarily suspended. During this inspection we were informed the previous day services element of the Marie Curie hospice in the Belfast site has been repurposed to provide an outpatient day service. The community and outpatient day service is available Monday to Friday from 9.30am to 4.30pm. Patients are seen at the community and outpatient department and domiciliary visits are also offered by the multi-disciplinary team.

Marie Curie Nursing Service
The Marie Curie Nursing Service provides palliative and end of life care to terminally ill adults and their families and is contracted to provide services in all five Health and Social Care Trusts in Northern Ireland. The service is operated from offices in a dedicated area within the Marie Curie Hospice, Belfast site. In addition, there is a Rapid Response Team that operates within all five Health and Social Care Trusts.

Registration of Marie Curie
On 16 March 2021 a notification of absence was submitted to RQIA on behalf of Mrs Miriam McKeown, Registered Manager to inform RQIA that Mrs McKeown had resigned from her post and Mrs Heneghan, Registered Manager for the Marie Curie Nursing Service was the

acting manager for the inpatient unit. During October 2021 Mr Eamon O'Kane, Responsible Individual resigned from his post and Mrs Heneghan was the acting responsible individual. Subsequently a responsible individual application was submitted on behalf of Mrs Heneghan and a registered manager application was submitted on behalf of Miss Jo Browne. Following review of these applications registration of Mrs Heneghan and Miss Browne was granted.

Following the inspection a proposal was submitted to RQIA to amalgamate the registration of Marie Curie Hospice and Marie Curie Nursing Service. Additional information in regard to these registration matters can be found in section 5.2.7 of this report.

2.0 Inspection summary

An unannounced inspection was undertaken to Marie Curie Hospice and Marie Curie Nursing Service which commenced with an onsite inspection on 31 March 2022 from 09.45 am to 5.00 pm, followed by a request for the submission of information electronically. The purpose of this inspection was to focus on the themes for the 2021/22 inspection year. A further follow up visit was undertaken on the 19 May 2022 to review medical personnel files.

Our multidisciplinary inspection team examined a number of aspects of the hospice including the management of operations in response to COVID-19 pandemic; infection prevention and control (IPC); the provision of palliative care; medicines management; maintenance of the premises; and the management and oversight of governance across the organisation. The inspection team met with various staff members, reviewed care practices and relevant records and documentation used to support the governance and assurance systems.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Independent Health Care Regulations (Northern Ireland) 2005, The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health (DoH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

The inspection team found the care provided and delivered in the hospice to be of an excellent standard. There was evidence of a high standard of practice in respect to the management of operations in response to the COIVD-19 pandemic; IPC and medicines management. The provision of specialist palliative care was noted to be of an extremely high standard concerning the services offered and the support provided to patients and relatives.

It was noted that the governance structures within the hospice continue to provide the required level of assurance to the senior management team (SMT); Local Advisory Board (LAB); regional and national governance structures; and the Council of Trustees.

The premises were maintained to a high standard of maintenance and décor. Through a review of documentation, discussion with staff and observation of the environment it was evidenced that robust arrangements were in place concerning the maintenance of the premises, equipment and the environment.

No immediate concerns were identified in relation to patient safety and the inspection team noted multiple areas of strength, particularly in relation to the delivery of front line care in the hospice. No areas for improvement were identified as a result of this inspection.

3.0 How we inspect

RQIA is required to inspect registered services in accordance with legislation. To do this, we gather and review the information we hold about the service, examine a variety of relevant records, meet and talk with staff and management and observe practices on the day of the inspection.

The information obtained is then considered before a determination is made on whether the establishment is operating in accordance with the relevant legislation and minimum standards. Examples of good practice are acknowledged and any areas for improvement are discussed with the person in charge and detailed in the quality improvement plan (QIP).

Prior to the inspection we reviewed a range of information relevant to the hospice. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the hospice
- written and verbal communication received since the previous care inspection
- the previous care inspection report
- the returned QIP from the previous care inspection

In response to the COVID-19 pandemic RQIA reviewed the inspection methodology used during the 2020/21 inspection year and considered various options to undertake inspections. The purpose of this was to minimise risk to patients and staff, including our staff, whilst being assured that registered services are providing services in keeping with the minimum standards and relevant legislation. Having considered different inspection methodologies a decision was taken to undertake multidisciplinary blended themed inspections to hospice services. The blended methodology included an onsite inspection and electronic submission of additional documentation to be reviewed remotely by pharmacist and estates inspectors.

