Unannounced Inspection Report
8 February 2021

Foyle Hospice

Type of Service: Independent Hospital (IH) – Adult Hospice
Address: 61 Culmore Road, Londonderry, BT48 8JE
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Assurance, Challenge and Improvement in Health and Social Care

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

1.0 What we look for

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

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

Membership of the inspection team

Jo Browne	Senior Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Stephen O'Connor	Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Carmel McKeegan	Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Judith Taylor	Pharmacist Inspector, Pharmacy Team Regulation and Quality Improvement Authority
Phil Cunningham	Senior Inspector, Estates Team Regulation and Quality Improvement Authority
Dr Leanne Morgan	Clinical Lead

2.0 Profile of service

Foyle Hospice is registered as an independent hospital with adult hospice and private doctor categories of care. Foyle Hospice is registered for 12 inpatient beds, operates a day hospice service and provides specialist palliative care to patients living in the community.

We established that as a direct result of the COVID-19 pandemic the inpatient beds have been reduced to seven and the day hospice services have been temporarily suspended.

3.0 Service details

Organisation/Registered Provider: Foyle Hospice **Responsible Individual:** Mr Donall Henderson	**Registered Manager:** Mrs Bernie Michaelides
Person in charge at the time of inspection: Mr Donall Henderson	**Date manager registered:** 9 October 2020
Categories of care: **Categories of care:** Independent Hospital (IH) Hospice Adult – H(A) Private Doctor - PD	**Number of registered places:** 12 inpatients Day Hospice - 12

4.0 Inspection summary

An unannounced inspection was undertaken to the Foyle Hospice which commenced with an onsite inspection on 8 February 2021. We employed a blended multidisciplinary inspection approach. The onsite element of our inspection was completed on 8 February 2021 by three care inspectors. We provided a list of specific documents to be sent electronically to our pharmacist inspector and estates inspector on or before Monday 15 February 2021 for review remotely. Feedback of the inspection findings was delivered to the Foyle Hospice senior management team on 11 March 2021 during a zoom teleconference.

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

The purpose of this inspection was to focus on the themes for the 2020/21 inspection year. Our multidisciplinary inspection team examined a number of aspects of the hospice including the management of operations in response to COVID-19 pandemic; infection prevention and control (IPC); the provision of palliative care; medicines management; maintenance of the premises; and the management and oversight of governance across the organisation. We met with various staff members, reviewed care practice and relevant records and documentation used to support the governance and assurance systems.

No immediate concerns were identified in relation to patient safety and the inspection team noted multiple areas of strength, particularly in relation to the delivery of front line care in the hospice. We confirmed good governance measures were in place for the preparation and maintenance of a COVID-19 safe environment and IPC arrangements.

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

We found that the governance structures within the hospice had improved since our last inspection and are able to provide the required level of assurance to the senior management team and Board of Trustees.

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

No new areas from improvement were identified as a result of this inspection. As discussed, the day hospice services have been temporarily suspended, therefore we were not able to assess compliance with one area for improvement made during the previous inspection in relation to clinical interventions. This area for improvement has been carried forward for review at the next inspection.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1*	0

Details of the Quality Improvement Plan (QIP) were discussed with Mr Donall Henderson, Responsible Individual; Mrs Bernie Michaelides, Registered Manager; and the Chairperson of the Board of Trustees during the feedback session, via zoom teleconference, on 11 March 2021. Findings of our inspection are outlined in the main body of the report.

*An area for improvement made during the previous inspection in relation to clinical interventions undertaken in the day hospice has been carried forward for review at the next inspection.

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

4.2 Action/enforcement taken following the most recent unannounced inspection dated 25 and 26 February 2020

Other than those actions detailed in the Quality Improvement Plan (QIP) no further actions were required to be taken following the most recent inspection on 25 and 26 February 2020.

5.0 How we inspect

In response to the COVID-19 pandemic, we reviewed our inspection methodology and considered various options to undertake inspections. The purpose of this was to minimise risk to service users and staff, including our staff, whilst being assured that registered services are providing services in keeping with the minimum standards and relevant legislation.

