The Regulation and Quality Improvement Authority

Inspection Report

3 February 2022 and 22 February 2022

Southern Area Hospice Services

Type of Service: Independent Hospital (IH) – Adult Hospice
Address: Courtenay Hill, Newry BT34 2EB
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Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/; The Independent Health Care Regulations (Northern Ireland) 2005 and the Minimum Care Standards for Independent Healthcare Establishments (July 2014)

1.0 Service information

Organisation/Registered Provider: Southern Area Hospice Services Limited **Responsible Individual:** Mrs Elizabeth Cuddy	**Registered Manager:** Mrs Bernadette Torley **Date registered:** 27 January 2022
Person in charge at the time of inspection: Mrs Elizabeth Cuddy	**Number of registered places:** 14 inpatients Day Hospice, Newry - 10 Day Hospice, Dungannon - 7
Categories of care: Independent Hospital (IH) – Adult Hospice	
Brief description of how the service operates: This service was previously registered with the Regulation and Quality Improvement Authority (RQIA) under the name of St John's House however since the previous inspection the name of the service has changed to Southern Area Hospice Services. Southern Area Hospice Services is registered with the RQIA as an independent hospital providing in-patient hospice services for up to 14 adults with life-limiting, life-threatening illnesses and palliative care needs. The registration also includes day hospice services for adults with life-limiting, life-threatening illnesses and palliative care. The day hospices operate from two sites, one based in the same site as the inpatient unit in Newry and one based in Dungannon. It was confirmed that as a direct result of the COVID -19 pandemic the day hospice services based in Newry have been temporarily suspended and the day hospice based in Dungannon is operational on an appointment basis only.	

2.0 Inspection summary

An unannounced inspection was undertaken to Southern Area Hospice Services which commenced with an onsite inspection on 3 February 2022. On arrival members of the senior leadership team confirmed that management were responding to staffing issues due to the impact of the COVID 19 pandemic. As result of this it was agreed that the inspection would not continue as planned. The inspection was recommenced on 22 February 2022.

The purpose of this inspection was to focus on the themes for the 2021/22 inspection year.

Our multidisciplinary inspection team examined a number of aspects of the hospice including the management of operations in response to the COVID-19 pandemic; infection prevention and control (IPC); the provision of palliative care; medicines management; maintenance of the premises; and the management and oversight of governance across the organisation.

The inspection team met with various staff members, reviewed care practices; and reviewed relevant records and documentation used to support the governance and assurance systems.

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

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

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

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

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

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
- the returned QIP from the previous care inspection

In response to the COVID-19 pandemic RQIA reviewed the inspection methodology used during the 2020/21 inspection year and considered various options to undertake inspections.

The purpose of this was to minimise risk to service users and staff, including our staff, whilst being assured that registered services are providing services in keeping with the minimum standards and relevant legislation. Having considered different inspection methodologies a decision was taken to undertake multidisciplinary blended themed inspections to hospice services. The blended methodology included an onsite inspection and electronic submission of additional documentation to be reviewed remotely by pharmacist and estates inspectors.

As the COVID-19 pandemic is ongoing a decision was taken to continue with this inspection methodology during the 2021/22 inspection year. The onsite component of our inspection was completed on 22 February 2022 by three care inspectors. The onsite inspection team examined a number of aspects of the hospice services as outlined in section 2.0 of this report. A tour of the in-patient unit was undertaken and posters informing patients and staff that an inspection was being conducted were displayed during the inspection.

At the onset of the onsite inspection the hospice was provided with a list of specific documents requesting items to be reviewed remotely in respect of medicines management and the maintenance of the premises and grounds. These items were to be sent electronically to our pharmacist and estates inspectors for review.

It was agreed that formal feedback would be provided to the Southern Area Hospices Services senior leadership team at a mutually agreeable date and time upon completion of our inspection process. Feedback of the inspection findings was delivered to Mrs Cuddy, Responsible Individual; the chairperson of the Board of Directors; and members of the senior leadership team on 26 April 2022 during a Zoom teleconference. This feedback also included the pharmacy and estates inspectors findings following their review of the documents submitted electronically.

4.0 What people told us about the service?

In response to the COVID-19 pandemic the inspection team decided not to meet with patients on the day of the inspection. Patient feedback was assessed by reviewing the most recent patient satisfaction surveys.

