Unannounced Care Inspection Report
13, 14 & 15 February 2019

Northern Ireland Hospice and Northern Ireland Hospice Adult Community Services

Type of Service: Independent Hospital (IH) – Adult Hospice
Address: 74 Somerton Road, Belfast, BT15 3LH
Tel No: 028 9078 1836
Inspector: Carmel McKeegan

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

Membership of the Inspection Team

Dr Lourda Geoghegan	Director of Improvement and Medical Director Regulation and Quality Improvement Authority
Lynn Long	Assistant Director Regulation and Quality Improvement Authority
Dr John Simpson	Senior Medical Advisor Regulation and Quality Improvement Authority
Jo Browne	Senior Inspector, (acting) Independent Healthcare Team Regulation and Quality Improvement Authority
Sheelagh O'Connor	Senior Inspector, Healthcare Team Regulation and Quality Improvement Authority
Carmel McKeegan	Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Norma Munn	Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Helen Daly	Inspector, Medicines Management Team Regulation and Quality Improvement Authority
Raymond Sayers	Inspector, Premises Team Regulation and Quality Improvement Authority
Gemma Fitzsimmons	Estates Support Officer, Premises Team Regulation and Quality Improvement Authority
Dr Orla O'Kane	Speciality Doctor, palliative care
Alan Craig	Lay assessor
Paulina Spychalska	Inspection Coordinator Regulation and Quality Improvement Authority
Claire McNicholl	Inspection Coordinator Regulation and Quality Improvement Authority

2.0 Profile of the services

The Northern Ireland (NI) Hospice and the Northern Ireland (NI) Hospice Adult Community Services are located in Belfast and share a large site on the Somerton Road. These are purpose built facilities which opened in May 2016.

The NI Hospice

This is a registered independent hospital providing in-patient hospice services for up to18 adults with life limiting, life-threatening illnesses and palliative care needs. This service supports patient's families and provides ongoing bereavement support.

The NI Hospice Adult Community Services

This is a registered day hospice and community based hospice service for adults with life limiting, life-threatening illnesses and palliative care needs.

The NI Hospice Adult Community Services has capacity to care for 30 patients in its day hospice in Belfast. The day hospice service is known as the Hospice Hub and is operational four days a week, with one day focusing on the care and support of patients with dementia. A day hospice service is also provided for up to seven patients one day a week (Thursday) in the Robinson Hospital site, located at 8 Eastermeade Park, Ballymoney, BT53 6HP.

The community hospice service consists of eight specialist palliative care teams which operate within the Northern, Belfast, and South Eastern Health and Social Care Trusts and the southern sector of the Western Health and Social Care Trust. In addition, there is a Hospice at Home service which operates within the Northern, Belfast, and South Eastern Health and Social Care Trusts.

3.0 Service details

The NI Hospice

Organisation/Registered Provider: Northern Ireland Hospice **Responsible Individual:** Mrs Heather Weir	**Registered Manager:** Mrs Hilary Maguire
Person in charge at the time of inspection: Mrs Hilary Maguire	**Date manager registered:** 16 December 2016
Categories of care: Independent Hospital (IH) – Adult Hospice	**Number of registered places:** 18

The NI Hospice Adult Community Services

Organisation/Registered Provider: Northern Ireland Hospice **Responsible Individual:** Mrs Heather Weir	**Registered Manager:** Mrs Gemma Aspinall
Person in charge at the time of inspection: Mrs Gemma Aspinall	**Date manager registered:** 2 April 2019
Categories of care: Independent Hospital (IH) – Adult Hospice	**Number of registered places:** Day Hospice, Belfast – 30 Day Hospice, Ballymoney – 7

4.0 Inspection summary

An unannounced inspection was undertaken to the NI Hospice and the NI Hospice Adult Community Services over three days, commencing on Wednesday 13 February 2019 and concluding on Friday 15 February 2019. RQIA employed a multidisciplinary inspection methodology during this inspection. Feedback of the inspection findings was delivered to the NI Hospice senior management team on the last day of inspection.

We would like to thank Mrs Weir, Mrs Maguire, Mrs Aspinall and all of NI Hospice and the NI Hospice Adult Community Services staff for being welcoming, open and transparent, and for providing the inspection team with all information and documents required in a timely manner.

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 multi-disciplinary inspection team examined a number of aspects of the hospice, from front line care and practices, to management and oversight of governance across the organisation. The inspection team met with various staff groups, spoke with several patients, observed care practice and reviewed relevant records and documentation to support the organisational 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.

Patients and their representatives advised they were very happy with their care and spoke positively about how they have been treated by all members of staff. Staff were observed to treat patients and/or their representatives with dignity and were respectful of their right to privacy and to make informed choices.

Staffing levels and morale in the NI Hospice and the NI Hospice Adult Community Services were good with evidence of good multidisciplinary team working and open communication between staff. Staff also provided positive feedback to the inspection team regarding the care provided and their working environment. They told us that they were happy, felt supported and well engaged, that there were good productive working relationships throughout the hospice and a positive working culture.

Examples of good practice were evidenced across all four domains. These included: the care delivered to patients and the support provided to their families; medicines management; management of staff including recruitment, appraisal, professional development opportunities, specialist palliative care staff, supervision and performance management; admission and discharge arrangements; the provision of information to patients and/or their families; bereavement care services; and aspects of the governance arrangements.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	11	4

Eleven areas for improvement were identified against the regulations. Two areas related to reviewing and strengthening the governance arrangements. Other areas identified related to:

- the provision and location of emergency medicines;
- arrangements for the proposed interventional clinical treatments in the Hospice Hub;
- notification of all medicine related incidents to RQIA; and
- review and strengthening of infection prevention and control procedures.

Four areas were identified in relation to estates and related to:

- implementation of the action plan recommendations listed in the 14 January 2019 Medical Gas Pipelines Systems (MGPS) Authorizing Engineer audit report;
- establishment of a multidisciplinary Water Safety Group to monitor and verify the Water Safety Plan;
- completion of a fire risk assessment (FRA) review; and
- establishment of regular examination of the passenger lifts.

Four areas requiring improvement were identified against the standards. These related to:

- implementing an audit process to ensure compliance with the hospice's antimicrobial policy;
- ensuring the bed pan washer is maintained in accordance with the manufacturer's instructions;
- ensuring gas appliances are inspected in accordance with statutory requirements; and
- ensuring the air conditioning units are maintained in accordance with manufacturer's instructions and Health Technical Memorandum 03-01.

Details of the quality improvement plan (QIP) were discussed with Mrs Heather Weir, Chief Executive (responsible individual); Mrs Hilary Maguire, Registered Manager of the NI Hospice; Mrs Gemma Aspinall, Registered Manager of the NI Hospice Adult Community Services; in-patient unit manager; consultant in palliative care; co medical leads; and director of care and quality governance (via teleconference), during the feedback session on Friday 15 February 2019.

The Quality Improvement Plan (QIP) should be completed and detail the actions taken to address the areas for improvement identified. The Registered Persons should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

At the conclusion of the inspection, Mrs Weir provided some feedback to the inspection team with respect to the multidisciplinary inspection methodology. Mrs Weir stated that the hospice considered the multidisciplinary approach beneficial for the organisation as it produced a detailed assessment of the hospice and commented positively on the culture within the hospice. However staff at the frontline on occasion felt overwhelmed with the larger inspection team compared to previous experiences. We thanked Ms Weir for this feedback and advised that the inspection team would address the issue identified.