In order to meet with best practice guidance we reduced the number of inspectors and employed a blended multidisciplinary inspection approach. Two care inspectors and a senior inspector undertook an unannounced onsite inspection on 8 February 2021 from 10:00 to 17:00 hours. Prior to the onsite inspection we had determined the additional information we would require to confirm compliance with the legislation and minimum standards for the areas inspected and were satisfied that this information could be provided to us electronically and reviewed remotely.

At the outset of our inspection on 8 February 2021 we provided Foyle Hospice with a list of documents to be sent electronically to our pharmacist and estates inspectors who were available offsite. Our pharmacist and estates inspectors reviewed the submitted documents and also held discussions with a staff nurse and the Human Resources Manager by telephone in the days following the onsite inspection. The pharmacist and estates inspectors provided their feedback to the inspection team to share with the hospice senior management team.

At the onsite inspection we advised Foyle Hospice that any outstanding issues could be followed up by email or teleconference following the inspection in an effort to minimise time spent in the premises.

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

Prior to the inspection we reviewed a range of information relevant to the service. 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
- the previous care inspection reports
- the returned QIP from the previous care inspection

We were unable to meet with patients on the day of the inspection and assessed patient feedback by reviewing the most recent patient satisfaction survey completed by the Foyle Hospice. We invited staff to complete an electronic questionnaire. One completed staff questionnaire was submitted following the inspection. Staff and patient feedback are further discussed in section 6.11 of this report.

A poster informing patients that an inspection was being conducted was displayed during the inspection.

During the onsite inspection we met with and spoke with the following staff Mr Henderson, Responsible Individual; Mrs Michaelides, Registered Manager; the medical director; the human resources manager; one of the inpatient unit ward sisters, a nurse, a community nurse; a nursing auxiliary; a domestic and a chef.

Following the inspection Jo Browne, Senior Inspector, spoke with the Chairperson and vice chairperson of the Board of Trustees and Dr Leanne Morgan spoke with the medical director.

We were informed that the day hospice element of the Foyle Hospice was temporarily closed to patients due to the impact of the COVID-19 pandemic. We were also informed that the day hospice staff had been redeployed to the in-patient unit. We established that the Integrated Outpatient Clinic was operating in the day hospice premises on Tuesdays and Wednesdays and that the hospice continues to provide community services to patients who are able to remain in their own homes.

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

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

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 25 and 26 February 2020

The most recent inspection of Foyle Hospice was an unannounced inspection on 25 and 26 February 2020. The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 25 and 26 February 2020

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Clinical governance		
Area for improvement 1 **Ref:** Standard 12.7 **Stated:** First time	The registered persons shall ensure that a daily safety brief is incorporated into the daily handovers. The safety brief should be a short multidisciplinary briefing, held at a predictable time and place, and focused on the patients most at risk, as well as all other emerging issues that have the potential to impact of the provision of services.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.6.8.	
Area for improvement 2 **Ref**: Regulation 17 **Stated:** First time	The registered persons shall address the following matters to strengthen the governance arrangements: • the Medical Advisory Committee (MAC), which sits within the Corporate Risk and Governance meeting, should have clear terms of reference in order to provide written evidence of the functions and systems in place to provide assurance and to evidence safe practice to the Foyle Hospice, Board of Trustees and RQIA; • business relating to the MAC should be a standing agenda item and be clearly identifiable within the minutes of the Corporate Risk and Governance Meeting; • the medical director must review and scrutinise appraisal documents for all medical practitioners and clearly record the outcome of their review; • Morbidity and Mortality (M&M) meetings should be formally documented. If M&M discussions remain within the Clinical Governance and Risk Management Meetings, the minutes must clearly reflect the details in relation to M&M discussions.	**Met**

	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.9.2.	
Area for improvement 3 **Ref:** Standard 12.7 **Stated:** First time	The registered persons shall ensure that the minutes of the Board of Trustees meetings clearly detail the reports/documents reviewed by the Board of Trustees and any subsequent actions recommended by them.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.9.1.	
Audit		
Area for improvement 4 **Ref:** Standard 17.1 **Stated:** First time	The registered persons shall address the following matters with respect to audits: • audit reports must include information in relation to the name of the person completing the audit; • the timeframe the audit applied to; the date the audit was completed; • the date the audit was shared with the various committees; • the dates by which any subsequent action plans must be achieved; and • the name of person responsible for implementing the action plan.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.9.3.	
Area for improvement 5 **Ref:** Standard 9.7 **Stated:** Second time	The registered person shall ensure that a range of clinical quality indicators is developed and audits undertaken to provide assurances in respect of the standard and quality of services provided.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.9.5.	

