Unannounced Inspection Report
25 and 26 February 2020

Foyle Hospice

Type of Service: Independent Hospital (IH) – Adult Hospice
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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

Membership of the Inspection Team

Jo Browne	Senior Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Phil Cunningham	Senior Inspector, Premises Team Regulation and Quality Improvement Authority
Stephen O'Connor	Lead Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Carmel McKeegan	Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Steven Smith	Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Paul Nixon	Inspector, Medicines Management Team Regulation and Quality Improvement Authority
Nicola Delaney	Nursing Peer Reviewer
Gary McMaster	Inspection Coordinator Regulation and Quality Improvement Authority

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 and also operates a day hospice service and provides specialist palliative care to patients living in the community.

3.0 Service details

Organisation/Registered Provider: Foyle Hospice **Responsible Individual:** Mr Donall Henderson	**Registered Manager:** Ms Yvonne Martin
Person in charge at the time of inspection: Mr Donall Henderson	**Date manager registered:** 17 November 2008
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

We undertook an unannounced inspection to Foyle Hospice over two days, commencing on Tuesday 25 February 2020 and concluding on Wednesday 26 February 2020. We employed a multidisciplinary inspection methodology during this inspection. Feedback of the inspection findings was delivered to the Foyle Hospice senior management team on 26 February 2020.

We would like to thank Mr Donall Henderson, Responsible Individual, Ms Yvonne Martin, Registered Manager and all Foyle Hospice staff for being welcoming, open and transparent, and for providing the inspection team with all the information and documents required in a timely manner.

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

Our multidisciplinary inspection team examined a number of aspects of the hospice, from front line care and practices, to management and oversight of governance across the organisation. The inspection team reviewed the arrangements in respect of the inpatient unit, the day hospice and the community specialist palliative care team. Our inspection team met with various staff groups spoke with several patients, observed care practice and reviewed relevant records and documentation to support the organisational governance and assurance systems.

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

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

Staff provided positive feedback to us regarding the care provided and their working environment. They told us that they were happy; felt supported and well engaged that there were good productive working relationships throughout the hospice and a positive working culture.

In general, we found that the delivery of patient care was excellent and noted that all feedback received by us from patients and relatives had been very positive. All patients and relatives spoken with advised they felt safe, felt they were being well cared for and the inspection team observed compassionate care being provided.

We found evidence of good practice in relation to the care delivered to patients and the support provided to their families; the management of care records; good communication between staff and patients; good multidisciplinary working; robust systems in relation to the recruitment and selection of staff; the management of medical emergencies and infection prevention and control; the provision of specialist palliative care staff; the provision of information to patients and/or their families; the management of the bereavement care services; and the environment which was found to be very peaceful and conducive to the delivery of care.

The findings of this report will provide the hospice with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	2	9

Two areas for improvement were identified against the regulations, these relate to:

- strengthening the governance arrangements with particular focus on the Medical Advisory Committee (MAC); strengthening the arrangements to review medical appraisal documents and formalising arrangements in respect of Morbidity and Mortality (M&M) meetings; and
- formalising the arrangements in respect of clinical interventions undertaken in the day hospice.

Nine areas for improvement were identified against the standards, these relate to:

- introduction of a safety brief;
- further developing the minutes of Board of Trustee meetings;
- development of an antimicrobial stewardship policy;
- strengthening the arrangements in respect of audits;
- developing a range of clinical quality indicators that are audited (stated for the second time); and
- addressing identified issues in respect of the environment (repairing damaged plaster, refreshing the legionella risk assessment, instigating checks of emergency lighting and installing toilet roll holders).

Details of the quality improvement plan (QIP) were discussed with Mr Henderson, Responsible Individual, Ms Martin, Registered Manager, the Chairperson of the Board of Trustees, one of the inpatient unit Ward Sisters, the Human Resources and Administrative Services Manager, the Day Hospice Team Leader and the Team Leader for the Community Team.

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

At the conclusion of the inspection Ms Martin provided some feedback to the inspection team with respect to the multidisciplinary inspection methodology. Ms Martin stated that the hospice considered the multidisciplinary approach beneficial to the organisation as it produced a detailed assessment of the hospice and commented positively on the culture within the hospice.

This inspection did not result in enforcement action.

4.2 Action/enforcement taken following the most recent care inspection dated 21 February 2019

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 21 February 2019.

5.0 How we inspect

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

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

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

Posters informing patients, staff and visitors of our inspection were displayed while our inspection was in progress.

We met and spoke with the following staff, Mr Henderson, Ms Martin, the Chairperson of the Board of Trustees and another Board member, one of the inpatient unit Ward Sisters, the Human Resources and Administrative Services Manager, the Day Hospice Team Leader and the Team Leader for the Community Team, nurses, care assistants, administration staff, domestic staff, the chef and kitchen assistants.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 21 February 2019

The most recent inspection of Foyle Hospice was an announced care inspection. The completed QIP was returned and approved by the care inspector.

Areas for improvement from the last care inspection		
Action required to ensure compliance with the Minimum Care Standards for Independent Healthcare Establishments (July 2014)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 9.5 **Stated:** First time	The responsible individual shall ensure that six monthly unannounced visits by the responsible individual or their nominated representative, as outlined in Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005, as amended, are carried out. Written reports of the unannounced visits should be available for inspection.	**Met**
	Action taken as confirmed during the inspection: We reviewed reports detailing the findings of unannounced quality monitoring visits undertaken on 1 April 2019 and 3 December 2019 and found that they provided a comprehensive record of the visit, an action plan detailing actions required and the person responsible with associated timeframes. The reports were in accordance with Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005. We found the reports of the quality monitoring visits to be of a good standard.	

