The Regulation and Quality Improvement Authority

Inspection Report

6 February 2023

Marie Curie Hospice

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:** 22 August 2022
Person in charge at the time of inspection: Miss Jo Browne	
Categories of care: Independent Hospital (IH) Hospice Adult – H(A) Private Doctor - PD	
Brief description of how the service operates: Following the previous inspection on 31 March and 19 May 2022 a proposal was submitted to RQIA to amalgamate the registration of Marie Curie Hospice and Marie Curie Nursing Service. Following a 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. All services delivered by Marie Curie Hospice are registered and regulated under the Marie Curie Hospice (10623) registration. 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. Following the previous inspection, the day hospice services were reconfigured. The Marie Curie community and outpatients facility operates Monday to Friday 9am - 5pm providing patients and their families with a full range of multidisciplinary services including visits to patient's own homes by members of team. The Marie Curie community nursing service is a generalist palliative and end of life care nursing service which is commissioned in all five Northern Ireland Health and Social Care Trusts. The service provides care and support to adults over the age of 18 years, facilitating choice in where the patient wishes to be cared for at the end of life. The service operates over a 24-hour period with care being delivered by both Marie Curie registered nurses and healthcare assistants who have enhanced training and skills in palliative and end of life care.	

2.0 Inspection summary

An announced inspection was undertaken to the Marie Curie Hospice on 6 February 2023 from 09:30 am to 6:00pm by three care inspectors supported by RQIA's Adept Fellow. The care inspection was followed up with an onsite medicines management inspection by a pharmacist inspector on 7 February 2023. Feedback of the onsite care and medicines management inspections was delivered to the hospice senior management team (SMT) on the day of the inspections. The electronic submission of additional documentation in relation to the premises aspect of the inspection was reviewed remotely by an RQIA estates inspector and feedback was provided to the hospice following the inspection.

The purpose of the inspection was to assess compliance with the legislation and minimum standards.

Examples of good practice were evidenced in respect of: staffing; staff training; recruitment and selection of staff; safeguarding; management of medicines; infection prevention and control; adherence to best practice guidance in relation to COVID-19; the provision of palliative care and the management of the patients' care pathway; clinical and organisational governance; engagement to enhance the patients' experience and the maintenance of the environment.

The inspection team found the care provided and delivered in the hospice to be of an excellent standard. 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 SMT and the Board of Trustees.

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.

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

One week prior to the onsite inspection the hospice was provided with a list of specific documents requesting items to be reviewed remotely in respect of the maintenance of the premises and grounds. These items were to be sent electronically to our estates inspector on or before 17 February 2023 for review remotely.

During the onsite inspection the team undertook a tour of the premises and met with various staff members, observed care practices and reviewed relevant records and documentation.

4.0 What people told us about the service?

Posters were provided to the hospice by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire. No completed staff or patient questionnaires were submitted following the inspection.

Patient feedback was assessed by reviewing the most recent patient and carer experience report for feedback received between July and September 2022 (regional report) and the patient experience report for the Belfast site for feedback received between January and October 2022. 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. Since the previous inspection two new volunteers have received training to support patients and their representatives to complete the patient experience surveys and two new patient experience leads have been identified for the inpatient and community nursing service.

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.

5.0 The inspection

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

There were no areas for improvement identified at the last inspection undertaken on 31 March and 19 May 2022.

5.2 Inspection outcomes

5.2.1 How does the hospice ensure that safe staffing arrangements are in place to meet the needs of patients?

The staffing arrangements in respect of the Marie Curie community and outpatients' facility service and the inpatient unit (IPU) were reviewed.

The community nursing service and out-patient facility is staffed by a multidisciplinary team consisting of specialist doctors, nurses and healthcare assistants who are supported by occupational therapists; rehabilitation assistant; physiotherapists; and social workers with specialist palliative care expertise.

The team had recently collaborated with the haematology medical and nursing staff at the Macmillan Unit at Ulster Hospital Dundonald (UHD) to allow for a suitable cohort of their patients to have their transfusional services facilitated at the Marie Curie Hospice Belfast. This collaborative working allows the UHD Macmillan Team to offer treatment spaces to more acute patients within their department.