<table>
<tr><th colspan="3">Interventional procedures</th></tr>
<tr><td rowspan="2">Area for improvement 6

Ref: Regulation 15 (1)

Stated: First time</td><td>The registered persons shall ensure the following matters in relation to clinical interventions undertaken in the day hospice are addressed:

• clearly outline the clinical interventions that can be undertaken;
• ensure that clinical intervention treatment protocols have been developed by the Medical Consultants and are in line with current best practice guidelines;
• copies of the clinical intervention treatment protocols should be made available and easily accessible to all staff involved; and
• implement an assurance mechanism for the Foyle Hospice’s senior management team and Board of Trustees to provide assurance that the quality of practice and care delivered in relation to clinical interventions is of the required standard.</td><td rowspan="2">Carried forward to the next care inspection</td></tr>
<tr><td>Action taken as confirmed during the inspection:
We were told that the day hospice is not currently operating in response to the COVID-19 restrictions. Mrs Michaelides told us that work has commenced to address this area for improvement. However, as we were not able to verify compliance this has been carried forward for review during the next inspection.</td></tr>
<tr><th colspan="3">Environment</th></tr>
<tr><td rowspan="2">Area for improvement 7

Ref: Regulation 25 (2) (a) Standard 22.11

Stated: First time</td><td>The Registered Persons shall arrange for the repair of the defective plaster rendering in the staff dining room and redecoration of same.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
We observed that the defective plaster in the dining room had been repaired and the room redecorated.</td></tr>
</table>

Area for improvement 8 **Ref:** Regulation 15 (7) Standard 22.3 **Stated:** First time	The registered persons shall arrange to bring forward the review of the legionella risk assessment and address any issues arising from same.	**Met**
	Action taken as confirmed during the inspection: We confirmed that a legionella risk assessment had been completed by an external organisation during July 2020. We confirmed that appropriate action had been taken to address the recommendations within the legionella risk assessment and that appropriate legionella control measures are in place.	
Area for improvement 9 **Ref:** Standard 22.3 **Stated:** First time	The registered persons shall arrange for the reinstatement of the monthly user checks to the emergency lights in accordance with BS5266.	**Met**
	Action taken as confirmed during the inspection: We confirmed that Foyle Hospice recruited a maintenance person who commenced work during August 2020. We reviewed records and confirmed that the appointed maintenance person undertakes routine monthly user checks of the emergency lighting installation in accordance with BS5266.	
Area for improvement 10 **Ref:** Standard 20.1 **Stated:** First time	The registered persons shall arrange for the provision of toilet roll holders in all toilets in the premises in liaison with the Infection Control Nurse.	**Met**
	Action taken as confirmed during the inspection: We reviewed the arrangements in a random sample of toilets and observed that toilet roll holders had been installed in all toilet facilities reviewed.	

Antibiotic/antimicrobial stewardship		
Area for improvement 11 **Ref**: Standard 25 **Stated:** First time	The Registered Persons shall ensure that an antimicrobial stewardship policy is developed and implement a system for carrying out formal audits regarding the use of antimicrobial medicines to provide assurance that the policy is adhered to and reasons for non-adherence are known and documented.	**Met**
	Action taken as confirmed during the inspection: There was evidence that an antimicrobial stewardship policy had been developed and implemented in June 2020 in consultation with the antimicrobial pharmacist in the Western Health and Social Care Trust. The medical direct is responsible for the policy and training was provided to staff in July 2020. Antibiotic stewards is one of the KPIs (Key Performance Indicators) fo this hospice. A specific audit tool has been designed and implemented to ensure adherence to the polic and appropriate prescribing which is completed twice yearly.	

6.3 Inspection findings

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

COVID-19 has been declared as a public health emergency resulting in the need for healthcare settings to assess and consider the risks to their patients and staff. We sought assurance of effective governance arrangements in the planning and delivery of IPC measures by reviewing the key areas of collaborative working, COVID-19 risk assessments, the monitoring of staff practices, work patterns and staff training.