Area for improvement 2 **Ref**: Standard 9.7 **Stated:** First time	The responsible individual 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.	**Not met**
	Action taken as confirmed during the inspection: We were informed that a range of clinical quality indicators had not been developed. This area for improvement has not been addressed and has been stated for a second time.	
Area for improvement 3 **Ref**: Standard 17.1 **Stated:** First time	The responsible individual shall ensure that all notifications are submitted to RQIA in keeping with the RQIA guidance document entitled 'Statutory notification of incidents and deaths' (September 2017).	**Met**
	Action taken as confirmed during the inspection: We were informed that all accidents and incidents are recorded in an accident book. Separate accident books are maintained in respect of the inpatient unit, day hospice and by the community specialist palliative care team. We were informed that following an accident or incident staff complete an IR1 form. We reviewed all IR1 forms completed since the previous inspection and evidenced that all relevant notifications had been submitted to RQIA as required.	

6.2 Inspection findings

6.3 Is the service well led?

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

6.3.1 Organisational governance

We reviewed documentation and discussed the governance arrangements with a number of staff including Mr Henderson, Ms Martin, the Chairperson of the Board of Trustees and another Board member, one of the inpatient unit Ward Sisters, the Human Resources and Administrative Services Manager, the Day Hospice Team Leader and the Team Leader for the Community Team.

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

We observed a nursing handover meeting which was attended by the Medical Consultant and all nursing staff working on the inpatient unit. We found that the meeting was well co-ordinated by the Ward Manager and facilitated the effective exchange of information, required for the continuity of care between the morning and afternoon shifts. These meetings do not include a safety brief. We advised that the safety brief should be a short multidisciplinary briefing, held at a predictable time and place, and focus on the patients most at risk, as well as all other emerging issues that have the potential to impact on the provision of services. We advised that the hospice should consider scheduling a daily safety brief to address live governance issues and further enhance information sharing within the organisation. An area for improvement against the standard has been made in respect of safety briefs.

6.3.2 Clinical governance

Foyle Hospice is registered for 12 inpatient beds and also operates a day hospice service and provides specialist palliative care to patients living in the community. The day hospice and community specialist team is included in the registration of Foyle Hospice.

There are currently separate managers for the inpatient unit, the day hospice and the community specialist team. Ms Martin has overall responsibility for the day to day management of the hospice services.

Mr Henderson is based onsite and is responsible for monitoring the quality of services and is required to undertake a visit to the premises at least every six months in accordance with legislation. Mr Henderson or a member of the Board of Trustees undertakes these quality monitoring visits at least six monthly. As discussed in section 6.1 we reviewed the reports dated 1 April 2019 and 3 December 2019 and found them to be detailed and a thorough record of the visit.

We were informed that the Corporate Risk and Governance Committee meet quarterly. We reviewed the minutes of four meetings held between 21 February 2019 and 6 January 2020. We found that matters relevant to the Medical Advisory Committee (MAC) were discussed and recorded, however, we did not see terms of reference for the MAC and matters relating to the MAC were not clearly identifiable within the minutes. An overarching area for improvement against the regulations has been made in relation to organisational governance. This area for improvement includes components in relation to the MAC as detailed below:

- the MAC should have clear terms of reference and be a standing agenda item on the Corporate Risk and Governance Committee 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; and
- business relating to the MAC should be clearly identifiable within the minutes of the corporate risk and governance meeting.

We were informed that the Quality and Clinical Governance Committee meets every six weeks. We reviewed the minutes of six meetings held between 28 March 2019 and 12 December 2019 and found a wide range of matters discussed during these meetings. We noted that deaths that occurred within the inpatient unit were discussed. In accordance with best practice we recommended further developing discussions in regards to deaths and instigating formal multidisciplinary Mortality and Morbidity (M&M) meetings. We advised that M&M meetings can provide a unique opportunity for health professionals to improve the quality of care offered through case studies. They can provide clinicians and members of the healthcare team with a routine forum for the open examination of the individual events surrounding a patient's death with a view to sharing learning. As discussed an overarching area for improvement against the regulations has been made in relation to organisational governance. This included ensuring that the M&M meeting are formally documented and 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.

We met with the Chairperson of the Board of Trustees and a Board member to discuss the role of the Board of Trustees in relation to the governance arrangements within the hospice. We were informed that the Board of Trustees meet ten times a year. The Chairperson advised that she makes herself available to the hospice at any time and visits the premises at least twice a week.

In general we found that Foyle Hospice had the broad elements required for an effective governance system. Through discussion, we found that the Board of Trustees were committed to developing and strengthening the governance systems within the hospice. The Chairperson outlined their plans for review of the governance arrangements and how the Board of Trustees will be involved. The Board of Trustees had appointed new members and had initially concentrated on the review and development of the corporate risk register. The Chairperson confirmed that they were aware that a quality assurance framework was not fully developed however they were fully committed to embedding this into the hospice.

We evidenced that various committees met and prepared documents and reports for the Board of Trustees. However, when we reviewed the minutes of five Board of Trustee meetings held between 30 May 2019 and 25 November 2019 we did not see reference to the documents and reports prepared by the various committees. An area for improvement against the standards has been made in this regard.

We found no evidence to confirm that appraisals submitted by Medical Practitioners had been reviewed by the Medical Director for the hospice, this has been included in the overarching area for improvement against the regulations in regards to corporate governance. Additional information in this regard can be found in section 6.4.1 of this report.

6.3.3 Management of operations

We found systems to ensure that the quality of services provided by the inpatient unit, the day hospice and the specialist community team is evaluated on an annual basis and discussed with relevant stakeholders. We reviewed the minutes of the Quality and Clinical Governance Committee meetings and found that this committee reviews information in respect of all areas of service provision.

