The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report

3 March 2021

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

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

In respect of hospice services for the 2020/21 inspection year we are moving to a more focused, shorter inspection which will concentrate on the following key patient safety areas:

- review of areas for improvement identified during the previous care inspection
- management of operations in response to COVID-19 pandemic
- infection prevention and control (IPC)
- provision of palliative care
- organisational and medical governance
- medicines management
- the environment
- patient and staff feedback

1.1 Membership of the inspection team

Jo Browne	Senior Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Stephen O'Connor	Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Norma Munn	Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Paul Nixon	Inspector, Medicines Management Team Regulation and Quality Improvement Authority
Gavin Doherty	Inspector, Estates Team Regulation and Quality Improvement Authority

2.0 Profile of service

Marie Curie Hospice

This 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. We established that 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. The day hospices operated from three sites, one based in the Marie Curie Belfast site, one based at the Ards Community Hospital, Newtownards and one based at the Downe Hospital, Downpatrick. We established that as a direct result of the COVID-19 pandemic the day hospice services have been temporarily suspended.

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. In addition, there is a Rapid Response Team that operates within the Northern, Western and Southern Health and Social Care Trusts.

3.0 Service details

Marie Curie Hospice

Organisation/Registered Provider: Marie Curie **Responsible individual:** Mr Eamon O'Kane	**Registered Manager:** Mrs Miriam McKeown

Person in charge at the time of inspection: Mrs Miriam McKeown	**Date manager registered:** 18 October 2019
Categories of care: Independent Hospital (IH) – Adult Hospice	**Number of registered places:** 18 inpatients Day Hospice Belfast - 15 Day Hospice Newtownards - 15 Day Hospice Downpatrick -15

Marie Curie Nursing Service

Applicant Organisation/Registered Provider: Marie Curie **Responsible Individual:** Mr Eamon O'Kane	**Registered Manager:** Mrs Paula Heneghan
Person in charge of the establishment at the time of inspection: Mrs Paula Heneghan	**Date manager registered:** 9 April 2020
Categories of care: Independent Hospital (IH) – Adult Hospice	

4.0 Inspection summary

An unannounced inspection was undertaken to Marie Curie Hospice and Marie Curie Nursing Service which commenced with an onsite inspection on 3 March 2021. We employed a blended multidisciplinary inspection approach. The onsite element of our inspection was completed on 3 March 2021 by three care inspectors. We provided a list of specific documents to be sent electronically to our pharmacist inspector and estates inspector on or before 10 March 2021 for review remotely. Feedback of the inspection findings was delivered to the Marie Curie senior management team on 29 March 2021 during a zoom teleconference.

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 purpose of this inspection was to focus on the themes for the 2020/21 inspection year. Our multidisciplinary inspection team examined several aspects of the establishment 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.
We met with various staff members, reviewed care practice and reviewed relevant records and documentation used to support the governance and assurance systems.

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 and the community nursing service. We confirmed good governance measures were in place for the preparation and maintenance of a COVID-19 safe environment and IPC arrangements.

In general, we found the delivery of patient care was excellent. We found evidence of good practice in relation to the support provided to patients and their families; the provision of specialist palliative care; medicines management; and bereavement care services. We observed the environment which was found to be very peaceful and conducive to the delivery of care.

We found that the governance structures are able to provide the required level of assurance to the senior management team at a local and national level and the Board of Trustees.

We determined that the premises were maintained to a high standard of maintenance and décor and confirmed that robust arrangements were in place with regards to the maintenance of the premises, equipment and the environment.

One area for improvement was identified against the standards in relation to ensuring that the role and function of the Medical Advisory Committee (MAC) is clearly defined. One area for improvement was identified against the regulations in relation to undertaking unannounced quality monitoring visits in keeping with Regulation 26.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	1

Details of the Quality Improvement Plan (QIP) were discussed with Mr Eamon O'Kane, Responsible Individual; Mrs Miriam McKeown, Registered Manager of Marie Curie Hospice; Mrs Paula Heneghan, Registered Manager of Marie Curie Nursing Service, and the medical director during the feedback session, via zoom teleconference, on 29 March 2021. Findings of our inspection are outlined in the main body of the report.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection dated 9 March 2020

Marie Curie Hospice

Other than those actions detailed in the quality improvement plan (QIP) no further actions were required to be taken following the most recent inspection on 9 March 2020.

Marie Curie Nursing Service

The last inspection to Marie Curie Nursing Service was undertaken on 7 February 2020; no areas for improvement were identified.

5.0 How we inspect

In response to the COVID-19 pandemic, we reviewed our inspection methodology 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 establishments are providing services in keeping with the minimum standards and relevant legislation.

