Inspection Report

26 January 2024

Foyle Hospice

Type of service: Independent Hospital (IH) – Adult Hospice
Address: 61 Culmore Road, Londonderry, BT48 8JE
Telephone: 028 7135 1010

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:** Miss Annmarie Casey (applicant) **Date registered:** Awaiting registration
Person in charge at the time of inspection: Miss Annmarie Casey	**Number of registered places:** Twelve
Categories of care: Independent Hospital (IH) Hospice Adult – H(A) Private doctor - PD	**Number of patients accommodated on the day of this inspection:** Eight
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, mostly in single occupancy accommodation. One larger bedroom is capable of accommodating two patients however as a result of the COVID-19 pandemic, shared accommodation had been put on hold. Due to the increased demand for in-patient care, the hospice management team are currently reviewing the possibility of reinstating the two bedded shared accommodation. They confirmed that a full risk assessment and business case will be completed prior to any decision being made in this regard. Foyle Hospice also operate a day hospice service with an integrated care clinic and a community specialist palliative care team to provide specialist palliative care to patients living in the community.	

2.0 Inspection summary

An announced inspection was undertaken to the Foyle Hospice which commenced on 26 January 2024 from 10.00 am to 5.30 pm by four care inspectors, supported by a senior doctor who is an Achieve Develop Explore Programme for Trainee (ADEPT) fellow, undertaking the clinical leadership fellow programme.

The electronic submission of additional documentation in relation to the premises aspect of the inspection was reviewed remotely by an RQIA estates inspector and feedback was provided to the hospice following the inspection.

The purpose of the inspection was to assess progress with areas for improvement identified during the last care inspection and to assess compliance with the legislation and minimum standards.

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

The inspection team found the care provided and delivered in the hospice to be of an excellent standard. The provision of specialist palliative care was noted to be of an extremely high standard concerning the services offered and the support provided to patients and relatives. It was noted that the governance structures within the hospice continue to provide the required level of assurance to the senior management team and the Board of Trustees.

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

3.0 How we inspect

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

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

Prior to the inspection we reviewed a range of information relevant to the hospice.

This included the following records:

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

One week prior to the onsite inspection the hospice was provided with a list of specific documents requesting items to be reviewed remotely in respect of the maintenance of the premises and grounds. These items were to be sent electronically to our estates inspector on or before 1 February 2024 for review remotely.

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

4.0 What people told us about the service?

We had the opportunity to meet with one patient on the day of the inspection who confirmed that the staff had been very caring and compassionate in all aspects of their care. The patient told us that their needs had been met in a timely manner and they also commented positively on the peaceful environment that has contributed to their overall sense of wellbeing.

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 that staff deliver a very high standard of care.

Staff were invited to complete an electronic questionnaire. No completed staff questionnaires were submitted to RQIA 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 ongoing challenges they face as a team as a result of the COVID-19 pandemic and how they manage these and continue 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?

There were no areas for improvement identified at the last inspection undertaken on 4 January 2023.

5.2 Inspection outcomes

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

The staffing arrangements in respect of the day hospice, the integrated care clinic, the community specialist palliative care team and the inpatient unit (IPU) were reviewed.

The day hospice currently operates three days per week and can accommodate a maximum of eight patients on each day. The day hospice provides a range of services individually tailored to the needs of patients and their families. The service is provided by specialist palliative care registered nurses, healthcare assistants and a team of volunteers.

The integrated day clinic also operates three days per week and is consultant led with the support of registered nurses and focuses on integrated care planning to improve patients' quality of life. This includes regular patient review and assessment; management of pain and other symptoms; provision of psychological, emotional, social and spiritual support; and complementary therapies.

The community specialist palliative care team operates within the Western Health and Social Care Trust and consists of a team of registered nurses who have completed a specialist palliative care qualification. This service operates seven days a week. The community specialist palliative care team meet weekly to review the current caseload and will prioritise and plan patient contact depending on the assessed needs of patients. Discussion with community specialist nursing staff confirmed that this service provides specialist community palliative care to a wider area that now includes Omagh and Enniskillen. Staff advised that they have a depleted nursing team at present however active recruitment is ongoing. Discussion with community specialist nursing staff demonstrated a passion to ensure those living at home in need of specialist palliative care would receive this in a timely manner.