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

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

6.3.4 Quality assurance

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

We found evidence of a rolling audit programme; some of the audits reviewed are listed below:

- patient discharge letters;
- do not attempt cardio pulmonary resuscitation (DNACPR)
- national audit of care at end of life;
- hand hygiene;
- linen;
- commode;
- environmental cleanliness;
- stock medication;
- sharps; and
- infection prevention and control.

We found that audit reports did not always include all relevant information pertaining to the audit. Some reports reviewed did not 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. We suggested that the stock medication audit could be used as an exemplar going forward. An area for improvement against the standards has been made in regards to audit.

As discussed in section 6.1 an area for improvement against the standards made during the previous inspection in relation to ensuring 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. This area for improvement has not been met and has been stated for a second time. We acknowledge that the Board of Trustees had already identified that a quality assurance framework needs to be developed and implemented.

We confirmed that a system was 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 Responsible Individual and the Registered Manager demonstrated a clear understanding of their roles and responsibilities in accordance with legislation.

We confirmed that the statement of purpose and patient's guide were kept under review, revised and updated when necessary and available on request. We observed copies of these documents prominently displayed in the main foyer area of the day hospice unit.

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

6.3.5 Practising Privileges

We reviewed the arrangements relating to practising privileges for Medical Practitioners working within the hospice. A practicing privileges policy and procedure was in place which outlines the arrangements for application, granting, maintenance, suspension and withdrawal of practising privileges.

Mr Henderson and Ms Martin outlined the process for granting practising privileges and confirmed Medical Practitioners meet with the Medical Director prior to privileges being granted. There are systems in place to review practising privileges agreements every two years. All Medical Practitioners working within the hospice 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.

We reviewed the staff register and had discussions with the Human Resources and Administrative Services Manager and found that there are two Medical Practitioners in the hospice that are private doctors. Foyle Hospice is a designated body with the GMC and the Medical Director of the Hospice is the RO for the private doctors. We discussed how concerns regarding medical practice are shared with the MAC and the wider HSC. We found that good internal arrangements were in place and the hospice's RO was linked in with the regional RO network.

We reviewed the personnel files for the two private doctors and confirmed that there was a written agreement between each private doctor and the hospice setting out the terms and conditions of practising privileges, which had been signed by both parties. We found that the hospice management maintained a robust oversight of arrangements relating to practising privileges.

Additional information in relation to the two private doctors can be found in section 6.4.1 under staffing.

6.3.6 Notifiable Events/Incidents

We reviewed the arrangements in respect of the management of notifiable events/incidents and found that all incidents were appropriately reported by the hospice to RQIA. We found that a robust incident management policy and procedure was in place.

We were advised that an identified member of administration staff in conjunction with heads of department reviews safety alerts and notices received and ensure that appropriate action is taken to address any issues that would affect the hospice. A record is retained of the relevant safety alert and the action taken.

6.3.7 Complaints Management

We reviewed a copy of the complaints procedure and found this to be in line with the relevant legislation and DoH guidance on complaints handling. A copy of the complaints procedure is made available for patients/and or their representatives. Patients who spoke with us confirmed that they were aware how to raise concerns. Staff who spoke with us demonstrated a good awareness of the processes for the management of complaints and staff confirmed that they have received complaints awareness training.

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

Areas of good practice: Is the service well led?

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

Areas for improvement: Is the service well led?

We identified areas for improvement in relation to introducing a daily safety brief; strengthening the governance arrangements with particular focus on the Medical Advisory Committee and Morbidity and Mortality (M&M) meetings; developing a range of clinical quality indicators; the Board of Trustee meetings; and the completion of audits.

	Regulations	Standards
Areas for improvement	1	4

6.4 Is care safe?

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

6.4.1 Staffing

We reviewed the staffing arrangements in respect of the day hospice, day clinic, community specialist palliative care team and the inpatient unit.

We found that the day hospice operates three days per week on a Tuesday, Wednesday and Thursday from 10.30 to 15.30 and can accommodate up to 12 patients each day. The day hospice provides a range of services including the opportunity for regular review and assessment of each patient's condition; management of pain and other symptoms; provision of psychological, emotional, social and spiritual support; and complementary therapies including aromatherapy, reflexology and reiki. The service is provided by registered nurses and healthcare assistants with specialist palliative care expertise and a team of volunteers.

We were informed that an integrated day clinic usually operates each morning the day hospice is operational, this clinic is Consultant led supported by a registered nurse. Patients attending the day hospice can also attend this clinic on an appointment based process. We found the integrated day clinic was not operational on the week of this inspection as the Consultant was on planned leave.

We met with the community specialist palliative care team which operates within the Western Health and Social Care Trust and consists of a team of six registered nurses. We were informed that five of the six nurses have completed a specialist palliative care nursing qualification and one nurse is in the process of completing a specialist palliative care nursing qualification. The community specialist palliative care team meet every Monday to review the current caseload and will prioritise and plan patient contact depending on the specific individual needs of patients.

We observed the weekly multidisciplinary team meeting taking place which was attended by a senior representative from day hospice services; the integrated day care clinic; the inpatient unit; and the community specialist palliative care team. The meeting demonstrated a holistic approach is taken by Foyle Hospice in their endeavour to maintain patients in the place of their choice and provide bespoke medical and nursing interventions to support patients and their families.