This inspection did not result in enforcement action.

4.2 Action/enforcement taken following the most recent care inspections

The NI Hospice

No further actions were required following the most recent inspection on 30 November 2017.

The NI Hospice Adult Community Services

No further actions were required following the most recent inspection on 18 December 2018.

5.0 How we inspect

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

- notifiable events since the previous care inspection;
- the registration status of the establishment;
- written and verbal communication received since the previous care inspection; and
- the previous care inspection reports.

Questionnaires were provided to patients during the inspection by the lay assessor on behalf of RQIA. Returned completed patient questionnaires were analysed following the inspection. We invited staff to complete an electronic questionnaire during the inspection. No staff questionnaires were received by RQIA.

Posters informing patients that an inspection was being conducted were displayed.

We met with and spoke with the following staff: Mrs Weir; Mrs Maguire; Mrs Aspinall; medical staff; nursing staff; healthcare assistants; allied health professionals (AHPs); the estates and facilities manager, catering staff; cleaning staff and volunteers.

Both facilities were inspected and the inspection team was provided with a tour of the NI Hospice and the Hospice Hub.

A sample of records were examined in relation to the areas inspected.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspections

The NI Hospice

The most recent inspection of the establishment was an announced care inspection undertaken on 30 November 2017. There were no areas for improvement made as a result of that inspection.

The NI Hospice Adult Community Services

The most recent inspection of the establishment was an announced follow-up care inspection undertaken on 18 September 2018. There were no areas for improvement made as a result of that inspection.

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

6.3.1 Staffing

We reviewed the staffing arrangements in both facilities. Staff were easily identifiable as they each wore a name badge with their name and profession/designation. Uniforms were also colour coded and identified different professionals and their level of responsibility.

The NI Hospice

The multi-professional team, includes doctors, nurses, healthcare assistants, occupational therapists, physiotherapists, and social workers, with specialist palliative care expertise. In addition, there is an art therapist and chaplaincy team who support the clinicians in providing holistic care. This service is supported by team of volunteers who provide a variety of services.

The NI Hospice Adult Community Services

The hospice adult community services comprise of the day hospice known as the Hospice Hub and is a nurse led service. This is supported by members of the multi-disciplinary team of doctors, physiotherapists, occupational therapists, social workers, a complementary therapy nurse and chaplains who are based in the inpatient unit. This service is also supported by volunteers.

The hospice at home team is a community based service and is staffed by registered nurses, nursing auxiliaries and a hospice at home co-ordinator. The community service consists of specialist palliative care teams and a hospice at home service. The specialist teams are staffed by hospice nurse specialists and hospice community nurses. The community service is supported by administrative staff and volunteers. There are seven consultants in palliative medicine who provide further clinical support to the community services.

The NI Hospice and the NI Hospice Adult Community Services

Discussions with staff and a review of the duty rotas in both facilities confirmed that there was sufficient staff in various roles to meet the assessed needs of patients. Staff were observed responding to patients in a timely and caring manner.

An active recruitment plan was in place to fill current vacancies. It was noted that the hospice was not experiencing the same level of staffing challenges as we have found in the other areas of health and social care we inspect.

Staffing levels and morale was good with evidence of effective multi-disciplinary working arrangements and communication between staff. Staff told us they were happy, felt supported and there were good working relationships throughout the hospice.

We found a thorough induction programme had been developed for each new member of staff which was relevant to their roles and responsibilities. Training records were available and a review of the training figures confirmed that the mandatory training provided is within desired levels. A training plan was examined which included a variety of mandatory training and non-mandatory training such as: communication skills; final journeys; and symptom management. Staff in both facilities confirmed that there was a system in place to ensure they receive appropriate training to fulfil the duties of their role in; keeping with the RQIA training guidance. Staff spoken with were supportive of the training they receive.

The hospice affords staff opportunities to undertake specialist qualifications such as the Specialist and End of Life Care Nurse (Adult). It was confirmed that all specialist nurses working in all hospice services have completed a Nursing and Midwifery Council (NMC) recordable specialist practice qualification.

A review of a sample of appraisal records evidenced that appraisals had been completed on an annual basis which was confirmed with staff. Staff reported they were well supported and fully involved in discussions about their personal and professional development.

Review of personnel files confirmed that medical practitioners had appropriate professional indemnity insurance in place and received the required annual appraisals. Discussion with both Registered Managers and the review of a sample of records confirmed that a robust system was in place.

We found there was also a robust process in place to review the registration details of all health and social care professionals. Four personnel files of medical practitioners were reviewed and evidenced the following:

- confirmation of identity;
- current registration with the General Medical Council (GMC);
- appropriate professional indemnity insurance;
- experience in palliative care;
- ongoing professional development and continuing medical education that meet the requirements of the Royal Colleges and GMC; and
- ongoing annual appraisal by a trained medical appraiser.

It was confirmed that each medical practitioner has an appointed responsible officer.

6.3.2 Recruitment and selection

We were advised of a number of staff who were recruited since the previous inspection. Three personnel files of newly recruited staff were sampled which evidenced that all relevant information had been sought and retained.

6.3.3 Safeguarding

We reviewed the arrangements in place for safeguarding and found that policies and procedures were in place for the safeguarding and protection of adults and children.

We discussed safeguarding with staff and found good general awareness of the types and indicators of abuse along with the actions to be taken in the event of a safeguarding issue being identified. Staff were able to identify the nominated safeguarding lead. Staff confirmed that training in safeguarding children and adults is provided and they receive a reminder to attend refresher training when it is due.

We spoke with volunteers in both facilities who demonstrated a good awareness of their safeguarding responsibilities. Volunteers were supportive of the initial training provided and confirmed that there is a process in place to ensure they all attend refresher training sessions. It was noted that volunteers have regular AccessNI checks, to review criminal history; this is above what is required.

6.3.4 Management of Medicines

We reviewed the arrangements in place for the management of medicines with in the hospice to ensure that medicines are safely, securely and effectively managed in compliance with legislative requirements, professional standards and guidelines.

Pharmacist input to the hospice is provided from the Royal Victoria Hospital for two and a half days each week. The pharmacist attends the morning handover to enable her to prioritise work. The pharmacist reviews the patient notes from admission or the last pharmacist visit. They check the medication records of individual patients from both a clinical and legibility/accuracy perspective. Any issues are discussed with the medical and nursing team.

In addition, since December 2018, a community pharmacist has been providing one session each week. The community pharmacist is currently reviewing the storage and ordering of medicines. It is hoped that this role will be further developed so that the community pharmacist can become more involved in the auditing systems. The Registered Manager advised that a business case had been prepared for increased pharmacy service provision.

Safe systems were in place for confirming medicines on admission. The electronic care record (ECR) and recent hospital letters are reviewed by staff. The drug history/medicines reconciliation sheet is completed by the pharmacist/doctor. A minimum of two sources are used to check medication history. The personal medication record is then documented by a doctor and checked by the pharmacist/second doctor.

Medicines brought into the hospice, by patients, especially controlled drugs, are returned to their families. However, some medicines may be retained for use if assessed as suitable and not currently available in the hospice. Medicines (other than controlled drugs) are stored securely in each patient's room. The time critical medicines list is available on at the front of the British National Formulary (BNF) on each zone medication trolley. Robust arrangements were found for medicines brought into the hospice and at discharge.