We were told how the hospice had developed a COVID-19 Task Group who meets regularly to review and implement measures to promote a COVID-19 safe environment for staff, patients and visitors.

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

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

We were informed the IPC lead was on an unplanned period of leave and that an internal trawl process had commenced to provide temporary cover for this position. We were informed that the IPC lead had developed strategies to incorporate COVID-19 training into IPC training and staff training matrixes were updated to reflect this. During our inspection we reviewed staff training records in relation to IPC and found that overall mandatory IPC training was up to date.

Additional training for staff in donning and doffing of personal protective equipment (PPE) and training on the completion of risk assessments in the workplace has also been facilitated by IPC lead. Discussion with staff confirmed they had received this training and that they have access to training materials.

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

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

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

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

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

We observed staff changing facilities, staff rest areas and nurses stations and found these areas had been included in the COVID-19 risk assessment. Notices were clearly displayed to remind staff of the maximum number of staff permitted in each area in accordance with social distancing guidance. Staff break times had been staggered to facilitate social distancing and staff told us these arrangements were working well. Management had also reviewed staff changing facilities and provided an additional staff changing area which further enabled staff to socially distance at staff change over times.

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

We found that staff were knowledgeable on COVID-19 pandemic restrictions. We confirmed the hospice had identified a COVID-19 lead; had reviewed and amended policies and procedures in accordance with DoH guidance to include arrangements to maintain social distancing; prepare staff; implement enhanced IPC procedures; COVID-19 patient pathways; and had amended their visiting guidance.

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

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

	Regulations	Standards
Areas for improvement	0	0

6.5 Infection prevention control (IPC)

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

We undertook a tour of the premises and found all areas to be clean, tidy and well maintained. We observed that hand hygiene posters were displayed for patients, visitors and staff regarding good hand hygiene and handwashing techniques.

As previously discussed, staff training records were reviewed which evidenced that overall staff mandatory IPC training was up to date and staff who spoke with us demonstrated a good understanding of IPC measures in place. The IPC team lead was commended by all staff for the support and training they had provided throughout the COVID-19 pandemic.

Staff were observed to undertake hand hygiene and donning and doffing of PPE at appropriate times in line with the hospice policies and best practice guidance.

We confirmed a policy was in place regarding aseptic non-touch technique (ANTT) and that 26 staff had undertaken both training and competency-based training assessments. Through discussion, staff demonstrated good knowledge and understanding of the application of ANTT into clinical practices and the management of invasive devices. We established a robust system of audit had been implemented regarding the management of invasive devices, with audit results being disseminated to staff through the hospice's governance systems.

Overall we observed equipment was clean, free from damage and in good repair. We spoke with support service staff who were knowledgeable of the daily, weekly and monthly cleaning and records to be completed and also discussed with us ongoing cleaning record audits. We were informed that the IPC lead had held regular meetings with support service staff to discuss the outcome of environmental audits and to provide support and guidance. Staff spoken with felt supported and well informed.

We observed that environmental cleanliness in all areas, clinical and communal, was of a high standard and the environment was well maintained and clutter free. We observed IPC information was displayed on notice boards in both clinical and non-clinical areas. This provided assurance of audit compliance to visitors and staff of a good standard of environmental cleaning. We were provided with evidence and assurance of the actions that would be taken if environmental standards were to fall below the expected standard.

Areas of good practice: IPC

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

Areas for improvement: IPC

No areas for improvement were identified in relation to IPC arrangements.

	Regulations	Standards
Areas for improvement	0	0

6.6 Provision of palliative care

6.6.1 Care pathway

We noted a good multi-disciplinary system was in place for the review of referrals and triage/assessment of cases referred to the Foyle Hospice inpatient unit and 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 (GPs). Multi-disciplinary assessments are furnished with the referral information through the regional referral arrangements. These systems were found to be robust. Staff spoken with confirmed they received relevant information about the patient prior to their admission.

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

We observed a range of patient information leaflets on prominent display throughout the hospice in relation to the inpatient unit, the day hospice and the community service.