We reviewed the staffing arrangements in respect of the inpatient unit and confirmed there was sufficient staff in various roles to fulfil the needs of the patients. There is a multidisciplinary team which includes doctors, nurses and nursing auxiliaries with specialist palliative care expertise. We reviewed the duty rota and found that there was adequate staff in place to meet the assessed needs of the patients accommodated at the time of inspection. Foyle Hospice is supported by a team of volunteers who provide a variety of services.

We reviewed the staff register and randomly selected three staff that had commenced employment since the previous inspection. We reviewed the personnel files for the three identified staff members and found that they had completed an induction programme, Further information in regards to these newly recruited staff can be found in the recruitment and selection section below.

We were informed that procedures were in place for appraising staff performance and staff confirmed that appraisals had taken place. As discussed previously, we reviewed the staff register and had a discussion with Ms Martin and found that two Medical Practitioners are considered to be doctors working in wholly private practice. We reviewed the personnel files of the two private doctors and evidenced the following:

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

As previously discussed we confirmed that each Medical Practitioner had an appointed Responsible Officer (RO). A number of Medical Practitioners working in the hospice either have substantive posts in the HSC or are on the GP performers list. These Medical Practitioners provide the hospice with a copy of their annual appraisal. There was no evidence to confirm these appraisals had been reviewed and scrutinised by the Medical Director for the hospice to provide an additional level of assurance, this has been included in an overarching area for improvement against the regulations in regards to corporate governance.

We were told that a designated member of staff had been assigned responsibility for checking that staff who require individual professional indemnity cover have the appropriate indemnity in place and for checking the professional registration status of professional staff with their respective regulatory bodies. We met with this staff member, reviewed the arrangements and confirmed that they had robust systems in place to maintain indemnity records and undertake checks with professional regulatory bodies.

6.4.2 Recruitment and selection

We reviewed how recruitment and selection of staff is undertaken by the hospice. We found there was a recruitment and selection policy and procedure available which was comprehensive and reflected best practice guidance. As previously discussed, we reviewed the personnel files for three staff members recruited following the previous inspection. We confirmed that all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained.

We confirmed there was an identified individual with responsibility for maintaining staff personnel files. We spoke with the identified staff member and confirmed that robust procedures were in place in respect of the recruitment and selection of staff. We observed a recruitment checklist retained within staff personnel files; this checklist had been prepared in accordance with legislative requirements.

As discussed Foyle Hospice is supported by a team of volunteers who provide a variety of services. We confirmed that prospective volunteers go through the same recruitment process as all other staff.

6.4.3 Safeguarding

We reviewed the arrangements for safeguarding and found that policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm. The policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child. The relevant contact details for onward referral to the local Health and Social Care Trust (HSCT) should a safeguarding issue arise were included. We were told that copies of the regional policy entitled 'Co-operating to Safeguard Children and Young People in Northern Ireland' (August 2017) and the regional guidance document entitled 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015) were both available for staff reference.

We discussed safeguarding with staff and found good general awareness of the types and indicators of abuse, along with the actions to be taken in the event of a safeguarding issue being identified. Staff were able to identify the nominated safeguarding lead for the hospice.

We reviewed the staff training record matrix and found that all staff had received training in safeguarding adults and children as outlined in the RQIA training guidance and the Minimum Care Standards for Independent Healthcare Establishments July 2014. We confirmed that the designated safeguarding lead had completed formal training in safeguarding adults and children in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016) and the Safeguarding Board for Northern Ireland (SBNI) training and development strategy.

We found that a whistleblowing/raising concerns policy was available which provides guidance to help staff make a protected disclosure should they need or wish to. Staff confirmed that they knew who to contact should they have concerns or need to discuss a whistleblowing matter.

6.4.4 Specialist palliative care team

We reviewed the arrangements for referral to the inpatient, day hospice and community services and confirmed that robust referral procedures were in place. We confirmed that referrals can be received from the palliative care team, hospital consultant, nurse specialist or GP's. Weekly meetings take place to review referrals, prioritise admissions and agree who will make contact with the patient and their family to make the necessary arrangements to engage with hospice services.

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

Staff told us that patients and/or their representatives can visit the inpatient unit or day hospice prior to admission or attendance to review the services and facilities available. On admission patients and/or their representatives are provided with information regarding the various assessments that may be undertaken by members of the multidisciplinary team. This includes medical, nursing, complimentary therapy and spiritual assessments. In both the inpatient unit and day hospice we observed staff treating patients with dignity and respect.

We reviewed the arrangements in respect of the provision of specialist palliative care and in the main found this to be in line with best practice guidelines. We noted a range of policies and procedures were in place to promote safe practice by the multidisciplinary team. A sample of policies were reviewed and included:

- admission/referral/discharge;
- management of hypercalcaemia;
- management of syringe driver; and
- management of death.

We identified that a small number of clinical interventions were being undertaken in the day hospice. Staff told us the administration of intravenous (IV) biophosphonates and blood transfusions had been undertaken in response to symptom management for a small number of patients on an infrequent basis. We were advised that Medical Practitioners will only facilitate a clinical intervention in the day hospice if this is in the best interest of the patient. The aim is to provide these procedures as an out-patient service thereby enabling patients to remain at home. We welcomed this approach as one that adds significant value to palliative care pathways.

We examined the arrangements for the interventional treatments and found that a blood transfusion policy and an administration of IV biophosphonates policy and procedure was in place. We identified that the IV biophosphonates policy and procedure had been due for review in January 2019. Overall we felt the arrangements for providing clinical interventions in the day hospice should be strengthened by the implementing the following actions:

- clearly outline the clinical interventions to be undertaken in the day hospice;
- 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.

An area for improvement against the regulations has been made in this regard.

Discussion took place with patients and their representatives regarding the quality of care, environment, staff and management. All felt that they were kept informed regarding their care and could discuss any concerns they had with the staff.