To meet with best practice guidance, we reduced the number of inspectors and employed a blended multidisciplinary inspection approach. Two care inspectors and a senior inspector undertook an unannounced onsite inspection on 3 March 2021 from 10:00 am to 5:00 pm. Before the onsite inspection, we had determined the additional information we would require to confirm compliance with the legislation and minimum standards for the areas inspected and were satisfied that this information could be provided to us electronically and reviewed remotely.

At the outset of our inspection on 3 March 2021, we provided Marie Curie Hospice with a list of documents to be sent electronically to our pharmacist and estates inspectors who were available offsite. Our pharmacist and estates inspectors reviewed the submitted documents and the pharmacist inspector also held discussions with Mrs McKeown and a pharmacist by telephone in the days following the onsite inspection. The pharmacist and estates inspectors provided their feedback to the inspection team to share with the hospice senior management team.

At the onsite inspection, we advised Marie Curie Hospice and Marie Curie Nursing Service that any outstanding issues could be followed up by email or teleconference following the inspection in an effort to minimise time spent on the premises.

We agreed that formal feedback would be provided to the Marie Curie Hospice and Marie Curie Nursing Service senior management team at a mutually agreeable date and time upon completion of our inspection process.

Before the inspection, we reviewed a range of information relevant to the service. This included the following records:

- notifiable events since the previous care inspections
- the registration status of the establishment
- written and verbal communication received since the previous care inspections
- the previous care inspection reports
- the returned QIP from the previous care inspection

We were unable to meet with patients on the day of the inspection and assessed patient feedback by reviewing the most recent patient satisfaction survey completed by Marie Curie Hospice and Marie Curie Nursing Service. We invited patients and staff to complete an electronic questionnaire. No completed patient or staff questionnaires were submitted following the inspection.

A poster informing patients, staff and visitors that an inspection was being conducted was displayed during the inspection.

During the onsite inspection we met and spoke with the following staff Mrs Miriam McKeown, Registered Manager of Marie Curie Hospice; Mrs Paula Heneghan, Registered Manager of Marie Curie Nursing Service; the inpatient unit ward manager; the infection prevention and control lead nurse; two health care assistants; a social worker; an occupational therapist; a pharmacist; a ward clerk; the personal assistant to the responsible individual; a receptionist; a staff nurse; the lead nurse; the day hospice manager; a chef and a housekeeping assistant.

Following the inspection Jo Browne, Senior Inspector spoke with Mr Eamon O'Kane, Responsible Individual and the medical director.

We undertook a tour of the in-patient unit including the staff rest areas.

We reviewed a sample of records in relation to the areas inspected.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 9 and 10 March 2020

The most recent inspection of Marie Curie Hospice was an unannounced inspection on 9 and 10 March 2020. The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 9 and 10 March 2020

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and The Minimum Care Standards for Independent Healthcare Establishments (2014)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 18.3 **Stated:** First time time	The Registered Person shall ensure that: • all emergency equipment is stored in a centralised area to ensure that it is readily accessible at all times; • the medical emergency and resuscitation policy is reviewed to reflect the revised arrangements in relation to the management and storage of emergency equipment provided; and • the need for the provision of emergency equipment and medication in the day hospice sites in Newtownards Hospital and Downe Hospital, Downpatrick is reviewed and risk assessed.	**Met**

	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.7.	
Area for improvement 2 **Ref:** Standard 20.3 **Stated:** First time	The Registered Person shall ensure the following areas are addressed to ensure that best practice in relation to aseptic non-touch technique (ANTT) is embedded into clinical practice: • ensure the ANTT training is cascaded to all relevant staff; • develop and implement competency-based assessments in relation to the application of ANTT and clinical practices; and • develop a robust system of audit to assure clinical practices.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.5.	
Area for improvement 3 **Ref:** Standard 6.5 **Stated:** First time	The Registered Person shall ensure that medical decisions made regarding or affecting a patient's condition are clearly communicated to all relevant staff in a timely manner. Daily multidisciplinary safety briefs should be implemented to share patient information with all members of the multidisciplinary team involved in their care and treatment and any other emerging issues that have the potential to impact on the provision of services.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.6.1.	
Area for improvement 4 **Ref:** Standard 6.5 **Stated:** First time	The Registered Person shall review the nursing handover system to ensure a robust system is in place to provide all staff and volunteers with accurate and up to date information in respect of each patient at the beginning of their shift.	**Met**

	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.6.7.	

6.3 Inspection findings

6.4 Management of operations in response to the COVID-19 pandemic

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

We reviewed a selection of documentation including minutes of meetings; COVID-19 risk assessments; audits of the environment and staff practices; and staff training records. The records confirmed good governance measures were in place for the preparation and maintenance of a COVID-19 safe environment.