6.6.2 Person centred care

We reviewed two patients' care records and 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 individual patients and their families. We found that care was patient centred.

Accessible facilities were provided to accommodate patients and their family to enable them to spend as much time together, as permissible, in the hospice in keeping with current visiting guidance issued by the DoH. We confirmed that one nominated family member or carer can stay overnight with their loved one.

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

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

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

6.6.3 Bereavement care service

We reviewed the provision of bereavement care within the hospice and found that they have a range of information and support services available. We confirmed that the staff who deliver bereavement care services are appropriately trained and skilled in this area. We were told that in response to the COVID-19 pandemic and subsequent restrictions that the usual bereavement services are temporarily on hold. However, arrangements are in place to ensure that urgent referrals for children are prioritised and bereavement services provided.

A volunteer counsellor has undertaken an audit of bereavement services and has facilitated bereavement counselling over the telephone and using zoom teleconference.

The senior management team 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.

6.6.4 Breaking bad news

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

Where this news is shared with others, 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.

6.6.5 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. We were informed that two care assistants have been trained on how to support and encourage patients to provide feedback.

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

6.6.6 Discharge

We reviewed the discharge 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.

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.

6.6.7 Medical emergency equipment and medicines

We reviewed the arrangements for the management of medical emergencies and resuscitation in the inpatient unit. We found that the hospice retains stock supplies of medicines that could be used in the event of a medical emergency. We reviewed the arrangements for checking the expiry dates of emergency medicines and equipment and found they were robust.

We reviewed training records and had discussions with staff and found that resuscitation and the management of medical emergencies are included in the induction programme and training is updated on an annual basis in keeping with best practice guidance. 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.

6.6.8 Daily safety brief

We confirmed that a daily safety brief is completed by the nurse in charge of the inpatient unit and discussed during handovers. Completed safety briefs are retained and accessible to staff. Emerging issues are recorded in a communication book that is accessible to all other disciplines of staff.

Areas of good practice: provision of palliative care

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

Areas for improvement: provision of palliative care

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

	Regulations	Standards
Areas for improvement	0	0

6.7 Medicines management

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

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

We found that policies and procedures for medicines management were in place and these included the development and implementation of an Antimicrobial Stewardship Policy. Policies were reviewed every two to three years or more frequently if there had been a change in practice/guidance, and implemented following approval by the relevant governance committees.

We established that the community pharmacist and trust pharmacist were involved in the development of policies. There were processes in place to ensure that policies were readily available for staff reference including reminders when there had been an update.

We found that in relation to medicines management training, nurses complete a period of induction training, which includes the use of syringe drivers and also annual refresher training as part of the hospice's mandatory training programme. Training may also occur following a medicine related incident. Doctors also receive medicines management training as part of their induction. The community pharmacist and trust pharmacist provide additional training, advice and support to nursing staff and doctors. In addition, training in the management of oxygen, mouth care and administration of topical medicines are also provided for care staff.

The community pharmacist supplies the medicines to the hospice, attends the hospice on a regular basis and is available out of hours. They are involved in the patient's discharge planning and ensuring the relevant information is shared with the patient's community pharmacy; this helps ensure that the patient has a continual supply of their medicines. This is to be commended as good practice. A pharmacy technician also attends the hospice to assist with the stock control of medicines throughout the week. We were informed that all medicines were stored safely and in accordance with the manufacturers' instructions.

We examined the admission process for new patients and found there were safe systems in place to ensure that the correct medicines information is provided at or prior to the patient's admission to the hospice; this involves discussion with the patient, cross-reference with hospital discharge letters, doctors' letters and the patient's electronic care record (ECR).
We reviewed a sample of patients' kardexes; which are records that detail the medicines prescribed for each patient. We found that most of these records were maintained appropriately, however, on occasion we queried the legibility of the doctors' handwriting and emphasised the need for clear and legible records. It was agreed that this would be followed up and monitored.

We reviewed the management of controlled drugs and found the Registered Manager is the Accountable Officer for the hospice and is responsible for all aspects of the management of controlled drugs. Practices in relation to controlled drugs are regularly reviewed through audit, discussed at clinical governance meetings and other senior meetings as required. There are arrangements in place to ensure the safe keeping of controlled drug cabinet keys and the completion of stock reconciliation checks for Schedule 2 and 3 controlled drugs. Nursing staff have been provided with red tabards which are worn during medication rounds to prevent distractions and promote the safe preparation, administration and record keeping of controlled drugs. This is good practice.