Comments we received indicated a high level of satisfaction with the standard of care and support offered to both patients and their representatives by the staff and management of the hospice. We also received very positive feedback in relation to the individualised approach to care; the quality of the environment; patient and relative facilities; and food provided.

6.4.5 Resuscitation and management of medical emergencies

We reviewed the arrangements for the management of medical emergencies and resuscitation in the inpatient unit and day hospice. We found that the hospice retain 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 is 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.

6.4.6 Infection prevention control (IPC) and decontamination procedures

We confirmed that Foyle hospice has a designated IPC lead nurse. The IPC lead nurse was not on duty during the inspection, therefore we did not have the opportunity to speak with her. We reviewed minutes of various committee meetings and evidenced that the IPC lead nurse had been completing appropriate audits and sharing the findings of audits with relevant personnel.

We observed that hand hygiene posters were on display near hand washing basins and we observed staff performing hand hygiene and wearing the correct personal protective equipment (PPE).

We found the hospice to be clean, tidy and generally well maintained. We observed cleaning schedules on display that had been fully completed.

We confirmed that the hospice facilitates core mandatory training days and a review of the training programme evidenced that IPC is one of the main topics discussed.

6.4.7 Environment

During day two of the inspection on (26 February 2020), we met with the Human Resources and Administrative Services Manager who furnished us with a range of documentation relating to the maintenance and upkeep of the premises, both by specialist contractors and by in-house staff. The documents indicated a comprehensive regime of maintenance and good attention to the upkeep of the building and engineering services. We were informed that the hospice was in the process of recruiting a permanent maintenance person. We recognise the benefits of having a permanent maintenance person.

We reviewed the fire risk assessment which was found to be up to date and there were no significant issues outstanding from the recommendations made in the action plan of the assessment report. We reviewed service records in respect of the fire safety equipment; although monthly checking of the emergency lights by staff has lapsed in recent months due to unexpected retirement of the volunteer maintenance man. The Human Resources and Administrative Services Manager stated that these would be reinstated immediately and the imminent recruitment of a permanent maintenance person would go some way to stabilising this as well as enhancing the full range of maintenance activities throughout the premises.

We found that certification relating to the recent servicing of the fire alarm system was not available but the fire alarm system log book confirmed that this had been carried out at the appropriate interval. The servicing certificate was submitted by email to RQIA following the inspection and found to be satisfactory.

We reviewed the legionella risk assessment which was in date and due to be reviewed in October 2020. A range of checks were in place in relation to the building's water system including water sampling. Sampling of water in the system on 12 August 2019 indicated the presence of pseudomonas at one outlet in a bedroom. The hospice undertook a range of measures to eradicate this and this included liaison with the Public Health Agency (PHA) as well as a subsequent scheme of alterations to the plumbing system on the recommendation of the specialist contractor responsible for the monitoring of the water system. The system was resampled in August 2019 and it was confirmed to RQIA on 27 August 2019 that sampling confirmed that the bacteria had been eradicated.

Due to the previous concerns regarding the presence of pseudomonas, we advised the senior management team to bring forward the date of the review of the legionella risk assessment to as soon as can be arranged; to take account of the series of events and the plumbing alterations which have occurred since the previous assessment in October 2018. The Human Resources and Administrative Services Manager agreed to action this.

We reviewed the arrangements for the servicing of patients hoists. While indicating no faults or issues with the patient hoists, service certificates did not state whether the checks undertaken were in line with the Lifting Operations and Lifting Equipment Regulations (LOLER); with particular reference to 'thorough examination' as outlined in schedule 1 of those regulations.

The Human Resources and Administrative Services Manager informed us that thorough examinations' were included in the contract with the specialist contractor and confirmed that she would liaise with them to resolve the issue around adequacy of their certification.

We found that certification relating to servicing of the staff/nurse call system was not available for inspection; this was submitted by email to RQIA following the inspection and found to be of an acceptable standard.

We carried out a review of the premises entering a sample of bedrooms accompanied by the Human Resources and Administrative Services Manager. We found the building to be well presented, bright and in good decorative order. Stores and plant-rooms were tidy and free from clutter. We found the plaster rendering on the inside of the external wall of the staff dining room was defective and required to be repaired. It was agreed that arrangements would be made to address this following the inspection.

We found that there were no toilet roll holders provided in the majority of toilets in the premises and we observed that additional toilet rolls were being stored on the cisterns of toilets which creates a risk of cross contamination.

We were advised that plans were currently in place to ensure that suitable covered toilet roll holders were provided in all toilets; in conjunction with advice from the hospice IPC lead nurse.

Overall, we found that the management of building and engineering services in the hospice was good. Four areas for improvement against the standards have been made to address the issues identified.

6.4.8 Medicines Management

We reviewed the arrangements for the management of medicines within the hospice to ensure that medicines are safe, secure and effectively managed in compliance with legislative requirements, professional standards and guidelines. We found clear lines of accountability for the safe, secure and effective management of medicines.

We found that the policies and procedures in place for the management of medicines were reviewed on a regular basis, however, we identified that an antimicrobial stewardship policy had not yet been implemented. We advised that the hospice should develop and implement an antimicrobial stewardship policy and 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. An area for improvement against the standards has been made in this regard.

We established that medicines were managed by registered nurses who had been trained and deemed competent. Staff advised us that they received a comprehensive induction and training on medicines management was completed annually, most recently in January and February 2020.