A multidisciplinary team works in the IPU and comprises of doctors; registered nurses; healthcare assistants; occupational therapists; physiotherapists and social workers with specialist palliative care expertise. In addition, there is a chaplaincy team who support the staff in providing holistic care and volunteers who provide a variety of services.

Discussions with IPU staff and a review of the duty rotas confirmed that there was sufficient staff in various roles to meet the assessed needs of patients. Staff morale was good with evidence of effective multi-disciplinary working arrangements and communication between staff. Staff told us they were happy, felt supported and there were good working relationships throughout the hospice services.

Staff discussed the benefits of effective communication within the hospice and confirmed that they have the opportunity to attend daily handover meetings, safety huddles, team meetings and felt supported by management. Staff have the opportunity to be included in decision making and are involved in quality improvement initiatives such as reviewing the outcome and learning from quality assurance audits. Staff confirmed that they can raise concerns openly and honestly with management.

A range of training records were reviewed and it was confirmed that mandatory training has been provided in line with RQIA training guidance. Staff also confirmed that there was a system in place to ensure they receive appropriate training to fulfil the duties of their role. Discussion with Miss Casey confirmed that staff compliance with mandatory training is currently monitored at senior manager level. A review of a sample of records and discussion with staff evidenced that supervision has been completed on a regular basis and appraisals had been completed on an annual basis. The hospice also provides staff opportunities for development to undertake specialist qualifications in palliative care, advanced care planning and communication skills Staff reported they were well supported and fully involved in discussions about their personal and professional development.

It was determined that the hospice ensures that there are safe staffing arrangements in place, in various roles, to meet the assessed needs of patients throughout the hospice services.

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

The arrangements in respect of the recruitment and selection of staff were reviewed.

A review of the policy and procedure for the recruitment and selection of staff found that the policy was in accordance with legislation and best practice guidance.

A staff register was available to review which included all relevant information as specified within Schedule 3 Part II of the Independent Health Care Regulations (Northern Ireland) 2005 with the exception of employment start dates. This was brought to the attention of Miss Casey who, during inspection, provided a list of start dates for all staff who had been recruited since the previous inspection. Miss Casey provided assurance that employment start dates would be included in the existing staff register for all staff members.

A review of a sample of four personnel files of newly recruited staff evidenced that all the relevant information as listed in Regulation 19, Schedule 2 of the Independent Health Care Regulations (NI) 2005, as amended had been sought and retained.

The Foyle Hospice has a human resources (HR) department which is responsible for gathering and collating the required recruitment documents as outlined in the legislation.

When a new member of staff is recruited they take part in an induction and undertake training commensurate with their roles and responsibilities. An induction programme had been developed for each new member of staff which was relevant to their roles and responsibilities.

It was determined that robust recruitment and selection procedures were in place to ensure compliance with the legislation and best practice guidance.

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

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

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

Miss Casey was identified as the safeguarding champion. It was evidenced however, that the organisation's safeguarding policies had not yet been updated to reflect this information. This issue was highlighted to Miss Casey who assured us that the required amendments to the policies would be made in due course. It was confirmed that Miss Casey had completed safeguarding training at the level required in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016) and minimum standards. It was also confirmed that there were appointed officers, trained to deputise in the absence of the safeguarding champion, if required.

Review of records demonstrated that clinical staff had received training in safeguarding adults as outlined in the Minimum Care Standards for Independent Healthcare Establishments July 2014. Staff spoken with were aware of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified.

It was confirmed that a copy of the regional guidance document entitled Adult Safeguarding Prevention and Protection in Partnership (July 2015) was available for reference.

Appropriate arrangements were in place to manage a safeguarding issue should it arise.

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

The arrangements for the management of medical emergencies and resuscitation were reviewed.