We discussed the management of operations in response to the COVID-19 pandemic with the senior management team, medical director, nurse in charge and other staff members during and following the onsite inspection. We found COVID-19 policies and procedures were in place in keeping with best practice guidance. We reviewed the governance systems in place and we were informed that timely communications were provided to update staff regarding COVID-19 guidance.

We were informed that the IPC lead had developed strategies to incorporate COVID-19 training into IPC training and staff training records were updated to reflect this. During our inspection, we reviewed staff training records in relation to IPC and found that overall mandatory IPC training was up to date.

Additional training for staff in donning and doffing of personal protective equipment (PPE) was facilitated by the IPC lead. Discussion with staff confirmed they had received this training and that they have access to training materials.

Staff demonstrated good knowledge surrounding PPE requirements; environmental cleaning; hand hygiene; and COVID-19 risk assessments. Staff discussed with us audits that had been implemented due to COVID-19. Staff also confirmed that increased frequency of hand hygiene audits and environmental audits were ongoing. We reviewed completed environmental risk assessments and found these to be in line with best practice.

We found COVID-19 risk assessments with agreed action plans had also been completed for shielding staff returning to work, to protect them against exposure to the virus in the workplace. The risk assessment staff with underlying health conditions/age; staff who were pregnant (>28 weeks); and staff with underlying moderate or high-risk medical conditions.

We observed one way systems and social distancing by staff were well adhered to in both clinical and non-clinical areas. We evidenced mechanisms in place at ward level to challenge non-adherence when social distancing measures were breached. Staff told us they would feel confident to challenge anyone not compliant with any aspect of COVID-19 precautions.

We were informed all patients admitted to the hospice must have a negative COVID-19 test result before admission. We were told visiting arrangements have been reviewed and facilitated in line with the most recent DoH guidance. We confirmed that patients and their family are advised of the visiting arrangements on admission.

We observed that the detail of all persons permitted to enter the inpatient unit is logged and retained to enable Public Health Agency (PHA) to track and trace if required. We noted PPE was provided to any person before entering the inpatient unit and all visitors were directed by reception staff to sanitise their hands before entering the inpatient unit.

We observed staff changing facilities, staff rest areas and nurses stations and found these areas had been included in the COVID-19 risk assessment. Notices were displayed to remind staff of the maximum number of staff personnel permitted in each area in accordance with social distancing guidance. Staff break times have been staggered to facilitate social distancing and staff told us these arrangements were working well. The senior management team had also reviewed staff rest areas and had provided additional rest areas and office space to further enable staff to socially distance themselves. Some staff were facilitated to work from home, where possible.

Areas of good practice: Management of operations in response to COVID-19 pandemic

We found that staff were knowledgeable on COVID-19 pandemic restrictions. We confirmed 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.

Areas for improvement: Management of operations in response to COVID-19 pandemic

We identified no areas for improvement regarding the management of operations in response to the COVID-19 pandemic.

	Regulations	Standards
Areas for improvement	0	0

6.5 Infection prevention control (IPC)

We reviewed arrangements for IPC procedures throughout the hospice to evidence that the risk of infection transmission to patients, visitors and staff was minimised. We confirmed that the hospice had an identified infection prevention and control lead nurse who is supported by a health care assistant. The IPC lead nurse supports the development and implementation of best practice.

We undertook a tour of the premises and found all areas to be clean, tidy and well maintained. We observed that environmental cleanliness in all areas, clinical and communal, was of a high standard and the environment was well maintained and clutter free. We found that cleaning schedules were in place that included all areas of the hospice and detailed daily, weekly and monthly cleaning protocols. All records had been completed and were up to date.

We observed IPC information was displayed on notice boards in both clinical and non-clinical areas. This provided assurance of audit compliance to visitors and staff of a good standard of environmental cleaning. We were provided with evidence and assurance of actions taken if environmental standards were to fall below the expected standard. We observed staff performing best practice with hand hygiene, the use of PPE and adhering to the uniform policy. Hand hygiene posters were displayed for patients, visitors and staff regarding good hand hygiene and hand washing techniques.

We found evidence that regular IPC audits are undertaken. We reviewed a range of IPC audits undertaken in clinical areas including environmental; hand hygiene; and catheter care audits which confirmed good compliance and oversight in these areas. We were told that should an audit identify poor compliance audit findings are escalated to the relevant head of department and that an action plan would be developed and implemented to affect change and improve practice, as applicable. We confirmed that a range of audit scores in relations to laundry; clinical waste and technical cleaning are used to benchmark against regional audit scores in these areas.