A checklist was in place to enable consistent practice and to ensure that discharge prescriptions and medicines do not delay a patient's discharge. Prescriptions and patient medication guides are checked by a second person.

Samples of medicine records were provided for inspection; these had been maintained in a satisfactory manner. In cases where medicines had been delayed or omitted, the reason for the delay or omission had been documented. The rationale for prescribing or changes in medicine regimes was clearly recorded in the patient's notes.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and prevent wastage. Separate requisition/receipt records were in use for general medicines and controlled drugs. The requisitions were signed by a doctor. Medicines for use during planned outings and for discharge are prescribed on HC21 forms. The prescription pad is stored securely and a log of prescriptions issued is maintained. The pharmacist and nursing staff advised that patients were provided with information regarding any medicines prescribed during their stay and as an integral part of the discharge process.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. Storage space was limited, more so when there were medicines awaiting disposal and discharge medicines present. The Registered Manager advised that plans were in place for a second room to be used for controlled drugs and syringe driver preparation. Satisfactory recordings were observed for the daily medicine refrigerator temperatures. The Registered Manager advised that the room temperature of the medication room is monitored centrally and that records could be made available from the date of the inspection onwards.

Medicines were stored in labelled drawers and registered nurses had been assigned specific drawers to date check each week. Some out of date medicines were identified and removed for disposal. It was agreed that a record of the date checking would be maintained.

Arrangements were in place to audit various aspects medicine management. In addition to the controlled drug checks, these included:

- the second clinical and accuracy check on personal medication records, medicines for planned outings and discharge prescriptions, by either a doctor or pharmacist;
- the second check of medicines for planned outings/discharge medicines by registered nurses;
- the second check on administration of medicines by a registered nurse following the medicines round;
- the weekly, monthly and quarterly review of medicine incidents;
- the daily monitoring of the medicine refrigerator; and
- the weekly expiry date checks of the medicine stocks by registered nurses.

A review of these auditing systems indicated that the second check following the medicines round was not being completed and that records of checking dates were not maintained. The registered manager advised, via email on 27 February 2019, that this had been discussed with the nurse manager for immediate resolution and would be monitored.

Robust arrangements were in place for the storage, security, administration, disposal and recording of controlled drugs. Records confirmed that stock checks of controlled drugs were carried out twice daily. Two registered nurses were observed preparing all syringe drivers.

6.3.5 Management of incidents

We found confusion over which medicine related incidents should be notified to RQIA. From November 2017 there had been 15 medicine incidents reported to RQIA; however it was confirmed that a number of medicine incidents had not been reported. It was acknowledged that these incidents had been recorded, investigated and the learning implemented. Most of the reported medicine incidents related to controlled drugs or time critical medications. However, there are other incidents which may impact patients' health and wellbeing, for example, delayed/missed doses of antibiotics, which should also be reported. It was clarified that all medicine related incidents must be reported to RQIA in line with the timescales outlined in legislation. An area of improvement has been made against the regulations in this regard.

6.3.6 Antibiotic/antimicrobial stewardship

The NI Hospice antimicrobial medicines prescribing policy was updated in January 2019. Copies of "Guidelines for first-line empirical antibiotic therapy in adults 2018-19" were readily available in the medicines room, zone trolleys and junior doctors' room. The hospice employ Belfast Health and Social Care Trust (BHSCT) guidelines in relation to antibiotic stewardship, doctors have access to the "Micro-guide" (the BHSCT App for antibiotics) and can contact microbiology in the Royal Victoria Hospital. However we did not find a system for carrying out formal audits regarding the use of antimicrobial medicines within the hospice to provide assurance that the policy is adhered to and reasons for non-adherence are known. Therefore an area for improvement to implement such a system, has been made.

We also reviewed the prescribing process in the Hospice Hub. HC21 forms (prescription forms) are not issued in this facility. Following consultation with the patient, if a change in medication is recommended by a hospice doctor, staff inform the patient's GP of the recommendation via a password protected email or phone-call. This is followed up by a letter. A registered nurse contacts the community pharmacist to ensure that the medicines are available without delay.

Any recommended changes to patients' medications are discussed and reviewed by the multi-disciplinary team at their weekly meeting. We recognise this example of good practice.

We found evidence of strong practice across various areas, the management of controlled drugs, multi-disciplinary review, reconciliation of medicines and assessment of changes in medicines. A good system is in place for assessing and tracking medicine related incidents, as well as good evidence of identification and implementation learning from these incidents.

Overall medicine management was found to be robust with two areas for improvement highlighted to enhance practice.

6.3.7 Resuscitation and management of medical emergencies

We reviewed the arrangements for the management of medical emergencies and resuscitation and found emergency medicines and equipment, as recommended by the Resuscitation Council (UK) guidelines, was retained.

An emergency trolley for the storage of emergency medicines and equipment was provided in the both facilities. A decision was made by the lead clinicians to include an anaphylaxis kit and a hypoglycaemia kit in each facility. Each trolley had a check list detailing the contents of the trolleys, including emergency medications and equipment and a template to record the daily checks was in place. Anaphylaxis and hypoglycaemia medicines will be stored in separate sealed boxes in each emergency trolley to enable immediate access in the event of an emergency.

At the time of the inspection the Hospice Hub trolley contained the anaphylaxis and hypoglycaemic medicines stored together in one box and the NI Hospice only had some of the required medicines which were stored in the emergency cupboard in the medicines room. It was also identified that the Hospice Hub emergency trolley is located in the room designated for the provision of clinical/interventional procedures which may not guarantee easy access if the room is in use.

An area for improvement has been made against the regulations to ensure:

- the emergency trolleys for both facilities are stocked with the correct emergency medicines;
- emergency medicines are stored in sealed boxes;
- daily checks are completed and recorded; and
- the location of the emergency trolley in the Hospice Hub is reviewed to ensure the trolley is readily accessible at all times.

Review of training records and discussion with staff confirmed that resuscitation and the management of medical emergencies is included in the induction programme and training is updated on an annual basis in keeping with best practice guidance. Discussion with staff demonstrated that they have a good understanding of the actions to be taken in the event of a medical emergency and the location of medical emergency medicines and equipment.

The arrangements for patients with a "do not attempt resuscitation" (DNAR) order were discussed. It was confirmed that DNAR decisions are taken in line with the NI Hospice policy and procedures, by a consultant in palliative medicine. The decision is fully documented and the patient's record includes a date for review of the decision.

The NI Hospice

We found that there are robust systems in place for arranging admission to the hospice. Patients and/or their representatives can visit the hospice prior to admission to review the services and facilities available. On admission patients and/or their representatives are provided with information regarding the various assessments that may be undertaken by members of the multi-professional team. These include medical, nursing, social work, allied health care professional, complimentary therapy and spiritual assessments.

Information was provided to patients and/or their representatives regarding the services available within the hospice and they received frequent updates regarding their care and treatment.

The provision of specialist palliative care was found to be in line with best practice guidelines. A range of policies and procedures were in place to promote safe practice by the multi-professional team. A sample of policies were reviewed and included:

- admission/referral/discharge;
- management of hypercalcaemia;
- management of syringe drivers;
- care of the dying adults in the last days of life;
- Cardio-pulmonary Resuscitation (CPR) policy;
- risk management of falls;
- prevention and management of pressure ulcers;
- verification of death by registered nurse;
- breaking bad news;
- bereavement service operational policy; and
- clinical audit and quality improvement policy for adult services.