The hospice had undertaken a risk assessment and have retained emergency medicines and equipment as recommended by the Resuscitation Council (UK) guidelines.

The emergency equipment and medicines were stored separately in the IPU treatment room, within a tagged container and cupboard respectively. We confirmed that they are readily available to staff in the event of an emergency. All staff spoken to were aware of the location of medical emergency medicines and equipment.

Checklists were available and kept with the emergency medicines and equipment. Discussion with staff confirmed that senior ward staff were designated responsibility for completing these checklists to ensure that emergency equipment and medicines are always stored in sufficient quantities and within their expiry dates.

Review of training records and discussion with staff confirmed that resuscitation and the management of medical emergencies is included in the induction programme. A review of training records identified that all staff had received basic life support training on an annual basis in keeping with best practice guidance. Discussion with staff demonstrated that they have a good understanding of the actions to be taken in the event of a medical emergency.

It was determined that satisfactory arrangements are in place to manage a medical emergency in line with legislation and best practice guidance.

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

Assurance of effective governance arrangements in place to minimise the transmission of COVID-19 was sought by reviewing the key documentation and discussion of procedures with staff.

It was evidenced that the policy for transmission based precautions had been updated in December 2023. Minutes of clinical governance meetings were reviewed and evidenced that COVID 19 remained a standing agenda item for discussion. The decision to downgrade the COVID-19 risk rating on the risk register in July 2023 was recorded.

We confirmed that appropriate mitigating actions in relation to the management of COVID-19 were documented and implemented as necessary to continue to keep risk of infection and transmission to a minimum in clinical areas and throughout the patient pathway.

Effective hand hygiene practices and effective use of personal protective equipment (PPE) were observed throughout the inspection. Excellent standards of environmental and equipment cleaning were also observed. Good signage to direct visitors and staff with respect to PPE and hand hygiene were observed to be in place.

All staff who spoke with us were knowledgeable of COVID-19 best practice guidance in relation to isolation requirements; PPE requirements and testing requirements for patients and staff. The identified infection prevention and control (IPC) lead nurse is available to provide COVID-19 guidance as and when required.

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

5.2.7 Does the hospice adhere to 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 overarching IPC policy and associated procedures in place. Good compliance with IPC practices was observed during inspection in relation to hand hygiene, use of PPE and equipment cleaning.

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. Staff who spoke with us demonstrated a good understanding of IPC measures in place including isolation procedures.

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. It was confirmed that IPC audits are a standing agenda item at clinical governance meetings and that staff are regularly given feedback of IPC audit scores. Staff stated that actions that would be taken if environmental standards were to fall below the expected standard. Staff were also able to describe the actions they would take to address areas requiring improvement and demonstrated a comprehensive understanding of this.

It was confirmed a policy was in place regarding aseptic non-touch technique (ANTT) and that staff had undertaken both training and competency-based training assessments. Through discussion, staff demonstrated good knowledge and understanding of the application of ANTT into clinical practices and the management of invasive devices. A 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 for both day and night shifts. Discussion with support service staff demonstrated that they were knowledgeable about the daily, weekly and monthly cleaning schedules and the records to be completed. Support staff were able to describe the ongoing arrangements concerning cleaning audits.

Review of the current arrangements with respect to IPC practice evidenced areas of good practice. 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.

It was noted that areas of IPC risks were being assessed and managed appropriately with robust auditing measures in place in clinical areas.

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

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

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

Well established referral procedures were evidenced to be in place. There was a robust multi-disciplinary system for review of referrals and the triage/assessment of cases referred to the Foyle Hospice IPU, the integrated care clinic or to the community specialist palliative care team. Patients and/or their representatives are given information in relation to all of the services provided by Foyle Hospice which is available in different formats, if necessary.

Referrals can be received from the palliative care team, hospital consultant, nurse specialist or general practitioners (GP). Multidisciplinary assessments are completed with the referral information received through the regional referral arrangements.

These systems were found to be robust. Staff spoken within the IPU confirmed they had always received relevant information about the patient prior to their admission.