We reviewed a range of IPC policies and procedures and staff confirmed that they have been provided with IPC training commensurate with their role. We were told that a staff member had been identified to deliver ANTT training to relevant staff. We reviewed ANTT training presentations developed by the identified staff member and confirmed that staff training had commenced. We noted that a further four training sessions had been scheduled for March 2021. We confirmed that once all relevant staff has completed training the trainer will undertake competency assessments and commence a rolling ANTT audit programme. This addresses the previous Area for Improvement 2 outlined in section 6.2.

We were informed that arrangements were in place to ensure the decontamination of equipment and reusable medical devices in line with the manufacturer’s instructions and current best practice. Staff confirmed single use equipment is used where possible.

Areas of good practice: IPC

We reviewed the current arrangements concerning IPC practice and evidenced areas of good practice. We were assured of strong governance mechanisms and collaborative working across the hospice and community nursing service. We observed risks being assessed and managed with training and robust auditing measures in place in clinical areas.

Areas for improvement: IPC

No areas for improvement were identified concerning IPC arrangements.

	Regulations	Standards
Areas for improvement	0	0

6.6 Provision of palliative care

6.6.1 Care pathway

Marie Curie Hospice

We reviewed the patient care pathway and noted a good multi-disciplinary system for the review of referrals and triage/assessment of patients referred to Marie Curie Hospice. We confirmed that staff receive relevant information about the patient before their admission.

Referrals can be received from the palliative care team, hospital consultant, nurse specialist or general practitioners (GP). Multi-disciplinary assessments are furnished with the referral information through the regional referral arrangements. These systems were found to be robust.

We found patients and/or their representatives are provided with relevant information, either before admission or on admission, regarding the hospice and the various assessments that may be undertaken by members of the multi-disciplinary team. This includes medical, nursing, physiotherapy, occupational therapy, social work and spiritual assessments.

Marie Curie Nursing Service

We were told that referrals are received in the Marie Curie Nursing Service coordination centre. Referrals are made by a range of other healthcare professionals who inform the patient of the service and gain the patient's consent to make a referral.

We found good communication channels with primary and community care teams and other agencies. A member of staff from the Marie Curie Nursing Service will contact the patient by telephone before visiting and will discuss how their needs can best be met.

The referral and assessment process embraces the holistic, cross-professional nature of palliative care and allows for engagement with patients and their representatives in all aspects of the provision of care provided by the nursing service team

We found good information is provided to prospective patients and their families regarding the Marie Curie Nursing Services available and how to access these.

We were told that a patient information pack is sent to the patient by post which provides information on being cared for at home including dealing with the physical, practical and emotional aspects of living with a terminal illness and organisations that can help.

We met with staff, reviewed relevant records and confirmed that multi-disciplinary daily safety briefs had been introduced since the previous inspection. These meetings are held at an agreed time and place and focus on the patients most at risk; as well as all other emerging issues that may have the potential to impact the provision of services. We were told that medical decisions made regarding or affecting a patient's condition had been clearly communicated during these safety briefs to all relevant staff in a timely manner. This addresses the previous Area for Improvement 3 outlined in section 6.2.

6.6.2 Person centred care

We reviewed two inpatient care records and discussed entries with staff. We established that the inpatient unit and each day hospice service had a computerised records system in place, called EMIS. Electronic care records retained were supplemented with paper records, where applicable. We found the plans of care and treatment were provided in a flexible manner to meet the expressed wishes and assessed needs of individual patients and their families. We found that care was patient centred.

Accessible facilities were provided to accommodate patients and their family to enable them to spend as much time together, as permissible, in the hospice in keeping with current visiting guidance issued by the DoH.

The hospice has a call system in place for patients to request assistance. We observed the system in operation as staff responded to patients to meet their needs in a timely manner.

We observed compassionate and positive interactions between staff and patients as staff entered and exited patients' rooms.

We found staff introduced themselves to patients and requested permission to enter the patient's room and then went on to explain why they were there in a kind and caring manner.

6.6.3 Bereavement care service

We reviewed the provision of bereavement care within the hospice and found that they have a range of information and support services available. The bereavement services offered by the hospice are managed by the social work team. We discussed the services provided with a member of the social work team and confirmed that the staff who deliver bereavement care services are appropriately trained and skilled in this area. We found this to be an excellent service that is offered at the time of the bereavement and provides ongoing bereavement care and support as necessary. The chaplaincy service available within the hospice provides spiritual support to patients and their families and we found that this was well utilised.

We were informed that counselling and support services were also available for staff if needed.

6.6.4 Breaking bad news

We were informed that the policy and procedure for delivering bad news to patients and/or their representatives are in accordance with the Breaking Bad News Regional Guidelines 2003. The hospice retains a copy of the regional guidelines and these were accessible to staff.

