The Regulation and Quality Improvement Authority

Inspection Report

18 October 2021

Foyle Hospice

Type of service: Independent Hospital (IH) – Adult Hospice
Address: 61 Culmore Road, Londonderry, BT48 8JE
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Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/; The Independent Health Care Regulations (Northern Ireland) 2005 and the Minimum Care Standards for Independent Healthcare Establishments (July 2014)

1.0 Service information

Organisation/Registered Provider: Foyle Hospice **Responsible Individual:** Mr Donall Henderson	**Registered Manager:** Mrs Bernie Michaelides **Date registered:** 9 October 2020
Person in charge at the time of inspection: Mr Donall Henderson	
Categories of care: Independent Hospital (IH) Hospice Adult – H(A) Private Doctor - PD	
Brief description of how the service operates: Foyle Hospice is registered as an independent hospital (IH) with adult hospice H(A) and private doctor (PD) categories of care. Foyle Hospice is registered for twelve inpatient beds and it operates a day hospice service and provides specialist palliative care to patients living in the community. It was confirmed that as a direct result of the COVID-19 pandemic the inpatient unit beds have been reduced to seven and the day hospice service is operating at a reduced capacity.	

2.0 Inspection summary

An unannounced inspection was undertaken to the Foyle Hospice which commenced with an onsite inspection on 18 October 2021 from 10.00 am to 5.00pm, followed by a request for the submission of information electronically. The purpose of this inspection was to focus on the themes for the 2021/22 inspection year.

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 practices and relevant records and documentation used to support the governance and assurance systems.

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

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

It was noted that the governance structures within the hospice continue to provide the required level of assurance to the senior management team and the Board of Trustees.

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

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

3.0 How we inspect

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

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

In response to the COVID-19 pandemic we reviewed our inspection methodology during the 2020/21 inspection year 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. Having considered different inspection methodologies a decision was taken to undertake multidisciplinary blended themed inspections to Hospice services. The blended methodology includes an onsite inspection and electronic submission of additional documentation to be reviewed remotely by pharmacist and estates inspectors.

As the COVID-19 pandemic is ongoing a decision was taken to continue with this inspection methodology during the 2021/22 inspection year. The onsite component of our inspection was completed on 18 October 2021 by three care inspectors supported by an Adept Fellow. An Adept Fellow is a senior doctor who is participating in a training programme with the Northern Ireland Medical and Dental Training Agency (NIMDTA). The onsite inspection team examined a number of aspects of the hospice services as outlined in section 2.0 of this report.

At the onset of the onsite inspection Mr Donall Henderson, Responsible Individual, was provided with a list of specific documents requesting items to be reviewed remotely in respect of medicines management and the maintenance of the premises and grounds. These items were to be sent electronically to our pharmacist estates inspectors on or before 26 October 2021 for review remotely.

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. Feedback of the inspection findings was delivered to the Foyle Hospice senior management team on 10 November 2021 during a Zoom teleconference. This feedback included the pharmacy and estates inspectors findings following their review of the documents submitted electronically.

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

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

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 report generated by Foyle Hospice. We also invited staff to complete an electronic questionnaire. Staff and patient feedback are further discussed in section 4.0 of this report.

An area for improvement (AFI) was identified during the unannounced inspection undertaken on 25 and 26 February 2020. This AFI specified actions to be taken concerning clinical interventions undertaken in the day hospice. During the unannounced inspection undertaken on 8 February 2021, it was confirmed that in response to the COVID-19 pandemic, the day hospice had temporarily closed. Therefore this AFI was carried over for review to this inspection.

During this inspection it was confirmed that the day hospice is operational. However, it is not offering the same range of services and its hours of operation are limited when compared to previous service provision. It was confirmed that clinical interventions were not being undertaken in the day hospice. Should a patient be assessed as requiring a clinical intervention a referral is made the Sperrin Unit (based in the Altnagelvin hospital site) or to the Rapid Response Hub (based in the Gransha Hospital site). In anticipation of the day hospice reverting to previous service provision, relevant policies and procedures have been developed. Following this inspection these policies and procedures, detailing the arrangements for the clinical interventions that have the potential to be offered within the day hospice, were submitted to RQIA. Taking this into consideration, alongside the fact the day hospice have temporarily ceased offering clinical interventions it has been agreed that this AFI has been assessed as met. It was also mutually agreed if clinical interventions were to be offered again Mrs Michaelides would inform RQIA.

We undertook a tour of the in-patient unit including the staff rest areas. Posters informing patients and staff that an inspection was being conducted were displayed during the inspection. We reviewed a sample of records in relation to the areas inspected and validated the previous QIP.

4.0 What people told us about the service?

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.