In relation to incident management, there are systems in place for identifying, recording, analysing and learning from medicines related incidents. Medicine related incidents are recorded on the hospice IR1 forms and each incident is investigated; and any learning or change of practice is shared with all relevant staff to prevent a recurrence. In the instances where a change in practice and policy review is necessary, this is discussed at senior management and governance meetings. The incidents are reported to RQIA and those which involve controlled drugs are also reported to the Local Intelligence Network (LIN).

We found there is a range of auditing systems in place to oversee the safe and effective management of medicines. These include the use of specific audit tools for controlled drugs, omitted doses and antibiotic stewardship, which is one of the KPIs in the hospice. Action plans are developed to drive forward any areas identified for improvement and these are monitored for completion.

Areas of good practice

Areas of good practice were identified in relation to policy review, staff training, the management of the medicines on admission to the hospice and discharge planning.

Areas for improvement

No areas for improvement were identified with regards to the management of medicines.

	Regulations	Standards
Areas for improvement	0	0

6.8 Environment

We completed the environment section of the inspection remotely and the senior management team of the hospice were requested to electronically submit relevant documents to our estates inspector. We reviewed building services documents and spoke with the Human Resources (HR) Manager. We found that satisfactory arrangements were in place for maintaining the premises' building services and the environment.

We reviewed the following documents:

- Health & Safety Policy dated March 2018 (review due March 2021)
- the Fire Risk Assessment
- service records for the premises' fire alarm and detection system
- service records for the premises' emergency lighting installation
- the Legionella Risk Assessment
- service records for the nurse call system
- service records for the fixed wiring installation
- records of portable appliance checks
- service record for the space heating boiler

We found that the Legionella Risk Assessment had been undertaken during July 2020 and all required actions addressed accordingly.

We reviewed the Fire Risk Assessment and found that it had been undertaken by a suitably accredited fire risk assessor in February 2021. The overall assessment was assessed as 'tolerable' and the HR Manager confirmed that the actions identified by the assessor had been addressed including several items of minor repair work completed.

Areas of good practice: Environment

We observed satisfactory systems were in place for all areas of estates management, with suitable arrangements in place for the provision of necessary specialist services. A maintenance person has been recruited in the hospice since the last inspection of estates related matters and the HR Manager informed us that this has greatly improved the general upkeep and maintenance of the premises on a day-to-day basis.

Areas for improvement: environment

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

	Regulations	Standards
Areas for improvement	0	0

6.9 Organisational and clinical governance

6.9.1 Organisational and clinical governance

We reviewed relevant documentation and minutes and met with Chief Executive, Registered Manager and medical director to review and discuss the organisational governance of the hospice. We spoke with the chairperson and vice chairperson of the Board of Trustees via zoom teleconference following the onsite inspection.

We confirmed that an organisational structure was in place with clear lines of accountability, defined structures and visible leadership. Staff who spoke with us were able to describe their roles and responsibilities and how they fitted into the overarching governance structures and committees.

Overall, we found that the governance structures within the hospice had improved since our last inspection and are able to provide the required level of assurance to the senior management team and Board of Trustees. It was good to note the involvement of Trustees on various committees and their commitment to driving continued improvement. Our discussions with the chairperson and vice chairperson of the Board of Trustees and the senior management team established that they have a shared vision and strategy for the hospice coupled with a cohesive and productive way of working together.

We would like to recognise the work undertaken by the Trustees, the senior management team 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.

Staff told us that the streamlining of the governance structures has ensured that appropriate and timely information is provided to the committees through fewer meetings while enabling the best use of clinical and staff expertise.

All staff that we spoke with were highly respectful of the previous manager and also spoke very positively regarding the positive impact that the new Registered Manager has had since she commenced her role. We were able to evidence these changes throughout all aspects of the inspection.