We confirmed that bad news is delivered to patients and/or their representatives by professionals who have experience in communication skills and act in accordance with the hospice's policy and procedure. Where this news is shared with others, consent must be obtained from the patient, where possible, and is documented in the patient's records. Following a patient receiving bad news, future treatment options are discussed fully with the patient and documented within their individual care records. Staff provide support to the patient and/or their representatives to help them to process the information shared. We were informed that the delivery of bad news is fully reflected in the care records. With the patient's consent, information is shared with the patient's GP.

6.6.5 Patient engagement

We reviewed how the hospice engages with patients and/or their representatives and found that this is 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. We reviewed the most recent survey undertaken in October 2020. The feedback was overall very positive about the quality of care and treatment provided.

The information received from these questionnaires is made available to patients and other interested parties to read as an annual report. This report is also considered by the hospice senior management team and informs the ongoing quality improvement of services.

6.6.6 Discharge

We reviewed the discharge policy and procedure and found robust discharge planning arrangements were in place that required full engagement with patients and/or their representatives.

We were informed that a discharge summary and plan is completed before the patient leaves the hospice.

A letter is provided to the patient's GP outlining the care and treatment provided within the hospice. Daily and weekly multi-disciplinary meetings take place to ensure the patient’s individual needs are at the centre of discharge planning.

We found that robust systems were in place to ensure that agreed discharge arrangements were recorded and coordinated with all services that were involved in the patient's ongoing care and treatment.

6.6.7 Nursing handover

We spoke to staff and were informed that the system to record the daily nursing handover had been reviewed since the previous inspection. Staff informed us that the handover takes place at the beginning of each shift and the information that all staff receive is accurate and up to date. We reviewed a copy of the daily nursing handover record for the day of the inspection and found that the information recorded was relevant and up to date in respect of each patient accommodated. This addresses the previous Area for Improvement 4 outlined in section 6.2.

Areas of good practice: provision of palliative care

We found examples of good practice in relation to care delivery; the management of clinical records; the care pathway including admission and discharge arrangements; patient engagement; and the provision of information to patients.

Areas for improvement: provision of palliative care

No areas for improvement were identified in relation to the provision of palliative care.

	Regulations	Standards
Areas for improvement	0	0

6.7 Medicines management

The medicines management element of the inspection was completed remotely. The senior management team of the hospice were provided with a self-assessment questionnaire to complete and were requested to submit documents to support the information provided. We spoke with the Registered Manager and one of the pharmacists as part of the inspection.

We examined the documents provided to determine if there were robust systems in place for the safe and effective management of medicines and that these were in compliance with legislative requirements, professional standards and guidelines.

Policies and procedures for the management of medicines were reviewed by the senior management team on a three yearly basis, or more frequently if there had been a change in practice/guidance. Information on any changes to policies and procedures was shared with nursing and medical teams via emails, daily handover, multi-disciplinary team meetings, operational meetings and feedback through line managers.

Medicines were managed by registered 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.

Safe systems were in place for confirming medicines on admission. The pharmacists' co-ordinate this process. The medical practitioner on duty is responsible for writing the prescription record.

We reviewed a sample of patients' kardexes. These are records which detail the medicines prescribed for each patient. We found that these records were legible and accurately maintained and indicated that the patients were receiving their medicines.

There were arrangements in place to audit various aspects of the management of medicines. The internal audits covered the management of controlled drugs; monitoring storage temperatures and date checking; the administration of medicines; the prescribing of medicines; and the review of medicine incidents. Over the previous 12 months, the pharmacists had completed specific audits concerning alfentanil prescribing, dexamethasone prescribing, reducing drug costs and opioid rotation. Action plans were developed to drive forward any areas identified for improvement and were monitored for completion.

There were systems in place for identifying, recording, analysing and learning from medicines related adverse events and near misses. Medicine incidents were reported to the registered manager or senior nurse on duty and any immediate actions were implemented. Incidents were discussed weekly by the registered manager, medical director, lead nurse and ward manager and were actioned or closed off. Medicine incidents were reviewed at meetings of the Medicines Management Committee and Clinical Governance Group.

Learning from medicine incidents was shared with staff and any changes to practice were implemented through:

- weekly teaching sessions
- daily briefing for all clinical staff
- case review
- root cause analysis
- clinical supervision
- ward meetings/medical staff meetings/emails
- serious untoward incident panel (sharing of information to clinical team)

The hospice has adopted the South Eastern Health and Social Care Trust antimicrobial stewardship policy. There was evidence that an annual antimicrobial prescribing audit was carried out and an action plan was devised to improve practice. The HAPPI (Happy Antibiotics Prudent Prescribing Indicator) audit outcome was presented to medical, nursing, pharmacy and allied health professional staff, including senior management through the audit meetings. Discussion of antimicrobial use took place through the use of COMPASS reports produced by the Health and Social Care Board.