The hospice staff provide satisfaction surveys to patients 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. Patient feedback regarding the hospice services was found to be very positive in respect to all aspects of care received and reflected staff deliver a very high standard of care.

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

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

5.0 The inspection

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

Areas for improvement from the last inspection on 24 January 2019		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 15 (1) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 3.0.	

5.2 Inspection outcomes

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

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

The inspection team were assured of robust governance and oversight of measures to prevent the spread of the virus.

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

The hospice's COVID-19 Task Group continues to meet regularly to review and implement measures to promote a COVID-19 safe environment for staff, patients and visitors. This task group recognises and responds to the COVID-19 risk and determines the frequency of meetings in response to the prevalence of community transmission. Robust assurance mechanisms were in place for the completion and reporting of risk assessments through the governance structures.

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

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

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

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

COVID-19 risk assessments, with agreed action plans, were also completed for clinically extremely vulnerable staff returning to work, to protect them against exposure to the virus in the workplace. The risk assessment considered black, Asian and minority ethnic (BAME) staff with underlying health conditions/age; staff who were pregnant (more than 28 weeks); and staff with underlying moderate or high risk medical conditions. The risk assessments included discussions with the staff member in respect of IPC precautions to be taken and considered options for staff including review of work conditions.

All patients admitted to the hospice must have a negative COVID-19 test result prior to admission. Visiting arrangements have been reviewed and facilitated in line with the most

recent DoH guidance. Patients and their families are advised of the visiting arrangements on admission.

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

A review of documents concerning the staff changing facilities, staff rest areas and nurses stations evidenced these areas had been included in the COVID-19 risk assessment. Staff were aware of the maximum number of 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 areas which further enabled staff to socially distance at staff change over times.

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

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

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

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

There was a dedicated IPC lead nurse available to advise staff on the management of infection control issues and the completion IPC audits. The IPC lead nurse attends IPC link nurse meetings in the local Trust. Staff confirmed there was good communication between the hospice staff and the IPC lead nurse. The IPC lead nurse had recently returned from a period of unplanned leave and was currently reviewing and updating all IPC and COIVD-19 policies and procedures. She confirmed that she had protected time to focus on IPC and that she delivers IPC training to staff during the annual mandatory training days. There were clear lines of accountability for IPC and staff commended that the senior management team for their support, communication and dissemination of guidance in the absence of the IPC lead.

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

A range of IPC audits undertaken in clinical areas including, environmental and hand hygiene audits were reviewed. These audits confirmed good compliance and oversight in IPC practices. A range of IPC audit scores were displayed to provide assurance of audit compliance to visitors and staff of a good standard of environmental cleaning and IPC practices. This information

was displayed on notice boards in both clinical and non-clinical areas and discussed at the daily safety briefs. Staff told us about the actions that would be taken if environmental standards were to fall below the expected standard.

Staff were also able to describe the actions they would take to address areas requiring improvement. Staff demonstrated a comprehensive understanding of this.

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

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

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

The current arrangements with respect to IPC practice and evidenced areas of good practice were reviewed and assurance of strong governance mechanisms and collaborative working across the hospice in respect of IPC was evidenced. It was noted that risks were being assessed and managed appropriately with robust auditing measures in place in clinical areas. It was confirmed satisfactory arrangements are in place to ensure the hospice staff adhere to infection prevention and control (IPC) best practice guidance.

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

Adherence to best practice guidance concerning palliative care was evidenced through examination of referral pathways, care records; policies and procedures.

Well established referral procedures were evidenced to be in place. Patients and/or their representatives are given information in relation to the hospice and this is available in different formats, if necessary. Referrals can be received from the palliative care team; hospital consultant; nurse specialist and or general practitioners. Multidisciplinary assessments are completed with the referral information through the regional referral arrangements. These systems were found to be robust. Staff spoken with confirmed they had received relevant information about the patient prior to their admission.

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

A review of two patients' care records evidenced 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.

It was noted that care was very patient centred with ongoing review to ensure care is adapted according to assessed need. It was noted that facilities were accessible and provided to accommodate patients and their family to enable them to spend as much time together, as permissible, in keeping with current visiting guidance issued by the DoH.

There is a call system in place for patients to request assistance. The inspection team observed the system in operation and staff responded to patients to meet their needs in a timely manner. The inspection team observed compassionate and positive interactions between staff and patients as staff entered and exited patients' rooms. Staff introduced themselves to patients and requested permission to enter the patient's room and then went on to explain why they were there in a kind and caring manner.