We found safe systems were in place for confirming medicines on admission. Prior to the patient's admission, their GP is requested to provide details of currently prescribed medicines. The admitting nurse cross-references this information with the details on the patient's electronic care record (ECR) and any recent hospital letters. Any discrepancies in the information are discussed with the Medical Practitioner on duty, who is responsible for writing the personal medication record. Nurses told us that the rationale for prescribing or changes in medicine regimens was recorded in the patient's notes. Referral forms were obtained prior to patient admission to ensure appropriate medicine stocks were in place.

We observed that medicines were safely and securely stored. Medication refrigerator temperatures were recorded daily and were found to be within the required range.

We reviewed a sample of medicine records which were legible and accurately maintained. However, in several instances, for medicines prescribed on a "when required" basis, we found the minimum dosage intervals and maximum daily dosage were not specified. The senior management team and the nurses were reminded that this information is required to enable nurses make appropriate clinical decisions for administering these medicines.

We found systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Separate requisition/receipt records were in use for general medicines and controlled drugs. The requisitions were signed by a Medical Practitioner. We reminded staff that any section not completed on the requisition form should be cancelled out to prevent additional entries being made after the form has been signed. We confirmed that safe systems were in place for the disposal of medicines which were expired or no longer required.

We found that robust arrangements were in place for the management of controlled drugs. We reviewed the controlled drugs registers and found they had been fully and accurately completed. Ms Martin is the Accountable Officer for controlled drugs within the hospice. We observed the preparation of medicines for administration through a syringe driver and noted the procedure to be robust; two nurses were involved in preparing and checking the medicines.

We were informed that the community pharmacist regularly attends the hospice. They provide medicines management advice to some patients and carers prior to patient discharge and also participate in the annual medicines management update training for nurses and nursing auxiliaries. The community pharmacy technician attends the hospice on most weekdays, assisting the nursing staff with medicines stock control and the ordering process. Out-of-hours support from the community pharmacist is available. Ms Martin advised that the hospice is currently in discussion with the DoH regarding the possible securing of funding to employ a part-time clinical pharmacist. We would regard this as a positive development and evidently recognise the additional benefits it would bring to patient care.

We reviewed the arrangements in place to audit various aspects of the management of medicines. A review of these audits indicated that action plans to address any shortfalls had been developed and implemented.

We reviewed the systems in place for identifying, recording, analysing and learning from medicines related adverse events and near misses. Medicine notifiable events/incidents were reported immediately to the registered manager or senior nurse on duty. Any immediate actions were implemented through the handover. We evidenced that medication related notifiable events/incidents were reviewed through the hospice's governance structures.

Areas of good practice: Is care safe?

Areas of good practice were found in relation to staff recruitment; induction; training; appraisal; safeguarding; the specialist palliative care team and multidisciplinary working; resuscitation and management of medical emergencies; infection prevention control and decontamination; and the management of medicines.

Areas for improvement: Is care safe?

We identified areas for improvement in relation to strengthening the arrangements in respect of clinical interventions undertaken in the day hospice; developing an antimicrobial stewardship policy and a system to assure the implementation and adherence to the policy; repairing the defective plaster rendering in the staff dining room; bringing forward the date to review the legionella risk assessment; instigating checks of emergency lighting; and installing covered toilet roll holders.

	Regulations	Standards
Areas for improvement	1	5

6.5 Is care effective?

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

6.5.1 Clinical records

We reviewed the care records of two patients admitted to the inpatient unit. We evidenced that all those involved in the patient's care made a contemporaneous record of the intervention where they were involved with the patient. There was evidence of ongoing review of the patients' health and wellbeing and a daily statement was recorded.

Patients were holistically assessed using validated assessment tools and care plans were developed in conjunction with patients and/or their representatives. Multidisciplinary meetings were held daily and weekly to discuss the patient's progress and multidisciplinary records were retained within the patient's care records. Arrangements were in place for ethical decision making and patient advocacy where this is indicated or required.

Care records for the in-patient unit were generally well documented however we found that generic care plans were in use. We suggested that care plans should be an area of focus for the hospice to ensure they reflected the individual current needs and priorities of the patient. We found some duplication in the care records, particularly around pain assessment and pain intervention. We advised these documents were reviewed to ensure that they remain fit for purpose and to prevent repetition of information.

The hospice has read access to the Northern Ireland Electronic Care Record (NIECR) system which enhances the communication between the hospice and the rest of HSC; leading to better continuity of care for patients. The hospice retains hard copy care records which are supplemented with an electronic record system. The patient care records were well documented, contemporaneous and clearly outlined the patient journey. There was evidence of clear decision making by the multidisciplinary team and we noted a holistic and empathetic approach to patients' care.

The care records reviewed contained the following:

- an admission profile;
- a range of validated assessments;
- medical notes;
- care plans;
- nursing notes;
- results of investigations/tests;
- correspondence relating to the patient;
- reports by allied health professionals;
- advance decisions;
- do not attempt resuscitate (DNAR) orders; and
- records pertaining to previous admissions and community palliative care team, if applicable.

We also reviewed the care records of three patients attending the day hospice. We could evidence that all those involved in the patient's care made a contemporaneous record of the intervention where they were involved with the patient. Records in the day hospice were found to be well documented.

We confirmed that systems were in place to audit the patient care records as outlined in the hospices quality assurance programme. A number of audits relating to patient care records were reviewed and an excellent compliance rate was noted. As discussed in section 6.4.4 we suggested that care planning should be an area of focus and incorporated into the audit programme.

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

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

We spoke with Ms Martin, staff and reviewed of the management of records policy and found that patients have the right to apply for access to their clinical records in accordance with the General Data Protection Regulations and where appropriate Information Commissioner's Office (ICO) regulations and Freedom of Information legislation. We confirmed that the hospice is registered with the ICO. Staff who spoke with us confirmed they had a good knowledge of effective records management. The management of records within the hospice was found to be in line with legislation and best practice.