We reviewed the minutes of the new governance structures and committees and found that these were functioning well to provide a level of assurance to the Board of Trustees and a multidisciplinary clinical governance system. We were advised that the Board are able to interrogate the data provided to them and provide appropriate challenge to the senior management team. Through our conversations with staff at ward level we were able to see a live governance system working from ward to Board. A review of the Board minutes confirmed that they detail the reports and documents reviewed by the Board of Trustees and the action taken. We determined that this addresses the previous area for improvement 3 as outlined in section 6.2.

We found that the Governance and Risk Committee is provided with data that gives robust assurances on safety and tangible evidence of ongoing audit and quality improvement.

We established that arrangements were in place to develop, implement and regularly review risk assessments. We reviewed the active and draft risk registers and acknowledge that the hospice is working to develop a cohesive risk management strategy that assesses risk using one model, where possible. We discussed our findings with the senior management team and offered some advice on the recording of risk in the proposed template.

We confirmed that the Statement of Purpose and Patient's Guide were kept under review, revised and updated when necessary and made available for all interested parties to read.

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

6.9.2 Medical governance

We met with the Medical Director during the inspection and our Clinical Lead, Dr Leanne Morgan also spoke with him via telephone following the inspection. We were assured from our discussions that there were suitable arrangements in place in relation to medical governance, medical leadership and medical cover within the hospice. The medical director advised that there are systems in place to receive and scrutinise the full appraisal documents for all doctors. We also discussed the benefits of providing and receiving letters of good standing for doctors as an additional level of assurance. We found that the medical director is fully involved in the governance arrangements of the hospice including the review of safety and quality information, incidents, complaints and KPIs through attendance at the Governance and Risk Committee Meetings.

We established that the Medical Advisory Committee (MAC) had been formalised within the Governance and Risk Committee. We were able to review the terms of reference for the MAC and a sample of MAC reports provided to the committee by the Medical Director.

We found that multidisciplinary Morbidity and Mortality (M&M) meetings (known as debriefing meetings) are held regularly and are formally documented. We confirmed that any learning from the M&M meetings would be shared with relevant staff and the senior management team through the governance structures. M&M meetings provide a unique opportunity for health professionals to improve the quality of care offered through the review of case studies. They also provide clinicians and members of the healthcare team with a routine forum for the open examination of individual events surrounding a patient's death, with a view to sharing any learning and improving practice. Feedback received from staff regarding these meetings was very positive.

We determined that this addresses the previous area for improvement 2 as outlined in section 6.2.

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 a responsibility to share this information with all relevant stakeholders in the areas of the doctor's work. We established that all medical practitioners working in the hospice have a designated RO. We discussed how concerns would be raised regarding a doctor's practice with the MAC and wider HSC and found that good internal arrangements were in place and the hospice was linked in with the regional RO network.

We reviewed a sample of personnel files held for medical practitioners and found that they contained all of the relevant information as outlined in Schedule 2 of the Independent Health Care Regulations (Northern Ireland) 2005, as amended.

We reviewed the provision of medical practitioners within the hospice to ensure that patients had access to appropriate medical intervention as and when required and determined that robust arrangements were in place to meet the needs of the patients accommodated. We found that a rota of medical practitioners was easily accessible to inform staff of the doctors working in the hospice and also arrangements for out of hours cover.

6.9.3 Quality assurance

We confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care and treatment delivered to patients at appropriate intervals. We reviewed the Quality Improvement Plan for 2020/21 and were informed that the audit programme is ratified by the Governance and Risk Committee. Discussion with the Registered Manager and review of completed audits confirmed that an audit programme was in place and that a new template for recording audits had been developed. Advice was given regarding the format of the audit template.

We noted that the results of audits are analysed and actions plans developed to address any areas for improvement, including the name of the person responsible for implementing the action plan and the timeframe. 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. We could also see where timeframes had been updated to show the action points that had been completed. We advised that once the revised audit programme has fully embedded the senior management team will be able to use this information to drive quality improvement within the hospice. We determined that this addresses the previous area for improvement 4 as outlined in section 6.2.