The provision of bereavement care was reviewed and this evidenced that a range of information and support services were available. Staff told us that arrangements were in place to provide counselling with referrals for children prioritised and bereavement services provided. It was noted that several staff are undertaking further specialist training to support bereavement services. Staff have the opportunity to attend regular debriefing sessions to support their wellbeing are made aware of these services and other support mechanisms in place.

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

The arrangements to engage with patients and/or their representatives were reviewed and found to be an integral part of the services delivered. Patients and/or their representatives are offered the opportunity to provide feedback through a questionnaire. The information received from these questionnaires is collated and made available to patients and other interested parties to read as an annual report. This report is also used by the hospice senior management team and informs the ongoing quality improvement of services.

The arrangements concerning discharge planning were reviewed and this evidenced that there was full engagement with patients and/or their representatives. Discussion with staff demonstrated that there was multi-disciplinary involvement. Daily and weekly meetings take place to ensure the patient's needs are at the centre of discharge planning. A comprehensive discharge summary and plan is completed prior to the patient leaving the hospice. A letter is provided to the patient's GP outlining the care and treatment which has been provided. Appropriate arrangements were in place to support discharge at short notice, when required. Robust systems were in place to ensure that agreed discharge arrangements are recorded and co-ordinated with all services that are involved in the patient's ongoing care and treatment.

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

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

The medicines management section of the inspection was completed remotely. The 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. Further information was obtained via telephone call with a ward sister on 4 November 2021, as part of the medicines management component of the inspection.

Medicines management policies and procedures were in place and had been developed in consultation with the community and Trust pharmacists. These were reviewed every few years. A system was in place to share and remind staff when there had been any updates.

The management of controlled drugs was reviewed. The Accountable Officer is the registered manager. Standard operating procedures for controlled drugs were in place and are under currently under review. It was agreed that these would be updated regarding the name of the Accountable Officer. There are robust arrangements in place to ensure the safe keeping and monitoring of controlled drugs. The arrangements concerning the disposal of controlled drugs were reviewed. It was confirmed that discontinued or unwanted controlled drugs are not denatured on site prior to disposal, but are removed from stock and disposed of at the community pharmacy. This was discussed and it was acknowledged that this had been recently identified. The registered manager advised that this was being followed up with the relevant departments and assured that their procedures would be updated in due course.

In relation to medicines management training, systems were in place to ensure this was provided for nurses and doctors as part of their induction; and refresher training is provided in accordance with the hospice's mandatory training programme. Additional training included antimicrobial stewardship, the management of syringe drivers, blood glucometers and mouth care.

There were safe arrangements in place for the stock control of medicines. Medicines are ordered on requisition forms signed by doctors with separate forms for controlled drugs. Medicines are supplied by the community pharmacist, who provides regular advice and support to the hospice, including out of hours as necessary. A pharmacy technician also attends the hospice to assist with the stock control of medicines throughout the week. Staff told us that all medicines were stored safely and in accordance with the manufacturers' instructions.

The arrangements for reconciling the medicines for new patients were reviewed. There were safe systems in place to ensure that confirmation of the patient's current medicine regime is obtained at each admission.

A medicine Kardex is a record that details the medicines prescribed for each patient and is unique to them. A sample of Kardexes were reviewed and it was evidenced these records were maintained appropriately, with the exception of the date of discontinuation was not effectively being recorded. It was reinforced that when a medicine is discontinued the date of discontinuation should be recorded on every occasion.

Concerning medicine incident management, there are systems in place for identifying, reporting, recording, analysing and learning from medicines related incidents. The incidents are reported

to RQIA and those which involve controlled drugs are also reported to the Local Intelligence Network.

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 and omitted doses; and also antibiotic stewardship, which is one of the Key Performance Indicators (KPI's)in the hospice. Action plans are developed to drive forward any areas identified for improvement and monitored for completion.

The current arrangements with respect to medicines management was noted to be of a high standard and adhered to current best practice guidance.

5.2.5 How does the service ensure the environment is safe?

The management of the environment section of the inspection was completed remotely. The management team of the hospice were provided with a checklist of estates related items to submit to the estates inspector for review. This included certification relating to the maintenance and upkeep of the building and engineering services as well as relevant risk assessments.

All requested documentation was submitted and was found to be in order. The maintenance of the building and engineering services is in line with relevant codes of practice and standards are carried out by a range of specialist contractors.

The fire risk assessment is carried out by a risk assessor who is on a recognised register of fire risk assessors who assessed the risk in the premises as 'tolerable'.

The legionella risk assessment was carried out by a specialist legionella control company. The provider confirmed that the recommendations made in the risk assessment report have been addressed.

The current arrangements with respect to estates management, was noted to be of a high standard with suitable arrangements in place for the provision of necessary specialist services.