As the COVID-19 pandemic is ongoing a decision was taken to continue with this inspection methodology during the 2021/22 inspection year. The onsite component of our inspection commenced on 31 March 2022 and a further follow up visit was undertaken on 19 May 2022. The onsite inspection team examined a number of aspects of the hospice services as outlined in section 2.0 of this report. A tour of the in-patient unit was undertaken and posters informing patients and staff that an inspection was being conducted were displayed during the inspection.

At the onset of the onsite inspection the hospice was provided with a list of specific documents requesting items to be reviewed remotely in respect of medicines management and the maintenance of the premises and grounds. These items were to be sent electronically to our pharmacist and estates inspectors for review.

On 5 May 2022 members of the inspection team facilitated a Zoom teleconference with a member of the LAB who also is a member of the UK Board of Trustees. The purpose of this meeting was to discuss the role and function of LAB members and the governance structures.

Feedback of the inspection findings was delivered to Mrs Heneghan, Miss Browne and members of the SMT at the conclusion of the inspection.

4.0 What people told us about the service

In response to the COVID-19 pandemic the inspection team decided not to meet with patients on the day of the inspection. Patient feedback was assessed by reviewing the most recent patient satisfaction surveys. Marie Curie engages with patients and/or their representatives as an integral part of the service they deliver. Patients and/or their representatives are offered the opportunity to provide feedback through a questionnaire. Where required, assistance can be provided to complete this. Marie Curie has a national patient experience team that gathers feedback about all services offered.

Staff and patients were invited to complete an electronic questionnaire. No completed staff or patient questionnaires were submitted following the inspection.

All staff spoken with during the inspection spoke about the hospice in positive terms. Staff spoke in a complimentary manner regarding the support they receive from the SMT. Staff discussed the challenges faced as a team as a result of the COVID-19 pandemic and how as a team they had overcome these and continued to provide high quality care. No areas of concern were raised during the onsite inspection.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 3 March 2021		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 **and** Minimum Care Standards for Independent Healthcare Establishments (July 2014)		**Validation of compliance**
Area for Improvement 1 **Ref**: Regulation 26 (3) **Stated:** First time	The responsible individual shall ensure that they undertake six monthly unannounced visits, as outlined in Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005, as amended, or they nominate an individual to undertake these visits on their behalf. Written reports of the unannounced visits should be available for inspection.	**No longer applicable**
	Action taken as confirmed during the inspection: At the time this area for improvement was made Mr Eamon O'Kane was the responsible individual and was not in day to day charge of the services delivered by Marie Curie therefore Regulation 26 unannounced visits were required. However, as discussed above, Mrs Heneghan is the Responsible Individual and is in day to day charge of all services delivered by Marie Curie Hospice therefore regulation 26 visits are no longer required.	
Area for Improvement 2 **Ref**: Standard 30.1 **Stated:** First time	The registered persons shall ensure the role of the Medical Advisory Committee (MAC) is formalised within the governance structures of the hospice with established terms of reference developed in accordance with Standard 30. The MAC should meet quarterly, as a minimum, with formal minutes kept and a record of meetings maintained.	**Met**

	Action taken as confirmed during the inspection: The terms of reference for the MAC were reviewed and found to clearly set out the working arrangements. The MAC meets at least quarterly and had an identified quorum. MAC meetings are minuted and minutes of the most recent MAC meeting on 30 March 2022 were reviewed. These minutes were noted to be a detailed account of the topics discussed and decisions made.	

5.2 Inspection outcomes

5.2.1 Are arrangements in place to minimise the risk of COVID-19 transmission?

COVID-19 has been declared as a public health emergency resulting in the need for healthcare settings to assess and consider the risks to their patients and staff.

Assurance of effective governance arrangements in the planning and delivery of IPC measures was sought by reviewing the key areas of collaborative working, COVID-19 risk assessments, the monitoring of staff practices, work patterns and staff training.

There was strong evidence of collaborative and multi professional working and good communication systems for the sharing of information and learning. Records confirmed that staff had received enhanced COVID-19 and IPC training and systems were in place for the monitoring of staff practices. Staff told us that they had received enhanced COVID-19 and personal protective equipment (PPE) training and that they can access training materials and the IPC lead nurse for advice.

The management of operations in response to the COVID-19 pandemic was discussed with the ward managers and other staff members. COVID-19 policies and procedures were in place in keeping with best practice guidance. Staff stated that all updates in guidance were regularly communicated to the team. The governance systems in place were reviewed and staff stated that timely communications were provided to update them regarding COVID-19 guidance.