We found that a set of clinical quality indicators had been developed and balanced score sheets (dashboards) were being used to display the data in relation to the inpatient unit and the community service. The score sheets along with other key quality indicators are provided to the Governance and Risk Committee and then shared with the Board of Trustees through the minutes of the Governance and Risk Committee minutes. We suggested using a similar dashboard format for sharing the other KQIs with the Board of Trustees and staff. We advised that a dashboard system is a very useful tool for the quick review of information, comparative data analysis and to share relevant information with all staff and patients, as necessary. We advised that the next stage would be to use the data from the KQIs to target areas for improvement across the hospice and drive the audit programme. We determined that this addresses the previous area for improvement 5 as outlined in section 6.2.

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

6.9.4 Notifiable events/incidents

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

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

We found that all subsequent learning from notifiable events/incidents that occurred were reviewed through the governance structures of the hospice, in a meaningful way, to identify trends and learning that could be used to affect change or influence practice. 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.

6.9.5 Complaints management

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

We reviewed the management of complaints within the hospice and noted that no formal complaints had been received since the previous inspection. Staff who spoke with us demonstrated good awareness of how deal with a complaint, if received.

We found 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 is used to improve the quality of services provided.

6.9.6 Regulation 26 unannounced quality monitoring visits

Where the entity operating a hospice is a corporate body or partnership or an individual owner who is not in day to day management of the service, Regulation 26 unannounced quality monitoring visits must be undertaken and documented every six months.

We confirmed that the Responsible Individual was in day to day control of the hospice.

Areas of good practice: Organisational and clinical governance

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

Areas for improvement: Organisational and clinical governance

No areas for improvement were identified in relation to organisational and clinical governance.

	Regulations	Standards
Areas for improvement	0	0

6.10 Equality data

The arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients was discussed. Review of information evidenced that the equality data collected was managed in line with best practice.

6.11 Patient and staff views

We were unable to meet with patients on the day of the inspection and assessed patient feedback by reviewing the most recent patient satisfaction surveys completed by Foyle Hospice.

We found the hospice undertakes patient satisfaction surveys on a monthly basis and findings are shared through their governance structures. A review of recent patient satisfaction reports demonstrated that the hospice pro-actively seeks the views of patients and/or their representatives about the quality of care, treatment and other services provided.

We invited staff to complete an electronic questionnaire. One staff member submitted a questionnaire response and indicated that they were satisfied with each area of patient care. This staff member raised concerns in relation to the low level of interaction between senior management/Board of Trustee members and frontline staff. This staff member also commented on the challenges faced by staff as a result of the COVID-19 pandemic and the impact this has on staff morale.

All staff spoken with during the inspection spoke about the hospice in positive terms and no areas of concern were raised during the onsite inspection. As discussed in section 6.9.1, staff told us that the streamlining of the governance structures has ensured that appropriate and timely information is provided and also spoke very positively regarding the positive impact of the new Registered Manager.

Following the inspection the staff members comment was shared with Mrs Michaelides who agreed to share the staff member's response with all heads of department so that they could discuss this with their staff.

Total number of areas for improvement

	Regulations	Standards
Total number of areas for improvement	0	1*

7.0 Quality Improvement Plan

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

*An area for improvement made during the previous inspection in relation to clinical interventions undertaken in the day hospice has been carried forward for review at the next inspection.

The area for improvement carried forward to the next inspection is detailed in the QIP. Details of the QIP were discussed with Mr Henderson, Responsible Individual; Mrs Michaelides,

Registered Manager; and the chairperson of the Board of Trustees during a zoom teleconference on 11 March 2021. 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 area for improvement within the QIP has been carried forward for review at the next inspection. The Registered Provider should review the QIP and return this via Web Portal.

Quality Improvement Plan

Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 15 (1) **Stated:** First time **To be completed by:** 26 May 2020	The registered persons shall ensure the following matters in relation to clinical interventions undertaken in the day hospice are addressed: • clearly outline the clinical interventions that can be undertaken; • ensure that clinical intervention treatment protocols have been developed by the Medical Consultants and are in line with current best practice guidelines; • copies of the clinical intervention treatment protocols should be made available and easily accessible to all staff involved; and • implement an assurance mechanism for the Foyle Hospice's senior management team and Board of Trustees to provide assurance that the quality of practice and care delivered in relation to clinical interventions is of the required standard. **Ref: 6.2**
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next inspection.

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

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