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

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

Staff confirmed that care was very patient centred with ongoing review to ensure care is adapted according to assessed need. It was good to note that patient care plans were personalised to individual patients and a system was in place for their ongoing review. 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 Department of Health (DoH).

Due to the COVID-19 pandemic patients are encouraged to remain in their room as much as possible. Staff were observed to be compassionate and positive interactions were observed between staff and patients as staff entered and exited patient's rooms. Staff introduced themselves to patients and requested permission to enter the patient's room and then went on to explain why they were there in a kind and caring manner. During observation of care practices and discussion with staff it was evident that patients' needs were being attended to in a timely manner.

The service of the lunchtime meal was well co-ordinated, with patients receiving their meals in a timely way and being assisted as needed. Feedback from one patient was positive in relation to the availability of food and fluids, menu choices and the quality of food served. Discussion with staff evidenced a wide choice of nutritious meals being offered that included specific meals for patients requiring specialised diets, and meal times that were flexible and individually tailored according to the patient's wishes and needs. Catering staff provided examples of how meals and snacks were often prepared in addition to the daily menu plans, to tailor to the specific requests of patients. Catering staff spoken with were compassionate and understanding of patient's nutritional needs. Nursing and catering staff were familiar with best practice guidance regarding nutrition and the specialised dietary descriptors outlined in the International Dysphagia Diet Standardisation Initiative (IDDSI).

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

There was evidence of good practice in the management of syringe drivers and discussion with staff confirmed that there was an adequate number of syringe drivers in place to meet the needs of patients. There was evidence of a robust system in place to manage the availability and return of syringe drivers when a patient was discharged. Discussion with staff confirmed that staff are adequately trained in medicines management and are competent in the administration of controlled drugs.

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

Staff also discussed the role of the tissue viability nurse (TVN) and dietician in relation to pressure area care and highlighted the valuable support that these services provide to patients.

The provision of bereavement care was reviewed and this evidenced that a range of information and support services were available. Foyle Hospice can provide internal individual and group based counselling services for patients, families, children and young people or can link with external providers. Ongoing bereavement care is available for families and children coping with the loss of a loved one. Discussions regarding the delivery of bereavement care services confirmed that staff are appropriately trained and skilled in this area.

The hospice has a policy and procedure for delivering bad news to patients and/or their representatives which is in accordance with the Breaking Bad News regional guidelines 2003. Staff confirmed that bad news is delivered to patients and/or their representatives by professionals who have experience in communication skills and who act in accordance with the hospice's policy and procedure. Where this news is shared with others, staff confirmed that consent must be obtained from the patient and this is documented in patient records. Following a patient receiving bad news, future treatment options are discussed fully with the patient and documented within their individual care records. Staff spoken with were very aware of the importance of being available to provide support to the patient and/or their representatives to help them to process the information shared.

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

The current arrangements with respect to specialist palliative care and bereavement support services were noted to be of an extremely high standard and adhered to current best practice guidance. There were examples of good practice found in relation to care delivery; the care pathway including admission and discharge arrangements; and patient engagement.

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

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

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

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

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

The multi-disciplinary care records reviewed contained the following:

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

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

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

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

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

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

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

5.2.10 How does the hospice ensure the environment is safe?

A review of the of the building engineering services maintenance documents was completed remotely. A checklist of building engineering documents was requested at the beginning of the inspection. The required documents were submitted electronically by the human resources and administration manager to the RQIA estates inspector for review.

The submitted documents were compliant with relevant standards and codes of practice.

Risk assessments were in place relating to: (1) fire safety and (2) water safety in the domestic water storage and distribution system.

The fire risk assessment recorded that the risk in the premises was 'tolerable', while the action plan of the legionella risk assessment relating to the water system was confirmed as having been addressed.

Maintenance validation certificates relating to a range building engineering services was received and indicated that the systems are subject to a programme of maintenance by specialist contractors. These included:

- fire alarm and detection system
- emergency lighting installation
- first aid and firefighting equipment
- fixed wiring installation
- electrical equipment
- emergency standby generator
- patient lifting equipment
- nurse call system
- space heating boiler

There were no estates issues listed as requiring areas for improvement (AFIs) on a Quality Improvement Plan.