A selection of documentation was reviewed including minutes of meetings; COVID-19 risk assessments; audits of the environment and staff practices; and staff training records. The COVID-19 risk assessments were comprehensively completed for clinical and non-clinical areas and many environmental control measures had been implemented to reduce the risk of transmission. The records confirmed good governance measures were in place for the preparation and maintenance of a COVID-19 safe environment.

A tour of the in-patient unit including the staff rest areas was undertaken. Social distancing and COVID-19 precautions taken by staff were adhered to in both clinical and non-clinical areas.

It was noted that mechanisms were in place at ward level to challenge non-adherence when social distancing and COVID-19 precaution measures were breached. Staff told us they would feel confident to challenge anyone not compliant with any aspect of COVID-19 precautions.

Effective hand hygiene practices and effective use of PPE was observed throughout the inspection. Staff were observed supporting patients and visitors to comply with COVID-19 and IPC measures. Excellent standards of environmental and equipment cleaning was observed. Good signage to direct visitors and staff in respect of PPE, hand hygiene and the wearing of face masks was observed to be in place.

COVID-19 risk assessments, with agreed action plans, were also completed for clinically extremely vulnerable staff returning to work, to protect them against exposure to the virus in the workplace.

The risk assessment considered black, Asian and minority ethnic (BAME) staff with underlying health conditions/age; staff who were pregnant (more than 28 weeks); and staff with underlying moderate or high risk medical conditions. The risk assessments included discussions with the staff member in respect of IPC precautions to be taken and considered options for staff including a review of working conditions.

All patients admitted to the hospice in-patient unit had been tested on admission and at regular intervals to ascertain and monitor the COVID-19 status of all patients. Discussions with staff confirmed that patients are informed of the COVID-19 test result in a timely manner. Visiting arrangements have been reviewed and facilitated in line with the most recent DoH guidance. Patients and their families are advised of the visiting arrangements on admission.

The contact details of all persons permitted to enter the inpatient unit are recorded and retained to enable the Public Health Agency (PHA) to undertake track and trace if required. PPE was provided to all persons prior to entering the inpatient unit and all visitors were directed by reception staff to sanitise their hands and don PPE before entering the inpatient unit.

A review of documents concerning the staff changing facilities, staff rest areas and nurses stations evidenced these areas had been included in the COVID-19 risk assessment. Staff were aware of the maximum number of personnel permitted in each area in accordance with social distancing guidance. Staff break times had been staggered to facilitate social distancing and staff told us these arrangements were working well. Management had also reviewed staff changing facilities and provided additional staff changing areas which further enabled staff to socially distance at staff change over times.

Staff were knowledgeable about the ongoing COVID-19 pandemic restrictions. The hospice had identified a COVID-19 lead; had reviewed and amended policies and procedures in accordance with DoH guidance to include arrangements to maintain social distancing; prepare staff; implement enhanced IPC procedures; COVID-19 patient pathways; and had amended their visiting guidance. The inspection team were assured that robust governance and oversight measures were in place to prevent the spread of the virus and minimise the risk of COVID-19 transmission.

5.2.2 Does the hospice adhere to infection prevention and control (IPC) best practice guidance?

The arrangements for IPC procedures throughout the hospice to evidence that the risk of infection transmission to patients, visitors and staff was minimised were reviewed. It was confirmed that the hospice had an overarching IPC policy and associated procedures in place.

During a tour of the premises all areas observed were found to be clean, tidy and well maintained. Hand hygiene posters were displayed for patients, visitors and staff regarding hand hygiene and hand washing techniques.

There was a dedicated IPC lead nurse available to advise staff on the management of IPC issues and the completion IPC audits. Staff confirmed there was good communication between the hospice staff and the IPC lead nurse. The IPC lead nurse has protected time to focus on IPC and ensure that IPC training is undertaken by all staff.

Line managers also have oversight of individual staff training records and are therefore aware of the IPC training compliance rates. In addition the IPC lead nurse is supported by the Marie Curie head of IPC who also monitors compliance rates of staff training and audit outcomes and is available to offer support and advice. There is an IPC group made up of the heads of each department who meet monthly, minutes are retained and the action points of meetings are shared with all relevant staff.

As previously discussed, a review of staff training records evidenced that overall staff mandatory IPC training was up to date. Staff who spoke with us demonstrated a good understanding of IPC measures in place.

A range of IPC audits undertaken in clinical areas including, environmental and hand hygiene audits were reviewed. These audits confirmed good compliance and oversight in IPC practices. A range of IPC audit scores were displayed to provide assurance of audit compliance to visitors and staff of a good standard of environmental cleaning and IPC practices. This information was displayed on notice boards in both clinical and non-clinical areas and discussed at the daily safety briefs. Staff told us about the actions that would be taken if environmental standards were to fall below the expected standard. Staff were also able to describe the actions they would take to address areas requiring improvement. Staff demonstrated a comprehensive understanding of this.