Staff confirmed that the needs and wishes of patients and/or their representatives are taken into account in the decision making process of the multi-professional team. We found that the multi-disciplinary team, with the patient's consent, provides information and support to the patient's representatives.

We observed a multi-disciplinary, holistic and empathetic approach to patient's care. The care records of four patients were reviewed and found to be well documented. Patients are holistically assessed using validated assessment tools and individual care plans are developed in conjunction with the patient and/or their representatives. There was a record of ongoing review and a daily statement of the patients' health and well-being. Multi-disciplinary meetings are held daily and weekly to discuss the patient's progress and multi-disciplinary records are retained within the patient's care records. Arrangements were in place for ethical decision making and patient advocacy; where this is indicated or required.

Discussion took place with patients and their representatives regarding the quality of care, environment, staff and management. All spoke positively about the services provided and reported that they were kept informed regarding their care and could discuss concerns they had with the staff.

The Hospice Hub

The Hospice Hub provides a variety of services for patients to access including a Wellbeing Clinic and Outpatient Clinic. The Wellbeing Clinic is a structured six week programme which runs every Tuesday from 10am to 3pm. Different sessions are run by the multi-disciplinary team including:

- managing medicines;
- breathlessness management;
- fatigue management and energy conservation;
- managing a decreased appetite;
- coping with changes in health;
- laughter and lifting spirits; and
- wellness action planning.

The programme begins with an assessment of the individual patient's needs which is undertaken by a nurse who is a specialist in palliative care. We found that the patient's main concerns are identified and an individual plan is provided for attending session's best suited to their needs.

The Outpatient Clinic takes place on Wednesday and Thursday each week and is run by the multi-disciplinary team who offer a variety of services including:

- a medical assessment and management of symptoms;
- a holistic nursing assessment for symptom assessment and management;
- occupational therapy;
- physiotherapy; and
- complimentary therapies which are non-medication treatments which can aid relaxation and help disturbed sleep, pain, anxiety and other symptoms.

In addition a social worker is available to provide social care and emotional support for patients, carers and family members. They will offer support in developing coping strategies to deal with serious illness; provide practical advice and information; and help with communication within the family circle; including direct work with children and young people.

We found that a comprehensive person centred approach to care was delivered to patients and/or their representatives by a multi-professional team of staff with specialist qualifications in palliative care.

6.3.8 Interventional procedures

The Hospice Hub is preparing to provide clinical/interventional procedures and have a treatment room dedicated for this purpose. The hospice has outlined that the procedures to be provided are: paracentesis, blood transfusion and management of hypercalcaemia. At present, patients who require these procedures are referred to an acute hospital either as an inpatient or outpatient or to the NI Hospice inpatient unit. The Hospice Hub aims to provide these procedures as an out-patient service thereby enabling patients to remain at home.

We welcome this approach as one which adds significant value to palliative care pathways. We examined the plans for the development and implementation of the interventional treatments and procedures to be provided in the Hospice Hub and felt these would be strengthened by the following actions:

- ensuring that the clinical and treatment protocols have been developed by the medical consultants and guided by best practice guidelines to support the delivery of the enhanced range of treatments outlined above;
- ensuring that copies of the clinical and treatment protocols are easily accessible to all staff involved; and
- implementing an assurance mechanism for the NI Hospice's Executive Team and Board of Trustees to demonstrate that the quality of the practice and care delivered in the treatment room is to the required standard.

We were informed that patients are holistically assessed using validated assessment tools and individual care plans are developed in conjunction with the patient and/or their representatives. The care records of four patients attending the Hospice Hub were reviewed and found to be well documented. We could see evidence of ongoing review of the patients' health and well-being was recorded. A multi-disciplinary team (MDT) meeting takes place each Thursday in the Hospice Hub to review changes to patients' conditions, needs and medication.

In the community a specialist hospice team provides services Monday to Friday, 9am to 5pm, with an on call rota over the weekend to provide specialist advice. We were informed that the community specialist palliative care team hold weekly clinical meetings, which are attended by the hospice specialist nurses, the hospice community nurses and a consultant in palliative medicine. The details of current caseloads are discussed and plans of care are developed with the aim of maintaining the patient in their home or usual place of residence. Staff confirmed that the wishes of patients and carers are central to these discussions.

We found arrangements in place for ethical decision making and patient advocacy where this is required. The multi-disciplinary team, with the patient's consent, provides information and support to the patient's representatives.

We spoke with patients in the day hospice about their quality of care. All felt that they were well looked after, kept informed and could discuss any concerns with the staff.

6.3.9 Infection prevention control (IPC) and decontamination procedures

At the outset of the inspection we met with Mrs Maguire and Ms Aspinall to understand the hospice's Statement of Purpose which suggested that the hospice was designated as an augmented care facility, because designation as an augmented care facility would mean that the hospice must undertake enhanced IPC measures.

We were informed that in 2017 the hospice made an internal decision to align itself with the enhanced IPC arrangements of an augmented care setting. This was following a review and risk assessment of patients cared for in the hospice, the immunocompromised patient profile and the level of care and interventions delivered.

There is no formal direction from the Department of Health (DoH) to designate hospice care as augmented care facilities. During the inspection Mrs Maguire and Ms Aspinall clarified that the hospice is not actually an augmented care facility. It was agreed that management will review all hospice documents to remove references to the hospice being designated as such.

The hospice was found to be clean, tidy and well maintained. IPC information was displayed on notice boards in both facilities. Good practice was observed in relation to hand hygiene and the use of personal protective equipment. We observed that there was a range of information for patients, visitors and staff regarding good hand washing techniques.

We evidence that there were clear lines of accountability for IPC. The designated infection control nurse, who is the deputy nursing sister, leads the multi-disciplinary IPC committee. The hospice currently has the following IPC groups:

- Estates Group – chaired by Director of Corporate Services and Director of Care Services; and
- Infection Prevention and Control Committee– chaired by the deputy nursing sister and the Medical Officer (MO) attends.

A Water Safety Group is yet to be established as further discussed in the following section of this report.

A range of IPC policies and procedures were in place and held within an IPC manual, staff confirmed that they have been provided with IPC training commensurate with their role.

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

We confirmed IPC audits were being conducted which including, hand hygiene, post treatment infection and environmental audits. The compliance rate was high and an action plan was in place to address any issues. However it was noted that some IPC audit tools in place were not in line with current best practice, these should be reviewed and updated. We emphasised the importance of evidencing appropriate clinical practices through audit, which provides assurance to the Executive Team and the Board of Trustees that clinical practices are being implemented to required standards.

We advised that the hospice requires expert advice in this area from an experienced IPC practitioner/nurse. This would support development and implementation of best practice. The hospice should explore its partnership with the Belfast Health and Social Care Trust (BHSCT) or seek alternative expert IPC arrangement in developing and supporting implementation of appropriate IPC pathways (e.g. MRSA pathway).

We highlighted that antibiotic stewardship arrangements are a core element of robust IPC arrangements. It was recognised that as the hospice is following the available trust guidelines evidencing robust antibiotic stewardship should be possible.