A multidisciplinary team works in the IPU of the hospice and comprises of consultants; doctors; nurses; healthcare assistants; occupational therapists; rehabilitation assistant; physiotherapists; and social workers with specialist palliative care expertise. In addition, there is a team of ancillary staff; administrative staff; and a chaplaincy team supported by volunteers in providing a variety of services.

Staff who spoke with us told us that they enjoy working in Marie Curie and that they felt supported in their roles. Some staff told us that there have been challenging times with some long standing staff and other staff leaving the hospice in the last year. It is recognised that when there are changes in a staff team there can be a period of adjustment for all concerned. Staff told us they felt able to discuss any concerns they had with senior management and felt that they were listened to and their concerns addressed. Staff described that following the initial period of adjustment communications between the medical and nursing staff had improved. Staff confirmed that there were good working relationships throughout the hospice. Evidence demonstrated that all members of the multi-disciplinary team have the opportunity to attend weekly multi-disciplinary meetings; daily handovers; staff de-briefs; team meetings; supervisions and appraisals.

Discussions with staff and a review of the duty rotas confirmed that there was sufficient staff in various roles to meet the assessed needs of patients. Whilst no concerns were raised in respect of staffing levels at the time of this inspection, the recruitment of staff has been identified as a potential issue and a corporate strategy is being developed in response to this matter.

A review of records and discussion with senior management confirmed that staff receive appropriate training to fulfil the duties of their role in keeping with the RQIA training guidance and also with Marie Curie training and development programme. The hospice has an electronic system which includes an online learning and development site offering a range of training modules.

Staff are notified electronically of any training that requires renewal and the system enables line managers to monitor individual staff member's training compliance at every level.

A review of the training compliance matrix confirmed that mandatory training has been provided in line with RQIA training guidance with the exception of basic life support (BLS) training. Accessibility issues regarding face to face BLS training were discussed and while a training date had yet to be confirmed at the time of the inspection, it was demonstrated that a BLS trainer was actively being sought as a priority action. The inspection team was assured that this matter continues to be raised at the monthly senior management group meetings.

Senior management confirmed that all matters in relation to training compliance is overseen and monitored by the senior management team on a monthly and quarterly basis.

The hospice affords staff opportunities to undertake specialist qualifications in palliative care. Additional training options for staff were discussed such as: specialist practice in palliative care; the Princess Alice award, diploma in health and social care, advanced nurse practitioner, post graduate diploma in health education, non-medical prescribing and specialist courses relating to loss and bereavement.

We were told that a clinical nurse specialist (CNS) team had been established within the community and outpatient services. The new nursing team were guided in their development by a career competency framework for this specialist nursing role. In establishing this team, a CNS with experience in palliative care was employed for six months to support and mentor the development of the staff in these roles. There are also plans in place to recruit an advanced nurse practitioner to work across all hospice services to assist with addressing projected workforce issues in the future.

An induction programme had been developed for each new member of staff which was relevant to their roles and responsibilities.

A review of a sample of records and discussion with management and staff evidenced that supervision is offered on a quarterly basis however it was recognised that supervision uptake has been impacted on by staffing levels on wards. Appraisals had been completed on an annual basis. Staff reported they were well supported and fully involved in discussions about their personal and professional development.

It was determined that there was sufficient staff in various roles to meet the assessed needs of patients throughout the hospice services.

5.2.2 How does the hospice ensure that recruitment and selection procedures are safe?

The arrangements for the recruitment and selection of staff were reviewed. A policy and procedure was in place in keeping with legislation and best practice.

Recruitment and selection is managed through an electronic system called Oracle. Miss Browne told us that, as the registered manager, she has access to all pre-employment recruitment documentation via the Oracle system. However, following the appointment of a staff member, the pre-employment documentation is only available to the human resource department (HR).

This matter was discussed with Miss Browne and following the inspection Miss Browne confirmed that she now has full access to all recruitment records and can check that all required recruitment records are in place prior to the commencement of employment of any new staff member.