It was confirmed a policy was in place regarding aseptic non-touch technique (ANTT) and that staff had undertaken both training and competency-based training assessments. Through discussion, staff demonstrated good knowledge and understanding of the application of ANTT and the management of invasive devices. A robust system of audit had been implemented regarding the management of invasive devices, with audit results being disseminated to staff through the hospice's governance systems.

Environmental cleanliness was of a high standard and there was a regular programme of environmental auditing and equipment cleaning schedules. Discussion with support services staff demonstrated that they were knowledgeable about the daily, weekly and monthly cleaning schedules and records to be completed. They were able to describe the ongoing arrangements concerning cleaning audits.

Good compliance with IPC practices was observed in relation to hand hygiene, equipment cleaning, appropriate use of PPE and donning and doffing of PPE. The collaborative approach by all staff in relation to IPC ensured efficiency and consistency in upholding the high standard of IPC practices evidenced throughout the hospice.

Review of the current arrangements with respect to IPC practice evidenced areas of good practice. It was noted that areas of IPC risks were being assessed and managed appropriately with robust auditing measures in place in clinical areas. Arrangements are in place to ensure the all staff adhere to IPC best practice guidance.

There were clear lines of accountability for all matters pertaining to IPC. There was evidence of effective governance mechanisms and collaborative working across the hospice. It was demonstrated that robust arrangements are in place to ensure the hospice staff adheres to IPC best practice guidance.

5.2.3 Does the hospice adhere to best practice guidance concerning the provision of palliative care?

Adherence to best practice guidance in regards to palliative care was evidenced through the review of referral pathways; care records; discussion with staff; observation of care delivery; and a review policies and procedures.

The patient pathway was reviewed through the hospice from the time of referral through to the point of discharge and many areas of good practice were identified. Well established referral procedures were evidenced to be in place. There was a robust multi-disciplinary system for review of referrals and triage/assessment of patients referred to the hospice. Patients and/or their representatives are given information in relation to the hospice which is available in different formats, if necessary.

Referrals can be received from the palliative care team; hospital consultants; nurse specialists or general practitioners (GPs). Multidisciplinary assessments are completed with the referral information through the regional referral arrangements. Staff in the inpatient unit confirmed they receive relevant information about the patient prior to admission.

On admission patients and/or their representatives are provided with information regarding the various assessments that may be undertaken by members of the multi-professional team. Staff told us that patients are given time to settle in with the opportunity provided for family members to be involved in the holistic care of the patient. Assessments are undertaken to include medical; nursing; physiotherapy; occupational therapy; complimentary therapy and spiritual assessments.

The hospice uses a computerised records system called EMIS to record medical and nursing notes. Electronic care records retained were supplemented with paper records, where applicable. A random sample of patient's nursing records was reviewed and there was evidence that a multi-disciplinary, holistic and empathetic approach to patients' care was being delivered. It was also noted that care delivered was patient centred and routinely reviewed to ensure care is adapted according to assessed need.

During the inspection staff were observed interacting with patients in a calm, caring and unhurried manner and were attending to the patients' needs in a timely way. Staff demonstrated good communication skills and it was evident that dignity and respect shown to patients was of a very high standard.

Staff discussed the light system outside each patient's room which provided a clear method of alerting staff and visitors to the privacy request of that patient, for whatever reason. Patients and their families had minimal interruptions and interventions were only undertaken having first gained the patient's consent.

Staff spoke positively regarding the good communication systems throughout the hospice that included involvement in staff meetings; safety huddles; daily and weekly multi-disciplinary team meetings and debriefing sessions. Staff reported a very supportive environment with opportunities for training, growth and development. Staff spoke positively on how initiatives are being developed to involve nursing staff in ward rounds and further enhance the debriefing sessions to offer support to smaller staff groups where the need is identified.

The provision of bereavement care was reviewed and this evidenced that a range of information and support services were available. The hospice can provide individual counselling services for patients and families or make referrals to external providers. Ongoing bereavement care is available for families and children coping with the loss of a loved one. It was confirmed that staff who deliver bereavement care services are appropriately trained and skilled in this area. Staff spoke positively on how initiatives are being developed to further enhance the bereavement service offered by the hospice and community services.