Staff confirmed they had a good knowledge and understanding of IPC measures. The following were identified as areas for improvement against the regulations, in relation to clinical practices:

- Provide an aseptic non touch technique policy (ANTT) or policies on device management, in relation to peripheral vascular lines and catheters;
- Ensure the external training and competency based assessment on ANTT, received by some staff, is cascaded to all other relevant staff;
- Develop and implement competency based assessments in relation to the application of ANTT and clinical practices;

- Develop a robust system of audit to assure clinical practices. For example, the urinary catheter audit related to the position of the catheter and bag as opposed to the clinical management of the device from insertion/care/removal;
- Evidence that device lines labels are in use and develop an audit process to assure appropriate line labelling is fully implemented in staff practice;
- Develop a policy for the management of Carbenpenemase-producing Organisms (CPO) and/or and Carbapenem-producing Enterobacteriaeaca (CPE);
- Implement a MRSA care pathway to guide staff and provide assurance of best practice; and
- Routinely screen patients admitted to the hospice.

6.3.10 Environment

The environment within both facilities was maintained to a high standard. The building fabric, decorated surfaces and finishes were in a good condition. However the following were identified in relation to estates management.

An Authorising Engineer Audit Report & Review of the Medical Gas Pipeline Systems was completed on 14 January 2019. A number of improvement/corrective works items were listed on a prioritised action plan for subsequent implementation by the Registered Person. Some of the recommended actions have been completed and works are ongoing to address the remaining items.

A fire risk assessment was completed on 4 October 2017 and a review of this risk assessment is arranged for May 2019. Staff fire safety training and practice drills have been arranged for February 2019.

The building services consultant engineers commissioned to review water safety control measures in the facility have recommended the establishment of a Water Safety Group (WSG) to monitor water safety in the premises. A Water Safety Plan (WSP) is to be completed and shall be compliant with the Water Safety Policy and Health Technical Memorandum 04-01 Part B. Water safety control measures are currently being implemented by an engineering contractor; we are informed that directly employed engineering operatives are to complete the maintenance tasks once employment contracts have been established.

The passenger lifts Lifting Operations and Lifting Equipment Regulations (LOLER) 'thorough examination' statutory reports were not available for examination. The Registered Person must ensure that LOLER regulation 9 'thorough examinations' are completed for the passenger lifts. We did not find that an effective bedpan washer maintenance regime is implemented in accordance with manufacturer`s instructions. Planned preventative maintenance inspection certificates relating to the maintenance inspection and calibration of the bed-pan washer were not available for review.

Certificates were not available for kitchen gas appliances and gas space heating boilers and thus were unable to find evidence of statutory gas safe register inspections of gas appliances were taking place.

Air Conditioning Units (ACUs) maintenance certificates were not available for examination and review. The Registered Person must ensure that an effective planned maintenance ACUs inspection/works programme is implemented in compliance with manufacturer`s instructions and the legionella risk assessment.

A review of building services maintenance documentation and discussion with the Consultant Engineer demonstrated that arrangements are in place for maintaining the built environment. The following maintenance validation certificates were reviewed:

- BS5839 fire detection and alarm competent person inspections;
- BS5266 emergency lighting competent person inspections;
- Fire-fighting equipment;
- Mobile hoist LOLER inspection; and
- BS7671 Periodic Inspection Report for the electrical installation.

We were advised of efforts to establish an Estates Management team, through the recruiting of new staff, to implement a planned preventative maintenance (PPM) works programme.

In the meantime, the hospice has commissioned consultant engineers to conduct audits of the building engineering services. Water safety, Medical Gas Pipeline Services (MGPS) and Fire Safety audits have been completed. The subsequent action plans are currently with the Registered Person for implementation and recommended improvement works are progressing.

Areas of good practice: Is Care Safe?

Areas of good practice were observed in relation to: staffing; training; recruitment and selection; safeguarding; medicines management; resuscitation; DNAR; specialist palliative care team; accessing hospice services and patient care delivery:

Areas for improvement: Is Care Safe?

Areas for improvement were highlighted in relation to: emergency medicines and equipment; some aspects of medicines management; the provision of interventional treatments and procedures in the Hospice Hub; incident management; IPC arrangements and estates management.

	Regulations	Standards
Areas for improvement	9	4

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

6.4.1 Clinical records

Both facilities have moved to a computerised system and have access to the Electronic Care Record (ECR) which will enhance communication between the hospice and the rest of HSC leading to better continuity of care for patients. The electronic care records retained are supplemented with paper records where applicable. It was confirmed that a business continuity plan was in place should electronic records not be accessible.

We reviewed a sample of patients' notes completed by a consultant and a sample of nursing care records in both the facilities. 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 delivery of the patient's care. We noted a multi-disciplinary, holistic and empathetic approach to patients' care.

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; and
- records pertaining to previous admissions and community care team, if applicable.

We evidenced that robust systems were in place to audit patient care records, as outlined in the hospice's quality assurance programme. It was encouraging to note that on reviewing some completed audits an excellent compliance rate had been achieved.

6.4.2 Records Management

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 which includes the arrangements for the creation, use, retention, storage, transfer, disposal of and access to records. 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 GMC guidance and Good Medical Practice. These policies had been updated to reflect the introduction of electronic clinical records for patients. Discussion with staff confirmed they had a good knowledge of effective records management.

Information was available for patients on how to access their health records in keeping with the General Data Protection Regulations (GDPR) and the hospice is registered with the Information Commissioner's Office (ICO).

6.4.3 Care pathway

We noted a good multi-disciplinary system for review of referrals and triage/assessment of cases referred to the NI Hospice and the NI Hospice Adult Community Services. Patients and/or their representatives are given information in relation to the hospice which is available in different formats, if necessary. Referrals can be received from the palliative care team, hospital consultant, nurse specialist or general practitioners. Multi-disciplinary assessments are furnished with the referral information through the regional referral arrangements. These systems were found to be robust.

On admission patients and/or their representatives are provided with information regarding the various assessments that may be undertaken by members of the multi-professional team. This includes medical, nursing, physiotherapy, occupational therapy, social work, complimentary therapy and spiritual assessments.

6.4.4 Nutrition and hydration

We observed that the meals service was well co-ordinated, with patients receiving their meals in a timely way and being assisted as needed. Nursing staff are responsible for the co-ordination of mealtimes and the recording of food and fluid intake. Feedback from patients was positive in relation to the availability of food and fluids, menu choices and the quality of food served.

Discussion with staff and review of a sample of menus evidenced good choice of nutritious in provision of meals offered that included specific meals for patients requiring specialised diets, and meal times that were flexible and 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).

6.4.5 Pain management

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 timely manner.

6.4.6 Communication

In both facilities, we found evidence of good multi-disciplinary working and effective communication between staff and patients and/or their representatives.

We found good structures in place for teams supported by effective lines of communication and regular staff meetings, which have minutes retained. Staff confirmed that they feel supported and felt their voice is heard by management. Staff have the opportunity to be included in decisions making and are involved in quality improvement such as reviewing the outcome and learning from quality assurance audits. Staff agreed that they can raise concerns openly and honestly with management.

6.4.7 Discharge planning

We found robust systems 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.

We reviewed the discharge planning arrangements and found 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 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.

Areas of good practice: Is Care Effective?

There were areas of good practice found in relation to the delivery of patient centred care; pain management; the completion of multi-disciplinary care records; meal and mealtimes; communication between patients, their families and staff; and discharge planning.

Areas for improvement: Is Care Effective?