A staff register was in place which was up to date in keeping with legislation.

A review of a sample of eight personnel files of staff, recruited since the previous inspection, evidenced that all documentation as outlined in Schedule 2 of The Independent Health Care Regulations (NI) 2005, as amended, were in place.

Discussion with Miss Browne and a review of records demonstrated that robust arrangements are in place to monitor the professional indemnity of relevant staff and the professional registration status of all clinical staff.

It was determined that the recruitment and selection of staff is in compliance with legislation and best practice guidance to ensure suitably skilled and qualified staff work in the practice.

5.2.3 Are the arrangements in place for safeguarding in accordance with current regional guidance?

The arrangements in respect of the safeguarding of adults and children were reviewed.

Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm that fully reflected the regional policies and guidance documents. The policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child. The relevant contact details were included for onward referral to the local Health and Social Care Trust should a safeguarding issue arise.

A review of records demonstrated that all staff had received training in safeguarding adults and children as outlined in the Minimum Care Standards for Independent Healthcare Establishments July 2014. Review of records demonstrated that clinical nurse leads, senior managers and the senior social worker had all completed formal level three training in safeguarding adults in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016) and minimum standards.

The inspection team spoke with one of the safeguarding leads who provided assurances that all staff were aware of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified.

It was confirmed that a copy of the regional guidance documents entitled ‘Adult Safeguarding Prevention and Protection in Partnership’ was available for staff reference.

It was determined that the hospice had appropriate arrangements in place to manage a safeguarding issue should it arise.

5.2.5 Is the hospice fully equipped and are the staff trained to manage medical emergencies?

Medicines management policies and procedures 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 and at daily handovers and were subsequently raised through appropriate meetings, for example, at Medicines Management Committee meetings and staff meetings.

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 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 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. Medicine kardexes were written by a doctor and checked by the pharmacist or a second doctor to ensure accuracy. The medicine kardexes were reviewed by the medical consultants each day and by the pharmacists during the working week. 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.

Medicine related records were maintained to a high standard. A medicine kardex was in place for each patient detailing the medicines prescribed. The medicine kardexes reviewed during the inspection had been completed to a satisfactory standard. Records of the administration of medicines were completed and medicines were available for administration when patients required them.

Standard Operating Procedures were in place for the management of controlled drugs and satisfactory arrangements for their management were observed. The Accountable Officer is responsible for the safe management of controlled drugs and related governance issues; the Accountable Officer for Marie Curie Hospice is the registered manager.

There were arrangements in place to audit various aspects of medicines management. There is a weekly incident meeting to review any medicine incidents and monitor for trends. Quarterly controlled drugs audits were completed by the pharmacists and an annual Accountable Officer controlled drug audit was also performed. An annual Happy Antibiotics Prudent Prescribing Indicator (HAPPI) audit was performed to ensure compliance with procedures. The most recent HAPPI audit had raised a couple of issues relating to documentation, which will be reviewed by the pharmacists at the next planned audit. A Marie Curie national audit had been performed on the prescribing of intravenous and end of life anticipatory medicines and the findings had resulted in an action plan being developed to assist management and staff address several issues that had emanated from it.

A recent initiative has been the setting up of a team to review patient falls; part of its role is to request the pharmacists to review the patient's medication and make any prescribing recommendations.

Any issues raised post audit were discussed at the audit meetings and followed up in the most appropriate forum (Senior Management Team meeting or the Medicines Management meeting, where they were subsequently fed back to the Senior Management Team). 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 pharmacists. 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.

A database is maintained of all medicine alerts received and the actions taken in response.

It was demonstrated that satisfactory arrangements were in place for the safe management of medicines.

5.2.6 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 to assess and manage the risks of COVID-19, and in particular healthcare settings need to consider the risks to their patients and staff.

The management of operations in response to the COVID-19 pandemic and the application of the current best practice guidance was discussed with senior management. It was demonstrated that arrangements were in place to ensure staff were knowledgeable and were aware of current best practice guidance. COVID-19 measures were in place throughout the patient pathway to minimise the risk of transmission.