The policy and procedure for delivering bad news to patients and/or their representatives was reviewed and this has been developed in accordance with the Breaking Bad News regional guidelines 2003. The hospice retains a copy of the guidelines which are accessible to staff. Staff told us that bad news is delivered to patients and/or their representatives by professionals who have experience in communication skills and who act in accordance with the hospice's policy and procedure. Where this news is shared with others, staff confirmed that consent must be obtained from the patient and this is documented in patient records. Following a patient receiving bad news, future treatment options are discussed fully with the patient and documented within their individual care records. Staff spoken with were very aware of the importance of being available to provide support to the patient and/or their representatives to help them to process the information shared.

The arrangements in relation to discharge planning were reviewed and this evidenced that there was full engagement with patients and/or their representatives. Discussion with staff demonstrated that there was multi-disciplinary involvement in discharge planning that included daily and weekly meetings to ensure the patient's needs were at the centre of discharge planning. A comprehensive discharge summary and plan is completed prior to the patient leaving the hospice. A letter is provided to the patient's GP outlining the care and treatment which has been provided. Staff spoke positively on how initiatives are being developed to further enhance the discharge process. Robust systems were in place ensuring that agreed discharge arrangements are recorded and co-ordinated with all services that are involved in the patient's ongoing care and treatment.

The current arrangements with respect to specialist palliative care were noted to be of an extremely high standard and adhered to current best practice guidance.

There were examples of good practice found in relation to care delivery; the management of care records; the care pathway including admission and discharge arrangements; and patient engagement.

5.2.4 Does the hospice adhere to best practice guidance concerning the management of medicines?

The medicines management inspection was undertaken remotely. The Marie Curie management team were requested to complete a self-assessment questionnaire and to submit a range of documents to support the information provided. Further information was obtained during a Zoom conference call with one of the pharmacists on 14 April 2022.

Policies and procedures for the management of medicines were reviewed by management on a three yearly basis or following any policy changes or changes to legislation. Information on any changes to policies and procedures were shared with nursing and medical teams via emails, daily handover and were subsequently raised through appropriate meetings, for example, at medicines management committee meetings and staff meetings. Changes may also be raised at safety brief handovers, where applicable.

Medicines were managed by nurses who had been trained in relation to the organisation's medicines management policies and procedures and deemed competent. Medicines management training was included as part of the induction programme and an update was completed on a three yearly basis or more frequently if required. All new nursing staff were required to complete an online medicines management training programme, which had been recently updated to include scenario-based learning as well as calculation tests designed to familiarise staff with day to day calculations and opioid equivalency. New nursing staff were not permitted to administer medicines via single nurse administration until six months in post and after having undergone a competency assessment by the ward manager or ward sisters. Medical staff have an induction programme which includes the relevant policies and procedures. This also includes a meeting with the pharmacist to discuss relevant resources and processes with respect to medicines.

Arrangements were in place to ensure the safe management of medicines when a patient was admitted to the hospice. Medicines were reconciled by the pharmacist or admitting doctor using the Northern Ireland Electronic Care Record (NIECR), information provided by the patient or their family and the patient's supply of medicines. The medicine kardexes were written by one doctor and checked by the pharmacist or a second doctor to ensure accuracy. Robust systems were in place to ensure that patients were given advice about their medicines and were provided with a continuous supply of their medicines at discharge.

There were arrangements in place to audit various aspects of the management of medicines. There is a weekly incident meeting to review any medicine incidents and monitor for trends. Quarterly controlled drugs audits were completed by pharmacists and an annual Accountable Officer controlled drug audit was also performed. There was an annual antimicrobial prescribing audit which was subsequently discussed with staff at IPC meetings. A recent medicines reconciliation audit had been performed, as well as an oxygen prescribing audit.

Any issues raised post audit were discussed at the audit meetings and followed up in the most appropriate forum (SMT meeting or the Medicines Management meeting, where they were subsequently fed back to the SMT). Learning was disseminated via the organisation governance structures, locally and nationally.

There were systems in place for identifying, recording, analysing and learning from medicines related adverse events and near misses. Medication incidents were identified either in the course of normal work, or by medication reviews undertaken by the pharmacy staff. Medication incidents were reviewed at weekly incident meetings and, additionally, at monthly medicines management meetings. There was also national oversight from the organisation's nursing and quality team who review the data, identify trends and produce action plans and quality reports, as necessary.

The hospice has adopted the South Eastern Health and Social Care Trust (SEHSCT) antimicrobial stewardship policy. An annual Happy Antibiotics Prudent Prescribing Indicator (HAPPI) audit was performed to ensure compliance with procedures. The HAPPI audit outcome was presented to medical, nursing, pharmacy and allied health professional staff, including senior management through the audit meetings.