No areas for improvement were identified during the inspection in relation to effective care.

	Regulations	Standards
Areas for improvement	0	0

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

6.5.1 Person centred care

In both facilities we found that care was very patient centred. Patients and their families advised they were very happy with the care provided. Compassionate and positive interactions between staff and patients were observed throughout the inspection. Staff introduced themselves to patients and explained procedures to patients in a kind and caring manner.

We found evidence of meaningful patient involvement in plans of care and treatment, provided in a flexible manner to meet the expressed wishes and assessed needs of each individual patient and their families.

Accessible facilities were provided to accommodate patients and their family and friends to enable them to spend time as much time together as they wish in the hospice. Family members can stay overnight with patients and there are no restrictions on visiting.

The hospice has a silent call system in place for patients to request assistance. This is conducted via mobile devices carried by care staff and reduces noise disturbance for other patients and their families. This establishes a peaceful and calm environment within a busy facility. We observed the system in operation as staff responded to patients to meet their needs in a timely manner.

A lay assessor was present on the first day of inspection to gain the views of patients and their representatives. The lay assessor spoke with patients and family members in both facilities and the feedback received was very positive. Examples feedback provided are as follows:

- “The care in here is unbelievable. It’s brilliant. It’s my second time here. They built me up body wise and spirit wise.”
- “Our experience is; it’s top of the range. We couldn’t find fault, staff couldn’t be nicer, what we have experienced is top marks.”
- “I don’t know what we would do without their support and help.”
- “Pain management was sorted out very quickly. I was supposed to be here four weeks but they got it sorted out within a week.”

6.5.2 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 hospice can provide internal individual counselling services for patients and families or 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.

Management confirmed counselling and support services are also available for staff. Staff confirmed they are made aware of these services and other support mechanisms in place.

6.5.3 Breaking bad news

We found that bad news is delivered to patients and/or their representatives by professionals who have experience in communication, and act in accordance with the hospice's policy and procedure. The hospice has a policy and procedure for delivering bad news to patients and/or their representatives which is accordance with the Breaking Bad News regional guidelines 2003. The hospice retains a copy of the guidelines which are accessible to staff.

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 provide support to the patient and/or their representatives to help them to process the information shared. A review of one patient's care record confirmed that delivering bad news is reflected in care records. With the patient's consent, information is shared with the patient's GP.

6.5.4 Patient engagement

We reviewed how the hospice engages with patients and/or their representatives and found that this 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.

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 senior management team, and informs improvements to services.

Focus groups are also held providing an opportunity for engagement with patients' families and explore how and where the hospice can do better or provide additional services. Patients who spoke with us were very positive about the efforts made to obtain their views.

Areas of good practice: Is Care Compassionate?

The following areas were noted to be examples of good practice: person centred care, meaningful patient/family involvement in their care, bereavement care services, breaking bad news and obtaining patient's views about the services provided.

Areas for improvement: Is Care Compassionate?

No areas for improvement were identified during the inspection in relation to compassionate care.

	Regulations	Standards
Areas for improvement	0	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

6.6.1 Clinical and organisational governance

We reviewed documentation and discussed the NI Hospice and NI Hospice Adult Community Services governance arrangements with a number of staff including Mrs Heather Weir, Chief Executive (Responsible Individual); Mrs Hilary Maguire, Registered Manager of the NI Hospice; Mrs Gemma Aspinall, Registered Manager of the NI Hospice Adult Community Services; in-patient unit manager; consultant in palliative care and the co medical leads.

6.6.2 Clinical governance

We found a clear organisational structure in place within both facilities. Staff described their roles and responsibilities and were aware of who to speak to if they had a concern. Staff reported there were good working relationships and that management were responsive to any suggestions or concerns raised.

There are currently separate managers for each facility and in future it is planned that a single manager will be responsible for both.

The Registered Provider monitors the quality of services and is required to undertake a visit to the premises at least every six months in accordance with legislation. We were able to confirm that this had been taking place.

We found that the NI Hospice had the broad elements required for an effective governance system, however the system and operational arrangements relating to governance should be strengthened and streamlined going forward.

We found that the functions of the Medical Advisory Committee (MAC) were split between the Multi-Professional Committee and the two Clinical Leads who link on an informal basis with the medical member of the Board of Trustees. The link between the two Clinical Leads and the Medical Trustee should be formalised moving forward.

We identified that aspects of the MAC outlined above are working well separately. However, in order for the hospice to comply with the regulations, these functions must be formally described, providing evidence of the systems in place and assurance to the NI Hospice, Board of Trustees and RQIA. We advised that there is no need to establish a new MAC provided the hospice can clearly describe the functions and evidence that these are being discharged by the current committee/working group structure.

We recommended that a strong link should be formed between the nursing Trustee and lead nurses providing care within the hospice. The Trustee responsible for nursing should be regularly connecting with the nursing leads, challenging their practice, and actively supporting them when necessary.

We noted there were a lot of committees and groups operating within the overall governance system, the structure and purpose of these committees should be reviewed, with an aim of streamlining them and reduce the number of active committees and groups.

We advised that the governance committee requires adequate time to allow it to reflect on challenges emerging and the learning which arises. We cautioned against combining governance arrangements with operational management arrangements, as governance staff need adequate time for reflection and oversight, to assure the Executive Team that all practices and operational aspects of the hospice are sufficiently robust.

We were advised by the Chief Executive that the hospice management team has begun its review of the governance system. The challenges relating to the large volume of meetings and the number of committees/groups in operation had previously been identified.

We recommended that the current Morbidity and Mortality (M&M) meetings become multi-professional, to include lead nursing staff and other relevant staff, with a view to sharing learning.

We highlighted that IPC is an important element of governance, and that the different elements of IPC (including environment, water and clinical practices) should be brought together across the hospice's operating systems to ensure a joined up, robust approach to IPC and water safety.

We identified elements of an improvement culture in NI Hospice, e.g. staff demonstrated good ideas and a willingness to assess and change what is needed.

6.6.3 Management of operations

We found systems to ensure that the quality of services provided by both facilities is evaluated on an annual basis and discussed with relevant stakeholders. The hospice has a clinical governance committee involving all areas of service provision.

We found that a range of policies and procedures were available for staff reference. We confirmed that policies and procedures were indexed, dated and systematically reviewed on at least a three yearly basis. Staff were aware of the policies and how to access them.

It was noted that arrangements were in place to ensure that all risks associated with the hospice are identified, assessed and managed. We reviewed a number of risk assessments and found systems in place to review these on a regular basis or more frequently if changes occur.

6.6.4 Complaints management

A copy of the complaints procedure was available in the hospice. We found this to be in line 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. Patients who spoke with us confirmed that they were aware how to raise concerns. Staff demonstrated good awareness of complaints management.

We found that complaints were investigated and responded to appropriately. Records were kept of all complaints and included details of all communications with complainants; the result of any investigation; the outcome and any action taken. Information gathered from complaints was used to improve the quality of services provided.

6.6.5 Quality assurance

The management team described arrangements were in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals. If required an action plan is developed and embedded into practice to address any shortfalls identified during the audit process.

We found evidence of the following audits being carried out:

- safe use of bed rails;
- discharge planning;
- accidents and incident;
- hand hygiene;
- infection prevention and control;
- mattress;
- sharps awareness;
- controlled drugs;
- documentation; and
- medical staff participate in surveys and audits conducted by Regional Palliative care group (if applicable).