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

The governance structures were reviewed to include a review of committee minutes and discussion with Mr Henderson, Responsible Individual and members of the senior management team. Discussions were held with the chairperson of the Board of Trustees and an additional board member, via Zoom teleconference following the onsite inspection. The member of the board of Trustees who attended the Zoom teleconference is also the chairperson of the governance and risk committee.

It was confirmed that a robust organisational structure was in place with clear lines of accountability, defined structures and visible leadership and staff were aware of these. Staff who spoke with us were able to describe their roles and responsibilities and how they fitted into the overarching governance structures and committees. 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 towards the Board of Trustees and the senior management team.

The minutes of the governance structures and committees meetings were reviewed. These evidenced that the governance structures were functioning well to provide a level of assurance to the Board of Trustees and the multidisciplinary clinical governance team. Review of documents and discussion with staff evidenced the Board are able to interrogate the data provided to them and provide appropriate challenge to the senior management team. Through 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 them and the action taken.

The governance and risk committee is provided with data that gives robust assurances on safety and tangible evidence of ongoing audit and quality improvement.

It was observed that arrangements were in place to develop, implement and regularly review risk assessments. The active risk register was reviewed and it was acknowledged that the hospice is working to develop a cohesive risk management strategy that assesses risk using one model, where possible. The risk register is being developed further to include a routine review of closed risks, to ensure that these have been effectively managed and do not need to be reopened.

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

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

The Medical Advisory Committee (MAC) had been formalised within the Governance and Risk Committee. The terms of reference for the MAC were reviewed as well as and a sample of MAC reports provided to the committee by the Medical Director.

Multidisciplinary Morbidity and Mortality (M&M) meetings (known as debriefing meetings) are held regularly and are formally documented. It was confirmed that any learning from the M&M meetings would be shared with relevant staff and the 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.

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. It was 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 within the wider Health and Social Care (HSC) sector and

found that good internal arrangements were in place and the hospice was linked in with the regional RO network.

A sample of personnel files held for medical practitioners were reviewed and it was 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.

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

It was confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care and treatment delivered to patients at appropriate intervals. The Quality Improvement Plan for 2021/22 was reviewed and it was confirmed that the audit programme is ratified by the Governance and Risk Committee. It was confirmed that an audit programme was in place and that the template for recording audits findings had been developed.

It was observed 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. Timeframes had been updated to show when action points had been completed. Staff told us that the senior management team use this information to drive quality improvement within the hospice.

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 KPI's 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. A similar dashboard format was observed for sharing the other KPIs with the Board of Trustees and staff. It was acknowledged that the dashboard system was 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.

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

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

We also 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.

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

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

It was evidenced that systems were in place to ensure that any complaints received would be fully investigated and responded to appropriately. Records are kept of all complaints and include details of all communications with complainants; the result of any investigation; the outcome and any action taken. Information gathered from complaints would be used to improve the quality of services provided.

Where the entity operating a hospice is a corporate body or partnership or an individual owner who is not in day to day management of the service, Regulation 26 unannounced quality monitoring visits must be undertaken and documented every six months. Mr Henderson, Responsible Individual, was in day to day control of Foyle hospice. However, the chairperson of the Board of Trustees undertakes unannounced quality monitoring visits as part of their internal governance arrangements. Mr Henderson receives a copy of the reports generated for review and sign off. The most recent unannounced quality monitoring visit report dated 20 April 2021 was reviewed. It was confirmed that should these unannounced visits identify issues an action plan would be developed to address any deficits; including timescales and persons responsible for completing the actions.

During the Zoom meeting with the chairperson and the member of the Board of Trustees, on 22 October 2021, the role and responsibilities of the Board and the governance structures were discussed. It was good to note that the Board members were actively reviewing their membership; identifying skill sets or areas of expertise that would further enhance the Board, for the benefit of the hospice and actively recruiting new members with the desired skills and knowledge, where appropriate. It was also confirmed that the Board members discuss succession planning on a regular basis. A discussion took place concerning the further development of the strategic plan and provision of services. The chairperson of the Board confirmed that members of the senior management team have an open door policy and make themselves available to Board members when required. They also felt the governance structures were effective and that the Board were fully assured about the quality and standard of services delivered by Foyle hospice.

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.

Overall, the governance structures within the hospice provided 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 quality improvement. Our discussions with the chairperson of the Board of Trustees and the senior management team established that they continued to have a shared vision and strategy for the hospice coupled with a cohesive and productive way of working together.

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

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

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

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mr Henderson, Responsible Individual; Mrs Michaelides, Registered Manager; the senior management team; and the chairperson of the Board of Trustees during a zoom teleconference on 10 November 2021, as part of the inspection process and can be found in the main body of the report.

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