We reviewed the provision and storage of emergency equipment and medication and found that it was stored in a centralised area beside the nurses' station.

We reviewed the medical emergency and resuscitation policy and found that it had been updated since the previous inspection and included the location, management and storage of the emergency equipment and medication.

We discussed the need for the provision of emergency equipment and medication in the day hospice sites and were advised that the day hospice sites had been closed since 18 March 2020 due to the COVID-19 pandemic. We have been advised that this will be reviewed and risk assessed when the day hospices become operational again. This addresses the previous area for improvement 1 outlined in section 6.2.

Areas of good practice: medicines management

We observed satisfactory systems for the following areas of the management of medicines staff training and competency assessment; the medicine records; the management of the medicines on discharge; and the provision of emergency equipment and medication.

Areas for improvement: medicines management

No areas for improvement were identified in relation to medicines management.

	Regulations	Standards
Areas for improvement	0	0

6.8 Environment

The estates element of the inspection was undertaken remotely. The following documents were submitted and reviewed:

- 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
- LOLER 'Thorough Examination' reports of the premises lifting equipment and staff passenger lift
- condition reports for the premises fixed wiring electrical installation
- condition report for the formal testing of the premises portable electrical appliances
- Legionella Risk Assessment, water safety plan and records of control measures
- service records and validation reports for the premises piped medical gas systems
- service records for the premises specialist ventilation

A current legionella risk assessment was in place and the required control measures continue to be implemented. 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 is also undertaken and the most recent results on file confirmed that legionella bacteria were not detected. A contract for the regular servicing of all thermostatic mixing valves throughout the premises was in place with the most recent service being completed on 10 November 2020.

A fire risk assessment had been undertaken by a suitably accredited fire risk assessor on 5 March 2020 and all required actions flowing from this assessment were signed-off as completed. Fire safety records inspected, confirmed that all systems were maintained in accordance with current best practice guidance. Regular fire drills and training continue to be undertaken, including an 'out of hours' fire drill which was recorded on 29 April 2020.

The review of the submitted records and validation reports demonstrated that the premises' piped medical gas systems and specialist ventilation systems were serviced in accordance with current best practice guidance and are suitably validated in accordance with the current health technical memoranda.

The premises' space and water heating services are fully maintained and serviced in accordance with best practice guidance. These include the service and testing of the premises' emergency standby electrical generator and gas detection systems.

Areas of good practice: environment

We observed satisfactory systems were in place for all areas of estates management, with suitable contracts in place for the provision of necessary specialist services.

Areas for improvement: environment

No areas for improvement were identified as a result of this inspection.

	Regulations	Standards
Areas for improvement	0	0

6.9 Organisational and clinical governance

6.9.1 Organisational and clinical governance

We reviewed the organisational governance of the hospice and found that Marie Curie Hospice, as part of a well-established UK wide organisation, had clear organisational structures in place and benefitted from the support of robust local, regional and national governance structures.

Marie Curie Hospice is registered for 18 inpatient beds and normally operates a day hospice service from three sites as previously outlined in section 2.0. Currently, the hospice is operating 14 inpatient beds and intends to use the additional beds to facilitate interventional procedures for day patients while the day hospices remain temporarily closed.

There are separate registered managers for the inpatient unit/day hospice and community services. Mrs McKeown is the Registered Manager and has overall responsibility for the day to day management of the inpatient unit and day hospices. We were informed that Mrs McKeown is retiring from her post at the end of March 2021. Mrs Heneghan is the Registered Manager for the Marie Curie Nursing Service. Following a restructure within Marie Curie, Mrs Heneghan has recently been promoted to Head of Strategic Partnerships and Services. Interim management arrangements have been agreed with RQIA while the hospice recruits into these positions. The discussions with Mr O'Kane, Ms Heneghan and the medical director outlined the strategic direction of the hospice, organisational restructuring and the integration of services in line with the Regional Palliative Care Strategy for NI.

Mr O'Kane, Responsible Individual, is also the Deputy Director Devolved Nations & National Programmes at Marie Curie. Mr O'Kane is responsible for Marie Curie Belfast, Marie Curie Nursing Service and hospice services in the other devolved nations.

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

We reviewed relevant documentation and discussed the governance arrangements with a number of staff including Mr O'Kane, Mrs McKeown, Mrs Heneghan, the medical director and other various grades of staff. Staff were able to describe to us their roles and responsibilities and how they fitted into the overarching governance structures and committees. Staff told us the governance structures ensure appropriate and timely information is provided to staff and the relevant committees that enables the best use of clinical and staff expertise.