We found a system was in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies as appropriate. As previously discussed an area of improvement has been made to ensure that all medicine related incidents must be reported to RQIA in line with the timescales outlined in legislation.

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.

Arrangements were in place to monitor the competency and performance of all staff and report to the relevant professional regulatory bodies in accordance to guidance. There were also systems in place to check the registration status of the health care professionals with their appropriate professional bodies on an annual basis.

The Registered Provider and Registered Managers demonstrated a clear understanding of 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 available on request.

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

Areas of good practice – Is Care Well Led?

Areas of good practice were found in relation to the following aspects of governance; management of complaints; incidents and alerts; arrangements for managing practising privileges; quality improvement and maintaining good working relationships.

Areas for improvement – Is Care Well Led?

Areas for improvement were identified in relation to strengthening the existing overall governance arrangements and formalising the link between the medical/nursing Trustees and the clinical and nursing leads.

	Regulations	Standards
Areas for improvement	2	0

6.7 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 were discussed. The equality data collected was found to be managed in line with best practice.

6.8 Patient and staff views

Two patients' relatives submitted responses to the RQIA questionnaires. Each relative indicated that they felt their care was safe and effective, that they were treated with compassion and that the service was well led. Both relatives also indicated that they were very satisfied with each of these areas of their care. Comments included:

- "The consultant has been amazing – very caring and considering (the patient's) needs all the staff are like that. It's truly an amazing place. Thank God for it."
- "This place is amazing."

We invited staff to complete an electronic questionnaire during the inspection. No staff questionnaires were received by RQIA.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Heather Weir, Chief Executive (responsible individual); Mrs Hilary Maguire, Registered Manager of the NI Hospice; Mrs Gemma Aspinall, Registered Manager of the NI Hospice Adult Community Services; in-patient unit manager; consultant in palliative care; co medical leads; director of care and quality governance (via teleconference), during the feedback session on Friday 15 February 2019, 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 further 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 should 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 The Minimum Care Standards for Independent Healthcare Establishments (2014)	
Clinical governance	
Area for improvement 1 **Ref:** Regulation 17 **Stated:** First time time **To be completed by:** 30 June 2019	The Registered Person shall address the following matters to strengthen the governance arrangements: • the Medical Advisory Committee (MAC) terms of reference should be formalised providing written evidence of the functions and systems in place to provide assurance and to evidence safe practice to the NI Hospice, Board of Trustees and RQIA; • review the current committees and working groups to determine what committees are required in order to assure best practice and to deliver appropriate oversight of services; • streamline these committees to develop a simplified and effective working governance arrangement; and • the current Morbidity and Mortality (M&M) meeting should become multi-professional and include nursing staff and other relevant staff with a view to sharing learning. **Ref: 6.6.2**
	Response by Registered Person detailing the actions taken: Completed and changes are being monitored. Medical Advisory Committee - added as a standing agenda item to our weekly clinical leads meeting and Terms of Reference completed. These meetings focus on developments in clinical practice, and a monthly review of patient safety and quality indicies. The meeting is minuted via action points. The MAC reports and escalates to the Corporate Quality Governance Committee (CQGC) via the Care Directorate Quality Improvement Clinical Leads. CQGC reports to the Board of Trustees every 6 months with escalated matters as required. Current committees and streamlining - the Quality Governance Structure has been reviewed and the process of changing to Directorate quality assurance is advancing. Thereby streamlining meetings, strengthening ownership of governance across the organisation and improving assurance with robust management information. M&M meeting - this is now multidisciplinary and commenced on 20 June 2019. It is held once a month for one hour (usually on last Thursday of the month)

Area for improvement 2 **Ref:** Regulation 17 **Stated:** First time time **To be completed by:** 30 June 2019	The Registered Person shall review the governing arrangements between the Board of Trustees and the executive team and operational staff in the hospice; consideration should be given to: • formalising the link between the two clinical leads and the medical member of the Board of Trustees; • formalising a nursing link to the Board of Trustees; • ensuring the Trustee responsible for nursing connects with the nursing leads; to support and also challenge practice, as appropriate; and • ensuring all links between the Board of Trustees and key personnel are captured in the governance structure. **Ref: 6.6.2**
	Response by Registered Person detailing the actions taken: Further to the Board meeting on 29 August 2019, the Board of Trustees have clearly indicated the success of clinical engagement is founded upon it being informal. Therefore all matters for escalation in relation to raising concerns about practice, patient safety and governance are formally raised via the Corporate Quality Governance Committee and through the appropriate organisational policies which support staff to raise concerns formally. This ensures compliance with regulation 17 and promotes good engagement and quality. The clinical leads continue to meet the clinical members of the Board of Trustees bi-monthly, prior to the Board of Trustees meeting. The purpose of this is to offer informal professional support and an open space for discussion on any matters the medical, nursing and AHP leads wish to share around clinical practice. The governance structure has been revised to reflect this arrangement and the Corporate Quality Governance Committee TORS are currently being updated to reflect the changes.
Resuscitation and management of medical emergencies	
Area for improvement 3 **Ref:** Regulation 15 (6) **Stated:** First time time **To be completed by:** 30 June 2019	The Registered Person shall ensure that mechanisms are in place for the provision of emergency medicines and equipment and should address the following: • emergency trolleys for the NI Hospice and the NI Adult Community Services Hospice must be stocked with the correct emergency medication to accommodate patients using these services and also visitors to the service; • emergency medicines should be stored in sealed boxes; • daily checks should be recorded and issues identified must be addressed in a timely manner; and • location of the resuscitation trolley in the Adult Community Services Hospice should be reviewed to ensure the trolley is easily accessible at all times. **Ref: 6.3.7**

	Response by Registered Person detailing the actions taken: Bullet point one complete. Bullet point two complete. Bullet point three complete. Bullet point four - complete. The location of the resuscitation trolley has been reviewed and risk assessed with the outcome being that the trolley will remain in the procedure room with the door unlocked and room accessable at all times during clinics.
Interventional procedures	
Area for improvement 4 **Ref:** Regulation 15 (1) **Stated:** First time time **To be completed by:** 30 June 2019	The Registered Person shall address the following matters in relation to the provision of treatments and procedures to be provided in the Adult Community Services Hospice: • ensure that clinical and treatment protocols that have been developed by the medical consultants are guided by best practice guidelines, to support the delivery of an enhanced range of treatments e.g. paracentesis, blood transfusion and the management of hypercalcaemia; • copies of the clinical and treatment protocols should be made available and easily accessible to all staff involved; and • implement an assurance mechanism for the NI Hospice's Executive Team and Board of Trustees to ensure that the quality of practice and care delivered in the treatment room is of the required standard. **Ref: 6.3.8**
	Response by Registered Person detailing the actions taken: Bullet point one - complete. Bullet point two - complete. Bullet point three - a hub procedure section has been added to the care QI reports to be reviewed on a monthly basis, included in the Direcorate QI report and shared with the CQGC quarterly.
Management of incidents	
Area for improvement 5 **Ref:** Regulation 28 (1) **Stated:** First time time **To be completed by:** 30 June 2019	The Registered Person shall ensure that RQIA is informed of all medication incidents, in a timely manner, in keeping with RQIA guidance statutory notifications of incidents and deaths for registered providers and managers. **Ref: 6.3.5**
	Response by Registered Person detailing the actions taken: Completed. To provide assurance a printed copy of the report to RQIA is attached to IR1s for review at divisional leads. The IR1 will not be processed any further in the absence of such a report until one has been provided, thereby ensuring statutory notifcation.
Infection prevention control (IPC) and decontamination procedures	
Area for improvement 6	The Registered Person shall address the following matters in relation to infection prevention and control (IPC) and care delivery:

Ref: Regulation 15 (7) **Stated:** First time time **To be completed by:** 30 June 2019	• the current audit tools should be updated to reflect and assure best practice in relation to clinical practices and aseptic non-touch technique (ANTT); • the hospice should engage expert involvement to support appropriate development and implementation of best practice for infection prevention and control; and • the involvement of the clinical educator should be considered when reviewing and/or implementing changes/improvements to clinical practice e.g. nutrition, hydration, pressure care, IPC and the environment. **Ref: 6.3.9**
	Response by Registered Person detailing the actions taken: Completed. IPC audit tools have been updated accordingly and a new audit programme using these has commenced. ANTT study day was delivered on 27 June 2019 to provide train the trainer education, employing expert input to deliver this. Link nurse training has commenced via Belfast HSCT. Hospice representatives have joined the infection prevention society and avail of all available resources via this. Also liaising with IPC nursing advisor in Northern HSCT to provide advisory opinion on further development of best practice. We have reveiwed all clinical policies to ensure that the updated ANTT policy is cross referenced as applicable. The clincal educator is fully engaged and active in reviewing and implementing all changes and improvements to clinical practice.
Area for improvement 7 **Ref:** Regulation 15 (7) **Stated:** First time time **To be completed by:** 30 June 2019	The Registered Person shall strengthen infection prevention and control (IPC) arrangements in the following areas: • the oversight of the environment, water and clinical practices must be brought together and reviewed holistically to ensure a joined up robust approach to IPC and water safety; • the implementation of IPC governance policies should include the updated IPC audit tools and water testing arrangements; and • the IPC/water safety group should form a key element of the overall patient safety group. **Ref: 6.3.9**
	Response by Registered Person detailing the actions taken: Completed and ongoing - The Water Safety Group has been formed (ensuring appropriate membership from clinical, estates and housekeeping) and added to the established IPC. ToR have been developed and provide a clear mechanism to ensure oversight of the environment holistically and a joined up approach. Microbiology input has been identified and joined the water safety group in September 2019.

Area for improvement 8 **Ref**: Standard 22.1 & 22.2 **Stated:** First time **To be completed by:** 30 June 2019	The Registered Person shall ensure that the bed pan washer/disinfector is maintained effectively and water temperatures are calibrated in accordance with manufacturer`s instructions. **Ref: 6.3.10**
	Response by Registered Person detailing the actions taken: Completed and Report (Arjo) available for inspection.
Environment	
Area for improvement 9 **Ref:** Regulation 25 (2) (d) **Stated:** First time time **To be completed by:** 30 June 2019	The Registered Person shall arrange for the implementation of the action plan recommendations listed in the 14 January 2019 Medical Gas Pipelines Systems (MGPS) Authorizing Engineer audit report; in accordance with Health Technical Memorandum 02-01 Part B and the action plan time frame. **Ref: 6.3.10**
	Response by Registered Person detailing the actions taken: In progress - All items in the MGPS audit action plan are currently under review. MGPS is currently under the control of an authorised person and all work is carried out in complaince HTM 02-01. All service work has been carried out under the control of a permit to work system. Records are available for inspection. The majority of outstanding items relate to installation issues. Meetings with the Architect, M&E Consultants and the contractor have advanced with solutions being agreed and negoitations progressing in terms of liability for costs. NI Hospice is constituting a medical gas group who will meet to discuss operational MGPS issues in accordance with HTM 02-01 and implement issues such as the operational policy, nurse training, quarterly testing etc. This group will initially meet on a quarterly basis.
Area for improvement 10 **Ref**: Standard 22.1 & 22.3 **Stated:** First time **To be completed by:** 30 June 2019	The Registered Person shall ensure that all gas appliances have valid Gas Safe Register engineer safety inspections completed in accordance with statutory requirements and that the following inspection, certificates are available for review for: • Kitchen gas appliances; and • Gas space heating boilers **Ref: 6.3.10**
	Response by Registered Person detailing the actions taken: Completed and inspection reports available for inspection (Scans).
Area for improvement 11	The Registered Person shall ensure that all Air Conditioning Units (ACUs) are maintained in accordance with manufacturer's instructions

Ref: Standard 22.1 & 22.3 **Stated:** First time **To be completed by:** 30 June 2019	and Health Technical Memorandum 03-01. **Ref: 6.3.10**
	Response by Registered Person detailing the actions taken: Completed - All HRU's & ACU's are maintained to HTM 03-01 guidance. service reports from specialist contractor. (To Follow).
Area for improvement 12 **Ref:** Regulation 25 (4) (f) **Stated:** First time time **To be completed by:** 30 June 2019	The Registered Person shall arrange for the completion of a fire risk assessment (FRA) review; any subsequent FRA action plan recommendations must be implemented in accordance with the action plan time frame. **Ref: 6.3.10**
	Response by Registered Person detailing the actions taken: Completed - FRA available for inspection, subsequent actions have been reviewed and implemented.
Area for improvement 13 **Ref:** Regulation 25 (2) (d) **Stated:** First time time **To be completed by:** 30 June 2019	The Registered Person shall arrange for the establishment of a multi-disciplinary Water Safety Group (WSG) to monitor and verify that the Water Safety Plan (WSP) is implemented. The WSP shall comply with the Water Safety Policy and Health Technical Memorandum 04-01 Part B: "The control of Legionella, hygiene, 'safe' hot water, cold water and drinking water systems". **Ref: 6.3.10**
	Response by Registered Person detailing the actions taken: Completed and ongoing. A multidisciplinary Water Safety Group (WSG) has been established with TORs agreed. The WSG meets initally on a monthly basis at present with a view to moving to quarterly to discuss all water compliance issues in accordance with HTM 04-01 & HSG 274 Part 2 NI Hospice has a up to date Water Risk Assessment, Water Safety Policy and Water Safety Plan.
Area for improvement 14 **Ref:** Regulation 25 (2) (d) **Stated:** First time **To be completed by:** 30 June 2019	The Registered Person shall arrange for the completion of Lifting Operations and Lifting Equipment Regulations (LOLER) thorough examinations of the passenger lifts, in compliance with LOLER Regulation 9. **Ref: 6.3.10**
	Response by Registered Person detailing the actions taken: Complete and evidence available for inspection.
Antibiotic/antimicrobial stewardship	
Area for	The Registered Person shall ensure that an antimicrobial auditing system

improvement 15 **Ref**: Standard 25. **Stated:** First time	is developed and implemented to ensure compliance with the hospice's antimicrobial policy and an action plan developed to address any deficits identified. **Ref: 6.3.6**
To be completed by: 30 June 2019	**Response by Registered Person detailing the actions taken:** Hospice has sought advice and guidance from the Belfast Health and Social Care Trust with whom we have a pharmacy SLA with. We have reviewed our Antimicrobial policy and agreed to follow best practice in keeping with the Trust. In addition we have initiated the HAPPI Audit in our adult inpatient unit.

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

The Regulation and Quality Improvement Authority

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