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

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

5.0 The inspection

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

Areas for improvement from the last inspection on 24 November 2021		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and Minimum Care Standards for Independent Healthcare Establishments (July 2014)		**Validation of compliance**
Area for Improvement 1 **Ref**: Regulation 18 (2) **Stated:** Second time	The registered person shall ensure that a robust system is developed to provide the senior management team of the hospice with an overview of all staff training undertaken.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. An overarching training matrix is maintained by the Director of Corporate Services; this is reviewed by the registered manager who is responsible for ensuring all staff undertake mandatory training.	
Area for Improvement 2 **Ref**: Regulation 17 **Stated:** Second time	The registered person shall review the role and function of the Medical Director position in order to strengthen the medical governance arrangements within the hospice. This role and function should: • provide strong medical leadership and advise on best practice; • have responsibility for the oversight of all medical staff working in the hospice; • have responsibility for patient safety; • have oversight and scrutiny of medical staff annual appraisals; • have responsibility for reviewing and reporting quality of care and patient safety issues to the hospice Board of Trustees; and • provide a key link to the HSC. A copy of the reports of quality of care and patient safety issues submitted to the hospice Board of Trustees should be forwarded to RQIA for February, March and April 2020.	**Met**

	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 5.2.6.	
Area for Improvement 3 **Ref**: Standard 30.1 **Stated:** First time	The registered person shall ensure that the role of the Medical Advisory Committee (MAC) is formalised with terms of reference provided in accordance with Standard 30.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 5.2.6.	
Area for Improvement 4 **Ref**: Regulation 19 **Stated:** Second time	The registered person shall address the following matters to strengthen the medical governance arrangements: • develop a system to review medical staff full annual appraisals and revalidation; and • develop a system to share information in respect of medical staff between the Health and Social Care (HSC) Trust and the hospice.	**Met**
	Action taken as confirmed during the inspection This area for improvement has been assessed as met, further detail is provided in section 5.2.6.	
Area for Improvement 5 **Ref**: Regulation 19 (1) **Stated:** Second time	The registered person shall review how all they engage the services of all medical staff and implement a practising privileges agreement for any staff who do not have a direct contract of employment with the hospice in line with Standard 11 of Minimum Care Standards for Independent Healthcare Establishments, July 2014.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section. 5.2.6.	

5.2 Inspection outcomes

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

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

As previously discussed, it was confirmed that as a direct result of the COVID-19 pandemic the day hospice services based in Newry have been temporarily suspended and the day hospice based in Dungannon is operational on an appointment only basis.

Assurance of effective governance arrangements in place to minimise the transmission of COVID-19 was sought by reviewing the key areas of collaborative working, COVID-19 risk assessments, the monitoring of staff practices, work patterns and staff training.

The management of operations in response to the COVID-19 pandemic was discussed with one of the IPC leads, a ward manager and several other staff members. It was determined that COVID-19 policies and procedures were in place and were in keeping with best practice guidance. Staff told us they are regularly updated in respect of COVID-19 and receive timely communications in respect of updated guidance and of the internal governance systems in place. All staff who spoke with us were very knowledgeable of COVID-19 best practice guidance in relation to isolation requirements; personal protective equipment (PPE) requirements; visiting restrictions; contact tracing requirements and ongoing staff testing requirements.

There was strong evidence of collaborative and multi professional working and good communication systems for the sharing of information and learning. Records confirmed that staff had received enhanced COVID-19 training and systems were in place for the monitoring of staff practices. Staff told us that they had received enhanced COVID-19 and personal protective equipment (PPE) training; that they can access training materials and have an identified COVID-19 lead.

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

A review of documents concerning the staff changing facilities, staff rest areas and nurses stations evidenced these areas had been included in the COVID-19 risk assessment. Observation of the in-patient unit including the staff rest areas confirmed that social distancing and COVID-19 precautions taken by staff were well adhered to in both clinical and non-clinical areas. Staff were aware of the maximum number of staff permitted in each area in accordance with social distancing guidance. Staff break times had been staggered to facilitate social distancing and staff told us these arrangements were working well. It was noted that mechanisms were in place at ward level to challenge non-adherence if social distancing and COVID-19 precaution measures were breached. Staff told us they would feel confident to challenge anyone not compliant with any aspect of COVID-19 precautions.

Effective hand hygiene practices and effective use of PPE was observed throughout the inspection. Staff were observed supporting patients and visitors to comply with COVID-19 IPC measures. Excellent standards of environmental and equipment cleaning was observed.

Good signage, to direct visitors and staff in respect of PPE, hand hygiene and the wearing of face masks was observed to be in place.

All patients admitted to the hospice in-patient unit are subject to COVID-19 testing on admission to ascertain their COVID-19 status; results of these tests are shared with the patients in a timely manner. Visiting arrangements have been reviewed and facilitated in line with the most recent DoH guidance. Patients and their families are advised of the visiting arrangements on admission.

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

Staff were knowledgeable about the ongoing COVID-19 pandemic restrictions. The hospice had identified a COVID-19 lead; had reviewed and amended policies and procedures in accordance with DoH guidance to include arrangements to maintain social distancing; prepare staff; implement enhanced IPC procedures; COVID-19 patient pathways; and had amended their visiting guidance. The inspection team were assured of robust governance and oversight of measures to prevent the spread of the virus.