Good practice or quality improvement initiatives undertaken in relation to medicines management in the last 12 months included:

- The introduction of therapeutic drug monitoring charts
- The update and completion of the new "treatment of hypercalcaemia in solid malignancy" guidelines and work to introduce these as core practice for treating outpatients in the day hospice
- Liaison with the SEHSCT to establish a route of supply for antiviral medications for appropriate patients
- Work to introduce an oxygen prescribing chart to the ward
- Involvement of the pharmacist in updating Regional End of Life Care Guidelines
- Participation by the pharmacist in the organisation wide non-medical prescribing forum (including attending teaching and disseminating to medical colleagues and nursing staff)
- The adoption of patient information leaflets in the community and outpatient department relating to ketamine, oramorph and lorazepam for shortness of breath, syringe drivers, and opioids in palliative care

Based on the inspection findings, RQIA are satisfied that the service adheres to best practice guidance concerning the management of medicines.

5.2.5 Does the service ensure the environment is safe?

The following documentation was reviewed in relation to the maintenance of the premises including the mechanical and electrical installations. Discussion with staff demonstrated that suitable arrangements are in place for maintaining the environment in accordance with current legislation and best practice guidance.

- Fire risk assessment
- Service records for the premises fire alarm and detection system

- Service records for the premises emergency lighting installation
- Service records for the premises portable fire-fighting equipment
- Records relating to the required weekly and monthly fire safety function checks
- Records relating to staff fire safety training
- Records of fire drills undertaken
- Lifting operations and lifting equipment regulations 'thorough examination' reports of the premises' passenger lifts and patient hoists
- Gas safe certification
- Condition report for the premises' fixed wiring installation
- Report for the formal testing of the premises' portable electrical appliances
- The legionella/pseudomonas risk assessment
- Service records, validation checks and audits for the premises' specialist ventilation systems.

The most recent risk assessment with regards to water borne pathogens in the premises hot and cold water systems was undertaken on 22 July 2019, and remains a live working document. A water safety audit was undertaken on 21 July 2021 and the required control measures implemented and maintained. Suitable temperature monitoring of the premises' hot and cold water systems was in place with records being maintained as recommended. Regular bacteriological sampling of the hot and cold water systems, most recently undertaken on 16 June 2021, confirmed that legionella and pseudomonas bacteria were not detected.

The fire risk assessment had been undertaken by a suitably accredited fire risk assessor on 20 July 2021. The overall assessment was assessed as 'tolerable' and all identified significant findings had been fully addressed. Through discussion with staff and review of the records we confirmed suitable fire safety training was being delivered and maintained at the required frequency. Fire drills are held quarterly at various times of the day to ensure all staff attend at least one drill annually. The most recent fire drill for the premises had been completed on 10 March 2022.

All gas appliances (boilers and kitchen equipment) are subject to regular 'gas safe' inspections in accordance with current legislation. The most recent inspections were undertaken on 23 February 2022.

The premises' specialised ventilation systems are serviced in accordance with current best practice guidance and suitable service contracts are in place in accordance with the current health technical memoranda. Records and service reports were available and reviewed at the time of the inspection.

Based on the inspection findings, RQIA are satisfied that the provider is maintaining the premises, mechanical and electrical services in accordance with current best practice guidance.

5.2.6 Are robust arrangements in place to regarding clinical and organisation governance?

The organisational governance structures of the hospice were reviewed and it was noted that Marie Curie Hospice is part of a well-established UK wide organisation, has clear organisational structures in place and benefits from the support of robust local, regional and national governance structures.

The review of governance structures included a review of committee minutes and discussion with Mrs Heneghan, Responsible Individual; Miss Browne, Registered Manager; members of the SMT and the director of service delivery (national role). Discussions were held with a member of the LAB who also is a member of the UK Board of Trustees via Zoom teleconference on 5 May 2022.

The review of the current arrangements for governance and managerial oversight found the arrangements to be robust. Staff reported there were good working relationships and that management were responsive to any suggestions or concerns raised.

It was confirmed that a robust organisational structure was in place with clear lines of accountability, defined structures and visible leadership and staff were aware of these.

Staff who spoke with us were able to describe their roles and responsibilities and how they fitted into the overarching governance structures and committees. All staff that we spoke with were highly respectful towards the SMT; LAB members and the regional SMT.

Each devolved nation has a LAB with direct links to the Marie Curie UK Board. It was good to note that there is a strong emphasis within Marie Curie UK to ensure that each of the devolved nations is represented at corporate governance level.