It was confirmed that the infection prevention and control (IPC) lead nurse is also the identified COVID-19 lead and is responsible for both the inpatient unit and for the community services. Arrangements were in place to ensure the hospice is regularly reviewing COVID-19 advisory information, guidance and alerts.

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 arrangements in place were discussed with senior management who stated that timely communications were provided to staff updating them regarding COVID-19 guidance and any arising issues locally via safety briefs, quarterly IPC meetings and specific COVID-19 meetings.

It was determined that satisfactory arrangements were in place to minimise the risk of COVID-19 transmission.

5.2.7 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 good hand hygiene and handwashing techniques.

As discussed an appointed dedicated IPC lead nurse is available to advise staff on the management of infection control issues and the completion IPC audits. Staff confirmed there was good communication from the IPC lead nurse and hospice staff felt they were kept up to date with best practice guidance.

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.

It was demonstrated that a good range of IPC audits are undertaken in clinical areas including hand hygiene, the management of sharps and invasive devises, waste management and the use of PPE. The results of audits are presented in quarterly IPC reports audits which evidenced good compliance rates. 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 and 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.

Environmental cleanliness was of a high standard and there was a regular programme of environmental auditing and equipment cleaning schedules in place. Discussion with support service 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 personal protective equipment (PPE) and donning and doffing. 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.

A 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.

It was determined that effective governance mechanisms and collaborative working across the hospice is in place to ensure that staff adhere to IPC best practice guidance.

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

The provision of palliative care delivered in the hospice was reviewed. Discussion with staff, observation of care practices and a review of documentation evidenced that palliative care was delivered in accordance with best practice guidance. This included a review of referral pathways, the arrangements for admission and discharge, the care pathway, and the provision of bereavement services.

Since the previous inspection a single point of referral of all hospice services has been implemented. Discussion with staff confirmed that there was a robust multi-disciplinary system for review of referrals and triage/assessment of cases referred to the Marie Curie IPU, the integrated care clinic or to the community specialist palliative care team. Referrals can be received from the palliative care team, hospital consultant, nurse specialist or general practitioners (GP). Patients and/or their representatives are given information in relation to all of the services provided by Marie Curie which is available in different formats, if necessary. Multidisciplinary assessments are completed with the referral information through the regional referral arrangements. These systems were found to be robust.

Staff spoken with in the IPU confirmed they had always received relevant information about the patient prior to their admission. On admission to the IPU, 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.

A review of two patients' care records evidenced meaningful patient involvement in planning care and treatments provided were flexible and met the expressed wishes and assessed needs of individual patients and their families.

Staff confirmed that care was very patient centred with ongoing review to ensure care is adapted according to assessed need, however evidence of this was not consistently documented in patient care records. It was noted that facilities were accessible and provided to accommodate patients and their family to enable them to spend as much time together, as permissible, in keeping with current visiting guidance issued by the DoH.

Due to the COVID-19 pandemic patients are encouraged to remain in their room as much as possible. Staff were observed to be compassionate and positive interactions were observed between staff and patients as staff entered and exited patient's rooms. 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. During observation of care practices and discussion with staff it was evident that patients' needs were being attended to in a timely manner.

The service of the lunchtime meal was well co-ordinated, with patients receiving their meals in a timely way and being assisted as needed. Feedback from one patient was positive in relation to

the availability of food and fluids, menu choices and the quality of food served. Discussion with staff evidenced a wide choice of nutritious meals being offered that included specific meals for patients requiring specialised diets, and meal times that were flexible and individually tailored according to the patient's wishes and needs. Nursing and catering staff were familiar with best practice guidance regarding nutrition and the specialised dietary descriptors outlined in the International Dysphagia Diet Standardisation Initiative (IDDSI).

The inspection team observed evidence of good pain management and control. Patients and their representatives confirmed that when patients experienced pain, staff responded in a compassionate and, in the main, a timely manner. Discussion with staff confirmed that pain was assessed daily and prior to routine practices being performed e.g. wound dressing and movement, with various pain assessment tools in place. It was also confirmed that the pain management of each patient was discussed during verbal handovers throughout the day and that medical staff were available if further pain relief prescriptions were required. Discussion with staff confirmed arrangements are place for pain relief to be prescribed out of hours, if required. It was also confirmed that pain medication is administered as prescribed in the medicine kardex.