6.5.2 Discharge planning

We found there was a discharge policy and procedure in place which was comprehensive. There are well developed discharge planning arrangements in place that require full engagement with patients and/or their representatives.

A discharge summary and plan is completed prior to the patient leaving the hospice. A letter is provided to the patient's GP to outline the care and treatment provided within the hospice.

We found robust systems 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.

6.5.3 Nutrition and hydration

We reviewed arrangements to ensure that patients had access to appropriate food and water and their nutritional needs were met. We found that nursing staff are responsible for the co-ordination of mealtimes and recording of food and fluid intake. We spoke with patients who gave positive feedback in relation to the availability of food and fluids, menu choices and the quality of food in the hospice.

Nursing and catering staff demonstrated a good knowledge of special diets and processes in place to ensure patients are provided with food and fluids suited to their specific dietary needs. Staff described how information relating to patients diets is shared, including specialised diets and food allergies. We concluded that the meal service was well managed, with patients receiving their meals in a timely way and assistance was provided as needed. Nursing and catering staff were familiar with best practice guidance regarding nutrition and the specialised dietary descriptors outlined in the International Dysphagia Diet Standardisation Initiative (IDDSI).

6.5.4 Pain management

We reviewed the management of patients' pain and found that staff responded appropriately to the needs of individual patients through various methods including assessment, therapeutic interventions and administration of pain relief medication. We spoke with patients about their pain and they confirmed that staff responded in a compassionate and timely manner when they experienced pain.

Areas of good practice: Is care effective?

Areas of good practice were found in relation to the management of clinical records; the care pathway including admission and discharge arrangements; and the provision of information to patients.

Areas for improvement: Is care effective?

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

	Regulations	Standards
Areas for improvement	0	0

6.6 Is care compassionate?

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

6.6.1 Patient/family involvement

We reviewed the arrangements for receiving feedback from patients and their representatives in relation to the quality and standard of services provided. We were informed that Foyle Hospice utilises a variety of means to gather patient feedback; from issuing satisfaction questionnaires to inpatients and patients attending the day hospice to sending postal questionnaires to former service users. We were also informed that two care assistants have been trained on how to support and encourage patients to provide feedback.

We were informed that completed questionnaires are used to generate patient feedback reports and we observed these report on prominent display in the main foyer of the inpatient unit. We reviewed the patient feedback reports and confirmed that patients were highly satisfied with the standard of care and treatment they have received. Many completed questionnaires included positive comments in regards to the professionalism of staff; the high standard of care received; the quality of the food; and how comfortable the environment is.

We found that care was very patient centred. We spoke with three patients and their representatives who confirmed that they have the opportunity to comment on the quality of the care and treatment provided, including their interactions with staff who work within the hospice.

Feedback indicated a high level of satisfaction with the quality of care and support provided within the in-patient ward. We found evidence of meaningful patient involvement in plans of care and treatment, provided in a flexible manner to meet the expressed wishes and assessed needs of each individual patient and their families. Compassionate and positive interactions between staff and patients were observed throughout the inspection. We observed staff introduce themselves to patients and explain procedures to patients in a kind and caring manner.

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

6.6.2 Bereavement care service

We observed a range of information leaflets on display in the foyer of the inpatient unit with regards to the provision of bereavement care services.

We were informed that Foyle Hospice provides bereavement services as outlined below:

- Forget-Me-Not Bereavement Support group meets twice a year usually in February/March and October/November. All families who have had a family member in receipt of hospice care in the 12 weeks prior to the date of commencement will receive a letter from the support group inviting them to attend the six week programme; and
- Healing Hearts delivers workshops and one to one support to all bereaved children, before, during and after the death of a loved one. This is not limited to patients referred to the hospice; services are provided and offered to children who are bereaved, irrespective of cause of death, right across the North West.

In addition the hospice can access individual counselling services for patients, families and staff if required.

We were informed that following the death of an inpatient staff meet to debrief to provide peer support and they can self-refer to a volunteer counsellor if they wish.

6.6.3 Breaking bad news

We reviewed the arrangements in respect of breaking bad news and confirmed that hospice has a policy and procedure for delivering bad news to patients and/or their representatives which was in accordance with the Breaking Bad News regional guidelines.

We confirmed that a copy of the Breaking Bad News Regional Guidelines 2003 was available and accessible to staff.

We were told by staff in the inpatient unit and day hospice 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.

Areas of good practice: Is care compassionate?

Areas of good practice were found in relation to obtaining patient's views about the services provided; meaningful patient/family involvement in their care; bereavement care services; and breaking bad news.

Areas for improvement: Is care compassionate?

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

	Regulations	Standards
Areas for improvement	0	0

6.7 Equality data

Equality data

We discussed 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 with staff throughout the inspection.

6.8 Patient and staff views

Eighteen patients submitted questionnaire responses to RQIA. All patients indicated that they felt their care was safe and effective, that they were treated with compassion and that the service was well led. All patients indicated that they were very satisfied with each of these areas of their care. Six questionnaires included positive comments. We reviewed the submitted comments and found that patients indicated that they were highly satisfied with the standard of care received.

We displayed posters in staff areas, inviting staff to complete an electronic questionnaire during and following the inspection. The electronic questionnaire was closed two weeks after the inspection. No completed electronic questionnaires were submitted to RQIA.