The Northern Ireland (NI) LAB meets at least quarterly and will arrange an extraordinary meeting if required. Terms of reference for the operation of the LAB were in place. The chairperson for the LAB is also a Trustee of Marie Curie UK and represents NI on national committees such as the policy and quality committee and the safety committee.

It was confirmed that the Marie Curie United Kingdom (UK) Chief Executive regularly attends LAB meetings and undertakes sites visits. It was good to note that each local subcommittee provides minutes of sub-committee meetings and relevant papers that had been prepared for those meetings to the LAB members.

Trustees have strong links with the Marie Curie National Board and members of the local SMT report directly to the UK directors.

Review of the minutes of various committees that sit within the governance structure, for example; senior management and governance meetings; NI oversight and performance group; quality committee; medicine management; and patient and client experience demonstrated that these committees were functioning well and provide the required level of assurance to the SMT and LAB. The membership of the various committee meetings was representative of the governance structures. It was confirmed that LAB members are able to interrogate the data provided to them and provide appropriate challenge to the SMT, where required.

Organisation learning is discussed at LAB; subcommittee meetings at local and regional level and shared with heads of department for dissemination with staff.

It was observed that arrangements were in place to develop, implement and regularly review risk assessments. The active risk register was reviewed and there was evidence of risks being reviewed with the overarching risk grading being amended following mitigations being put in place.

The arrangements concerning medical governance were reviewed. As discussed in section 5.1 the terms of reference for the MAC were reviewed and these have been developed in accordance with the Minimum Standards for Independent Healthcare Establishments (July 2014). The MAC meets at least quarterly and had an identified quorum. MAC meetings are minuted and minutes of the most recent MAC meeting on 30 March 2022 were reviewed and noted to be a detailed account of the topics discussed and decisions made.

The medical director was not available on the 31 March 2022; therefore a further visit was arranged to the hospice on 19 May 2022. The purpose of this visit was to discuss the arrangements with respect to medical governance with the medical director and to review personnel files for medical practitioners.

All medical practitioners working within the hospice must have a designated Responsible Officer (RO). In accordance with the General Medical Council (GMC) all doctors must revalidate every five years. The revalidation process requires doctors to collect examples of their work to understand what they are doing well and how they can improve. Experienced senior doctors (called Responsible Officers) work with the GMC to make sure doctors are reviewing their work. As part of the revalidation process, RO's make revalidation recommendations to the GMC. Where concerns are raised regarding a doctor's practice information must be shared with their RO who then has the responsibility to share this information with all relevant stakeholders in the areas of the doctor's work.

It was confirmed that all medical practitioners working in the hospice have a designated RO. The arrangements for discussing how concerns would be raised regarding a doctor's practice, if applicable with the MAC and wider Health and Social Care (HSC) system was discussed with the medical director. It was noted that good internal arrangements were in place and the hospice was linked in with the regional RO network. The medical director issues letters of good standing for medical practitioners whose appraisals are undertaken in the HSC Trusts. The letters include details of all activities of a medical practitioner within the hospice.

A review of a sample of personnel files held for medical practitioners found that they contained all of the relevant information as outlined in Schedule 2 of the Independent Health Care Regulations (Northern Ireland) 2005, as amended. It was confirmed that no private doctors are working in the hospice, all medical practitioners either have direct contracts with the hospice or have joint contracts with a Health and Social Care Trust. No staff are currently granted practising privileges.

The medical director is actively involved in the recruitment of medical practitioners and reviews relevant recruitment records.

Debrief meetings known as multidisciplinary morbidity and mortality (M&M) meetings are held regularly and are formally documented.

It was confirmed that any learning from the M&M meetings would be shared with relevant staff and the SMT through the governance structures at a local and regional level. M&M meetings provide a unique opportunity for health professionals to improve the quality of care offered through the review of case studies. They also provide clinicians and members of the healthcare team with a routine forum for the open examination of individual events surrounding a patient's death, with a view to sharing any learning and improving practice. Feedback received from staff regarding these meetings was very positive.

The arrangements for the provision of medical practitioners within the hospice were reviewed to ensure that patients had access to appropriate medical intervention as and when required.

This review evidenced that robust arrangements were in place to meet the needs of the patients accommodated. A rota of medical practitioners was easily accessible to inform staff of the doctors working in the hospice and also arrangements for out of hours cover.

It was confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care and treatment delivered to patients at appropriate intervals. There is a rolling audit programme in place and the hospice is linked into the national audit programme.

It was observed that the results of audits are analysed and action plans developed to address any areas for improvement, including the name of the person responsible for implementing the action plan and the timeframe. It is commendable that all grades of staff including medical staff are involved in the completion of audits as this increases ownership and accountability amongst staff. Timeframes had been updated to show when action points had been completed. Staff told us that the SMT use this information to drive quality improvement within the hospice.