There was evidence of good practice in the management of syringe drivers and discussion with staff confirmed that there was an adequate number of syringe drivers in place to meet the needs of patients. There was evidence of a robust system in place to manage the availability and return of syringe drivers when a patient was discharged. Staff also confirmed that alternative methods of pain relief were available to patients in the form of various complimentary therapies. Discussion with staff confirmed that staff are adequately trained in medicines management and are competent in the administration of controlled drugs.

The management of pressure area care was discussed and it was confirmed that various pressure area care assessment tools were in place, a review of a sample of patient care records, noted that these assessment tools were completed consistently. Discussion with staff confirmed a patient centred approach to pressure area care and advised of the various aims of wound care for patients with wounds and pressure sores. Staff had a sound knowledge of wound management and the use of ANTT. It was also confirmed that there was an adequate supply of pressure relieving equipment.

Staff also discussed the process for sourcing expert tissue viability advice and dietetics from the local HSC trust when required for patients.

The provision of bereavement care was reviewed and this evidenced that a range of information and support services were available. Marie Curie can provide internal individual counselling services for patients and families or a link with external providers. Ongoing bereavement care is available for families and children coping with the loss of a loved one. Discussion with staff confirmed that staff who deliver bereavement care services are appropriately trained and skilled in this area.

The hospice has a policy and procedure for delivering bad news to patients and/or their representatives which is in accordance with the Breaking Bad News regional guidelines 2003.

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 concerning 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. Daily and weekly meetings take place to ensure the patient's needs are 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. 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 care pathway including admission and discharge arrangements; and patient engagement.

It was determined that systems are in place to ensure that staff adhere to best practice guidance concerning the provision of palliative care.

5.2.9 How does the hospice ensure that record keeping is in line with legislation and best practice guidance?

The management of records within the hospice was found to be in line with legislation and best practice. A range of policies and procedures were in place for the management of records however these were not reviewed during this inspection.

Staff confirmed that the hospice maintains both electronic and paper records. The hospice has access to the Electronic Care Record (ECR) which will enhance communication between the hospice and the rest of the Health and Social Care (HSC) sector leading to better continuity of care for patients.

A sample of patients' notes completed by medical staff and nursing staff were reviewed. There was evidence of an up to date review of each patient, as well as clear decision making by the multi-disciplinary team involved in the delivery of the patient's care. A multi-disciplinary, holistic and empathetic approach to patients' care was evident.

The multi-disciplinary care records reviewed contained the following:

- an admission profile
- a range of validated assessments
- medical notes
- care plans
- nursing notes
- results of investigations/tests
- correspondence relating to the patient

- reports by allied health professionals
- advance decisions
- do not attempt resuscitate (DNAR) orders
- records pertaining to previous admissions and community care team, if applicable.

It was confirmed that systems were in place to audit the patient care records as outlined in the hospices quality assurance programme. A number of audits relating to patient care records were reviewed and an excellent compliance rate was noted.

There was a range of policies and procedures in place for the management of records which includes the arrangements for the creation, use, retention, storage, transfer, disposal of and access to records which were comprehensive and reflected best practice guidance.

The hospice also has a policy and procedure in place for clinical record keeping in relation to patient treatment and care which complies with the General Medical Council (GMC) guidance and Good Medical Practice.

Discussion with Miss Browne and staff and review of the management of records policy found that patients have the right to apply for access to their clinical records in accordance with the General Data Protection Regulations and where appropriate Information Commissioner's Office (ICO) regulations and Freedom of Information legislation. The hospice is registered with the ICO.

Staff who spoke with us demonstrated that they had a good knowledge of effective records management. The management of records within the hospice was found to be in line with legislation and best practice.

It was determined that systems are in place to ensure that staff adhere to best practice guidance concerning all aspects of record keeping.