We would like to recognise the ongoing work undertaken by the senior management team and staff of the hospice and nursing service during the difficult time of a global pandemic to ensure that safe, effective and compassionate palliative and end of life care continues to be delivered to patients and their families.

We were advised that the hospice maintains a corporate risk register. A review of this register evidenced that it included risks in relation to all areas of the hospice that have the potential to impact the delivery of services. We confirmed that the risk register included actions to mitigate against identified risks and that it is reviewed on a monthly basis through the hospice's clinical governance meetings.

Through discussion with us, the responsible individual and the registered managers demonstrated a clear understanding of their roles and responsibilities in accordance with legislation.

We 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 certificates of registration were up to date and displayed appropriately in the foyer of the hospice. We confirmed that current insurance policies were in place.

Overall, we found that the governance structures within the hospice were robust and the senior management team showed that they have developed a shared vision and strategy for the hospice and a cohesive and productive way of working together.

6.9.2 Medical Governance

We spoke with the medical director via telephone following the inspection. We were assured from our discussions that there were suitable arrangements in place in relation to medical governance, medical leadership and medical cover within the hospice. We found that the medical director is fully involved in the governance arrangements of the hospice including the review of safety and quality information, incidents, complaints and key performance indicators (KPIs) through attendance at the clinical governance group meetings and other relevant committees.

We found that the role and function of the Medical Advisory Committee (MAC) was being undertaken at the weekly medical practitioner's meeting. An area for improvement was identified to ensure that the role of the MAC is formalised within the hospice's governance structures and terms of reference developed in line with Standard 30 of the Minimum Care Standards for Independent Healthcare Establishments, July 2014.

We found that Morbidity and Mortality (M&M) meetings are held regularly and are formally documented as part of the multidisciplinary team meetings. We confirmed that any learning from the M&M meetings would be shared with relevant staff and the senior management team through the hospice governance structures. 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.

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. We established that all medical practitioners working in the hospice have a designated RO. We discussed how concerns would be raised regarding a doctor's practice with the MAC and wider Health and Social Care (HSC) system and found that good internal arrangements were in place and the hospice was linked in with the regional RO network.

We reviewed a sample of personnel files held for medical practitioners and 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. We found that all medical staff have direct contracts with the hospice and no staff are currently granted practising privileges.

We discussed with the medical director the benefits of reviewing the whole appraisal documents for medical staff. Most appraisals are undertaken by Marie Curie, however, for medical staff who have their appraisal undertaken by a trust, the hospice should have systems in place to receive a copy of the full appraisal, not just the sign off sheet. The appraisal should be scrutinised by the medical director and record retained of this review. This will provide an additional level of assurance to the hospice and also provide an opportunity for the hospice to be involved in the Personal Development Plan (PDP) of the doctor. The medical director confirmed that in the future the full appraisal document would be retained and reviewed.

We reviewed the provision of medical practitioners within the hospice to ensure that patients had access to appropriate medical interventions as and when required and determined that the hospice had robust arrangements in place to meet the needs of the patients accommodated. We found that 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.

6.9.3 Quality assurance

We 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. We found evidence of an audit system and rolling audit programme at a local and national level. We noted that the results of audits are analysed and actions plans developed to address any areas for improvement, including the name of the person responsible for implementing the action plan and the timeframe. The results of audits are displayed on notice boards and presented at relevant governance and clinical audit committees to provide robust assurances on safety and tangible evidence of ongoing audit and quality improvement. The hospice audits leads are supported nationally and meet through an established clinical audit group that drives the audit programme.

We were informed of a quality improvement (QI) initiative undertaken by one of the medical practitioners that gained a QI award. 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.

The hospice has a clear set of clinical quality indicators and KPI reports are produced by the Caring Services Management Team and dashboards were being used to display this data in relation to the inpatient unit and the nursing service. The results of the KPI reports and dashboards are shared locally and nationally through the organisation's governance structures.

We were advised that the hospice provides teaching sessions for staff one afternoon per week to further enhance staff development.

We found that 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.

Marie Curie UK has systems in place for a team to visit each hospice and measure their compliance against the regulations and standards that strengthens their organisational governance. The most recent visit to Marie Curie Belfast was undertaken in August 2020.

6.9.4 Notifiable events/incidents

The hospice has a policy and procedure in place for the management of notifiable events/incidents which includes reporting arrangements to RQIA.

We reviewed notifications submitted to us since the previous inspections and confirmed that all notifiable events/incidents were recorded, investigated and reported to RQIA or other relevant bodies, as appropriate, in a timely manner.

We found that all subsequent 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. Systems are in place to share learning on both a local and national level. We saw examples of Serious Adverse Events in other hospices being reviewed and shared with Marie Curie Belfast. This is good practice and promotes a culture of open and transparent learning.

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.