A system was also in place to ensure that urgent communications, safety alerts and notices are reviewed and, where appropriate, made available to key staff in a timely manner.

The hospice has a policy and procedure in place for the management of notifiable events/incidents which includes reporting arrangements to RQIA. Notifications submitted to RQIA since the previous inspection were reviewed. It was confirmed that all notifiable events/incidents were recorded, investigated and reported to RQIA or other relevant bodies, as appropriate, in a timely manner.

It was confirmed that any learning from notifiable events/incidents that occurred were reviewed through the governance structures of the hospice, in a meaningful way, to identify trends and learning that could be used to affect change or influence practice at both local and national levels. A trend analysis report is generated on a quarterly basis. A multidisciplinary approach is applied to the review of notifiable events/incidents and the hospice ensures the dissemination of learning to all staff. Staff described to us that the reporting of incidents is encouraged in an open and transparent way which leads to a no blame culture within the organisation and enhanced learning outcomes.

The hospice has a complaints policy and procedure in place in accordance with the relevant legislation and DoH guidance on complaints handling. A copy of the complaints procedure is made available for patients/and or their representatives. The management of complaints within the hospice was reviewed.

It was evidenced that systems were in place to ensure that any complaints received would be fully investigated and responded to appropriately. Records are kept of all complaints and include details of all communications with complainants; the result of any investigation; the outcome and any action taken. Information gathered from complaints would be used to improve the quality of services provided, if applicable. Staff who spoke with us demonstrated good awareness of how to deal with a complaint, if received.

Where the entity operating a hospice is a corporate body or partnership or an individual owner who is not in day to day management of the service, Regulation 26 unannounced quality monitoring visits must be undertaken and documented every six months. As discussed in section 5. 1 Mrs Heneghan, Responsible Individual, was in day to day control of the hospice therefore regulation 26 visits are not required.

During the Zoom conference meeting with a member of the LAB on 5 May 2022 the role and responsibilities of the LAB and the governance structures were discussed. It was good to note that the LAB members were actively reviewing their membership and identifying skill sets or areas of expertise that would further enhance the LAB for the benefit of the hospice. A discussion took place concerning the further development of the strategic plan and provision of services.

It was confirmed that the statement of purpose and patient's guide were kept under review, revised and updated when necessary and made available for all interested parties to read.

The RQIA certificate of registration was up to date and displayed appropriately and current insurance policies were in place.

RQIA would like to recognise the work undertaken by the LAB members, the SMT and staff of the hospice to progress the strengthening of the governance structures during a difficult time of a global pandemic while ensuring that safe, effective and compassionate palliative care continues to be delivered to patients and their families.

Overall, the governance structures within the hospice provided the required level of assurance to the SMT; LAB members and Marie Curie UK Board of Trustees.

5.2.7 Additional areas reviewed pertaining to the registration of Marie Curie

As discussed in section 1.0 of this report, the registered manager for Marie Curie Hospice and the responsible individual for Marie Curie Hospice and Marie Curie Nursing Service both resigned their positions prior to this inspection.

Mrs Heneghan was acting responsible individual for both services and following this inspection Mrs Heneghan submitted an application to be the responsible individual for both services. Following review of this application, registration of Mrs Heneghan as the responsible individual was approved with effect from 22 August 2022.

Prior to this inspection a registered manager application was submitted to RQIA on behalf of Miss Browne, following review of this application registration of Miss Browne as the registered manager was approved with effect from 22 August 2022.

Mrs Heneghan and Miss Browne informed the inspection team that all services delivered by the hospice (inpatient; day hospice and community nursing service) now report through the one governance structure therefore they wished to incorporate the Marie Curie Hospice and Marie Curie Nursing Service under one registration.

Following the inspection a proposal to amalgamate both services was submitted to RQIA. Following review of this proposal and discussion with the members of the senior management and senior representatives within RQIA the proposal to amalgamate both services under on registration was granted. Subsequently a voluntary cancellation of registration was submitted and approved with respect to the Marie Curie Nursing Service. Mrs Heneghan and Miss Browne are aware that going forward all services delivered by Marie Curie Hospice will be registered and regulated under the Marie Curie Hospice (10623) registration.

5.2.8 Does the service have suitable arrangements in place to record equality data?

The arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients was discussed with several members of the hospice team.

Discussion and review of information evidenced that the equality data collected was managed in line with best practice.

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Heneghan, Miss Browne and members of the SMT as part of the inspection process and can be found in the main body of the report.

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