5.2.10 How does the hospice 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.

- the 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 (LOLER) 'Thorough Examination' reports of the premises' passenger lift and patient hoists;
- condition report for the premises' fixed wiring installation;
- report for the formal testing of the premises' portable electrical appliances;

- the Legionella Risk Assessment;
- gas Safe Certification for the premises heating boilers and catering equipment;
- water safety scheme control measures;
- records, validation checks and audits for the premises' piped medical gas systems; and
- records, validation checks and audits for the premises' air conditioning 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 1 August 2022 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, continues to confirm that legionella and pseudomonas bacteria are not detected.

The fire risk assessment had been undertaken by a suitably accredited fire risk assessor on 1 August 2022. 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 9 January 2023.

The premises' fixed electrical installation and emergency standby electrical generator continue to be serviced and maintained in accordance with current best practice guidance. The passenger lift and patient hoist undergo regular thorough examination with the most recent examination being on the 25 October 2022. No defects or observations were noted at this time.

The premises' specialised ventilation systems and medical gas pipeline services are serviced in accordance with current best practice guidance and suitable validation is undertaken in accordance with the current health technical memoranda. Records and validation reports were available and reviewed at the time of the inspection.

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 2023.

It was determined that procedures are in place for maintaining the premises, grounds, engineering services and equipment in line with legislation, current standards of best practice and manufacturers' and suppliers' guidance and that these are regularly reviewed and updated.

5.2.11 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 Miss Browne, Registered Manager; the regional Head of Health and Safety; the Chairperson of the Local Advisory Board (LAB) and members of the SMT. A discussion was held with the medical director via MS Teams on 7 February 2023.

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. The chairperson of the LAB confirmed that four new committee members have joined the LAB since the previous inspection. Each of these individuals received an induction that included roles and responsibilities; a review of Marie Curie governance structures (local and regional) and had the opportunity to meet with the Chief Executive on a one to one basis. 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.

The chairperson of the LAB also confirmed that they are developing a new quality strategy and are identifying new opportunities for the hospice to deliver services (homeless population). The hospice is also working in collaboration with Cruise and are piloting a bereavement support service in schools.

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 sub-committee 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 risk register is discussed during the SMT meetings.

The arrangements concerning medical governance were reviewed. 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 has an identified quorum. MAC meetings are minuted and minutes of a MAC meeting held during November 2022 were reviewed and noted to be a detailed account of the topics discussed and decisions made. The medical director chairs the MAC meetings and provides feedback to the NI Caring Services Oversight and Performance group and to the Clinical Reference Group.

As previously discussed, we met with the medical director via MS Teams on 7 February 2023. The purpose of this was to discuss the medical governance arrangements with the medical director.

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

Personnel files for medical practitioners were reviewed during the onsite inspection on 6 February 2023. 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. Discussion with Miss Browne and a review of one personnel file for a medical practitioner that commenced work in the hospice during November 2022 confirmed that this doctor was considered to be a private doctor. On the day of inspection Miss Browne submitted a variation to registration to add a private doctor category of care to the Marie Curie registration. This variation was reviewed following the inspection and approved with effect from 20 March 2023.

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.

Miss Browne discussed plans to develop a quality improvement newsletter for staff that would include learning form complaints and incidents. Miss Browne advised that the hospice had secured funding from the Cancer Fund and had appointed two new clinical nurse specialists to work in the community and outpatient teams. Plans are in place to develop a psychology service to support patients/families and their representatives both within the inpatient unit and the community and to appoint advanced nurse practitioners to work in Trust emergency departments and GP surgeries. The hospice is also liaising with the Trust to appoint a consultant for the community and outpatients team and the hospice is also exploring setting up an in reach service for prisoners who are in need of palliative care.

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. Mrs Heneghan, Responsible Individual, was in day to day control of the hospice therefore regulation 26 visits are not required.

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 is up to date and displayed appropriately and current insurance policies are 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.

5.3 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 staff.

Discussion with staff 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 Miss Browne and a member of the senior management team, as part of the inspection process and can be found in the main body of the report.

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

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