5.2.11 Are robust arrangements in place regarding clinical and organisational governance?

The governance structures were reviewed to include a review of committee minutes and discussion with Miss Casey, the chairperson of the Board of Trustees; the medical director and members of staff.

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 were able to describe their roles and responsibilities and how they fitted into the overarching governance structures and committees. Staff told us that the governance structures ensure that appropriate and timely information is provided to the committees through meetings that enable the best use of clinical and staff expertise. All staff spoken with were highly respectful towards the Board of Trustees and the senior management team.

The minutes of the governance structures and committee 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 of Trustees 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 detailed 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 in place and was last reviewed in July 2023 and included a routine review of closed risks, to ensure that these have been effectively managed and do not need to be reopened. Amendments to the risk register are discussed and ratified at the governance and risk committee.

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 it was confirmed that current insurance policies were in place.

The medical advisory committee (MAC) is formalised within the governance and risk committee and has an identified quorum. The terms of reference for the MAC were reviewed and these have been developed in accordance with the Minimum Standards for Independent Healthcare Establishments (July 2014). MAC meetings are minuted and minutes of a MAC meeting held during October 2023 were reviewed and noted to be a detailed account of the topics discussed and decisions made. The medical director produces a quarterly report for the governance and risk committee.

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 care, 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). ROs are experienced senior doctors, who work with the GMC, to make sure doctors are reviewing their work. In accordance with the 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. 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. How concerns would be raised, regarding a doctor's practice with the MAC and within the wider HSC sector, was discussed with the medical director. 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 (NI) 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 utilising the service. A rota of medical practitioners was easily accessible to inform staff of the doctors working in the hospice and also the 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. Miss Casey generates a quarterly report for the governance and risk committee that includes data on safeguarding; concerns; key performance indicators (KPI's); audit findings; training; complaints and incidents.

An audit programme and audit recording templates are in place. Results of audits are analysed and the findings are presented to the finance and audit committee. Actions plans are developed to address any deficits, including the name of the person responsible for implementing the action plan and the timeframe. It was good to note that all grades of staff were involved in the completion of audits as this increases ownership and accountability amongst staff. Audit findings are shared with relevant staff and committees.

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 IPU 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. 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 were reviewed. It was confirmed that all notifiable events/incidents were recorded, investigated and reported to RQIA or other relevant bodies, as appropriate, in a timely manner. Miss Casey reviews all incidents.

It was confirmed that any learning from notifiable events/incidents that occurred was identified and shared through the governance structures of the hospice, in a meaningful way, to identify trends and 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 management of complaints within the hospice was reviewed. Miss Casey confirmed that there were no active or ongoing complaints. Staff who spoke with us demonstrated good awareness of how to deal with a complaint, if received.

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.

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. Compliments received by hospice are retained and shared with staff.

The day hospice model to include community specialist palliative care services has been implemented. We were informed that the hospice received money from the Cancer fund in two phases. Money from phase one of this Cancer Fund had been used to create a health and wellbeing facilitator post and money from phase two has been used to further develop community services to include a physiotherapist; a carer support worker; complimentary therapists and speciality doctors for the community specialist palliative care team.

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, is 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 reports dated 4 July 2023 and 23 January 2024 were 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.

The role and responsibilities of the Board of Trustees and the governance structures were discussed with the chairperson of the Board. It was good to note that the Board members continue to actively review their membership; identifying skill sets or areas of expertise that would further enhance the Board, for the benefit of the hospice and actively recruits 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. The chairperson of the Board confirmed that members of the senior management team have an open door policy and make themselves available to the 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.

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 continued 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 members of senior management established that they continued to have a shared vision and strategy for the hospice coupled with a cohesive and productive way of working together.

5.3 Equality data

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

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

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Casey, Applicant Registered Manager; the medical director, the human resources manager and the IPU manager, as part of the inspection process and can be found in the main body of the report.

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

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