We spoke with a range of staff during the inspection who informed us that there is good communication within Foyle Hospice and that they all felt supported and valued. Staff also stated that patients were treated with dignity and respect and were provided with a high standard of care and treatment. There were no concerns raised by any staff members during this inspection.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Donall Henderson, Responsible Individual; Ms Yvonne Martin, Registered Manager; the Chairperson of the Board of Trustees; one of the inpatient unit Ward Sisters; the Human Resources and Administrative Services Manager; the Day Hospice Team Leader; and the Team Leader for the Community Team, as part of the inspection process. The timescales commence from the date of inspection.

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

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

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health (DoH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

7.2 Actions to be taken by the service

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

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and The Minimum Care Standards for Independent Healthcare Establishments (2014)</td></tr>
<tr><td colspan="2">Clinical governance</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 12.7

Stated: First time

To be completed by:
26 March 2020</td><td>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.

Ref: 6.3.1</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Accepted. It has been agreed that a daily brief will be included as part of the daily handover taking account of an impact on service delivery, health and safety for patients, visitors and staff to include general points e.g. any proposed fire tests, notifcation of water or electric outages in the area etc.</td></tr>
<tr><td>Area for improvement 2

Ref: Regulation 17

Stated: First time

To be completed by:
26 May 2020</td><td>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;</td></tr>
</table>

	• 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. Ref: 6.3.2
	Response by registered person detailing the actions taken: Accepted. The terms of reference for the Governance and Risk Sub Committee will be amended to reflect that this platform will also serve as the Medical Advisory Committee. This includes representation from the Board of Trustees along with relevant members of the Senior Management Team. Morbidity and mortality formal meetings will be set up and documented. A synopsis will be shared with the Clinical Governance Committee and will be overseen by the Governance and Risk Sub Committee.
Area for improvement 3 **Ref:** Standard 12.7 **Stated:** First time **To be completed by:** 26 March 2020	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. Ref: 6.3.2
	Response by registered person detailing the actions taken: Accepted. All papers are available electronically as we move towards paperless systems, but we will begin to reference document titles where they are reviewed/considered at Trustee meetings along with any appropriate decisions/action taken.
Audit	
Area for improvement 4 **Ref:** Standard 17.1 **Stated:** First time **To be completed by:** 26 March 2020	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. Ref: 6.3.4
	Response by registered person detailing the actions taken: Accepted. Relevant members of the Senior Management Team are now developing an audit plan in order to meet this area of improvement. The audit plan being devised includes an Quality Improvement/Audit Submission form that will be completed by the staff and approved by Senior Management Team. An annual Audit plan for each year will then be agreed with clear commencement and completion timeframes. An audit template is also almost completed to ensure standardisation in practice and will include all areas highlighted by RQIA as missing to date.
Area for improvement 5 **Ref:** Standard 9.7 **Stated:** Second time **To be completed by:** 26 March 2020	The Registered Persons 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. Ref: 6.1 and 6.3.4
	Response by registered person detailing the actions taken: Accepted. Relevant members of the Senior Management Team are now developing an audit plan in order to meet this area of improvement. There has been a change in personnel over the last few months and this has been postponed until such times as newly appointed persons were in position to do so. This will be reviewed and implemented in due course. Key performance Indicators for monitoring quality and performance are currently under discussion and in the process of being agreed. This will ensure a clear rolling programme which will be completed in 2020/21.
Interventional procedures	
Area for improvement 6 **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: 6.4.4
	Response by registered person detailing the actions taken: Accepted. The Director of Nursing and Clinical Care/Medical Director are working in partnership with the Day Hospice Nurse Manager to ensure appropiate protocols, policies and procedures are in place for clinical interventions.
Environment	
Area for improvement 7 **Ref:** Regulation 25 (2) (a) ?Standard 22.11 **Stated:** First time **To be completed by** 30 June 2020	The Registered Persons shall arrange for the repair of the defective plaster rendering in the staff dining room and redecoration of same. Ref: 6.4.7
	Response by registered person detailing the actions taken: Accepted. This had already been identified as an area needing attention. Our HR and Administration Manager appointed a suitably qualified contractor and this work has now been completed.
Area for improvement 8 **Ref:** Regulation 15 (7) Standard 22.3 **Stated:** First time **To be completed by:** 30 June 2020	The Registered Persons shall arrange to bring forward the review of the legionella risk assessment and address any issues arising from same. Ref: 6.4.7
	Response by registered person detailing the actions taken: Accepted. Legionella Risk Assessment has been undertaken by Chemical Treatment Services and as soon as their report is received any recommendations will be actioned as appropriate.

Area for improvement 9 **Ref:** Standard 22.3 **Stated:** First time **To be completed by:** 30 April 2020	The Registered Persons shall arrange for the reinstatement of the monthly user checks to the emergency lights in accordance with BS5266. Ref: 6.4.7
	Response by registered person detailing the actions taken: Accepted. We are currently recruiting a suitably qualified Maintenance Person and this will be included as part of their monthly duties.
Area for improvement 10 **Ref:** Standard 20.1 **Stated:** First time **To be completed by:** 30 June 2020	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. Ref: 6.4.7
	Response by registered person detailing the actions taken: Accepted. We have identified and sourced suitable equipment and these are currently being fitted.
Antibiotic/antimicrobial stewardship	
Area for improvement 11 **Ref**: Standard 25 **Stated:** First time **To be completed by:** 26 May 2020	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. Ref: 6.4.8
	Response by registered person detailing the actions taken: Accepted. A draft policy has been developed and is currently being reviewed prior to approval and implementation. A formal audit of this policy will take place regularly. Training on antimicrobial stewardship has been organised for the relevant staff on Thursday 16th July 2020 in Foyle Hospice. Training will be undertaken by Mrs Cairine Gormley Antimicrobial Pharmacist WHSCT.

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

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