We discussed with the senior management team and the medical director how the hospice implements learning from the regional Early Alert/Serious Adverse Incident (SAI) system and found that robust arrangements were in place.

Learning from a recent early alert in relation to identified choking hazards in other establishments resulted in the senior management team undertaking a review of the hospice's systems in relation to patients' dietary requirements and providing additional training to all relevant staff on the International Dysphagia Diet Standardisation Initiative (IDDSI). The IDDSI provides a framework and common terminology to describe food textures and drink thickness which improves safety for patients with swallowing difficulties. The use of regional learning to drive local improvements within the hospice is to be commended.

6.9.5 Complaints management

We found 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 in the patient information pack and on the website.

We established any complaints received were raised through the governance systems of the organisation and were investigated and responded to. Any complaints received are recorded on the hospice's risk management and quality assurance database and shared with the UK based complaints manager and the patient experience team. We confirmed complaints records included details of all communications with complainants; the results of any investigation; the outcome and any action taken to address the concerns. All managers complete training on managing complaints and incidents and complaints awareness training is provided annually for all other relevant staff.

Staff who spoke with us demonstrated a good awareness of the processes outlined within the complaints policy and procedures and the action to take if they received a complaint.

The hospice had systems in place to share any compliments received, regarding the care and services provided, with staff through their governance structures.

We reviewed the most recent national complaints audit undertaken and found a positive outcome in respect of Marie Curie Belfast.

6.9.6 Regulation 26 unannounced quality monitoring visits

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.

Mr O'Kane is responsible for monitoring the quality of services and is required to undertake a visit to the premises at least every six months in accordance with Regulation 26 of the legislation. We reviewed the most recent unannounced quality monitoring report undertaken in March 2020 and found the report to be detailed and a thorough record of the visit. Due to the COVID-19 pandemic Mr O'Kane had been working offsite and had not completed any further unannounced visits or nominated an individual to undertake this role on his behalf. An area for improvement has been identified in this regard.

Areas of good practice: Organisational and clinical governance

We found examples of good practice in relation to organisational and clinical governance arrangements, medical governance and leadership; quality assurance and improvement; management of incidents; and complaints management.

Areas for improvement: Organisational and clinical governance

Two areas for improvement were identified in relation to formalising the role of the Medical Advisory Committee and ensuring that six monthly unannounced visits by the responsible individual or their nominated representative, are carried out.

	Regulations	Standards
Areas for improvement	1	1

6.10 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. Review of information evidenced that the equality data collected was managed in line with best practice.

We were advised that diversity training has been provided to staff.

6.11 Patient and staff views

We reviewed how the hospice engages with patients and/or their representatives and found that this was an integral part of the service they deliver. Patients and/or their representatives were offered the opportunity to provide feedback through a questionnaire. Where required, assistance to complete the questionnaire was provided.

The information received from these questionnaires was made available to patients and other interested parties to read as an annual report. This report was also considered by the senior management team and informed improvements to services.

We were unable to meet with patients on the day of the inspection and assessed patient feedback by reviewing the most recent patient satisfaction surveys completed by Marie Curie. The feedback reviewed was very found to be very positive regarding the quality of care and treatment delivered to patients and their families.

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

7.0 Quality improvement plan (QIP)

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Eamon O'Kane, Responsible Individual; Mrs Miriam McKeown, Registered Manager of Marie Curie Hospice; Mrs Paula Heneghan, Registered Manager of Marie Curie Nursing Service; and the medical director, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to enforcement action. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the hospice. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and 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).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and Minimum Care Standards for Independent Healthcare Establishments (July 2014)	
Area for improvement 1 **Ref**: Regulation 26 (3) **Stated:** First time **To be completed by:** 26 May 2021	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. Ref: 6.9.6
	Response by registered person detailing the actions taken: The six monthly unannounced visits were interrupted by the pandemic and corporate IPC guidelines. An announced visit will now be completed by the Responsible Person and then instigated at least 6 monthly. In the event that future disruption might affect the visits the Associate Director of Strategic Partnerships and Services will be nominated to so the vists. This delegation will happen after October 2021 by which time the Associate Director will have been replaced in her role as Registered Manager by our newly appointed Head of Operations.
Area for improvement 2 **Ref**: Standard 30.1 **Stated:** First time **To be completed by:** 26 May 2021	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. Ref: 6.9.2
	Response by registered person detailing the actions taken: We currently have a monthy Doctor's meeting that addresses many of the aspects of a Medical Advisory Committee (MAC We will replace this meeting Quarterly with a Medical Advisory Meeting co-chaired by the Registered Manager and Medical Director and will develop a terms of reference for the first meeting to take place in August 2021)

Please ensure this document is completed in full and returned via Web Portal

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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