It was demonstrated that robust arrangements are in place to minimise the risk of COVID -19 transmission.

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

The arrangements for IPC procedures throughout the hospice to evidence that the risk of infection transmission to patients, visitors and staff was minimised were reviewed. It was confirmed that the hospice had overarching IPC policies and associated procedures in place. One of the IPC leads informed us that these polices were in the process of being reviewed and updated as required.

Southern Area Hospice Services had dedicated leads in respect of IPC and the leads were given protected time to provide staff training, update guidance, carry out audits and develop guidelines. It was demonstrated that the IPC audit findings are discussed at the Clinical Governance Committee meetings where further actions are agreed as appropriate.

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.

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

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

This information was displayed on notice boards in both clinical and non-clinical areas and discussed at the daily safety briefs. Staff told us about the actions that would be taken if environmental standards were to fall below the expected standard. Staff were also able to describe the actions they would take to address areas requiring improvement. Staff demonstrated a comprehensive understanding of this.

An aseptic non-touch technique (ANTT) policy was in place which outlined that 'standard' ANTT procedures take place and that 'surgical' ANTT is not used. It was confirmed that ANTT training is incorporated into the IPC training programme. Through discussion, staff demonstrated good knowledge and understanding of the application of ANTT into clinical practices and the management of invasive devices. A robust system of audit had been implemented regarding the management of invasive devices, with audit results being disseminated to staff through the hospice's governance systems.

Review of the staff training identified that IPC training was overdue for a high percentage of staff. However it was established that this was due to the impact of the COVID -19 pandemic as the majority of staff were due to update their IPC training during December 2021 and during January/February 2022. Staff were unable to complete training as direct patient care was prioritised. It was suggested that a record could be made in the minutes of governance meetings to evidence that where training shortcomings have been identified, a reason is recorded. As previously stated, all staff who spoke with us demonstrated a good understanding of IPC measures in place.

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

Review of the current arrangements with respect to IPC practice evidenced areas of good practice. It was noted that areas of IPC risks were being assessed and managed appropriately with robust auditing measures in place in clinical areas. Arrangements are in place to ensure the all staff adhere to IPC best practice guidance. There was evidence of effective governance mechanisms and collaborative working across the hospice in respect of IPC.

It was demonstrated that robust arrangements are in place to ensure the hospice adheres to IPC best practice guidance.

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

Adherence to best practice guidance in regards to palliative care was evidenced through the examination of referral pathways; a review of care records; discussion with staff; observation of care delivery; and a review policies and procedures. The patient pathway was reviewed through the hospice from the time of referral through to the point of discharge and many areas of good practice were identified.

Well established referral procedures were evidenced to be in place. There was a robust multi-disciplinary system for review of referrals and triage/assessment of cases referred to the hospice. Patients and/or their representatives are given information in relation to the hospice which is available in different formats, if necessary.

Referrals can be received from the palliative care team, hospital consultants, nurse specialists or general practitioners (GP). Multidisciplinary assessments are completed with the referral information through the regional referral arrangements. Staff spoken with confirmed they had received relevant information about patients prior to their admission.

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

Two patients' care records were reviewed and these evidenced meaningful patient involvement. The plans of care and treatment were provided in a flexible manner to meet the expressed wishes and assessed needs of individual patients and their families. There was evidence that a multi-disciplinary, holistic and empathetic approach to patients' care was being delivered. It was also noted that care delivered was patient centred with ongoing review to ensure care is adapted according to assessed need.

During the inspection staff were observed interacting with patients in a calm, caring and unhurried manner and were attending to patients needs in a timely way. Staff introduced themselves to patients and requested permission to enter the patients' rooms. Staff demonstrated good communication skills and it was evident that dignity and respect shown to patients was of a very high standard.

Staff spoke positively regarding the good communication systems throughout the hospice that included involvement in staff meetings; safety huddles; daily and weekly multi-disciplinary team meetings and debriefing sessions. Staff reported a very supportive environment with opportunity for training, growth and development.

The provision of bereavement care was reviewed and this evidenced that a range of information and support services were available. The hospice can provide internal individual counselling services for patients and families or links with external providers. Ongoing bereavement care is available for families and children coping with the loss of a loved one. It was confirmed that staff who deliver bereavement care services are appropriately trained and skilled in this area. Staff spoke positively on how initiatives are being developed to further enhance the bereavement service offered by the hospice and community services.

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

The arrangements in relation to 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 in discharge planning that included daily and weekly meetings to ensure the patient's needs were 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 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 management of care records; the care pathway including admission and discharge arrangements; and patient engagement.

5.2.4 What processes are in place for the management of medicines?

Medicines management was discussed during a virtual meeting held on 10 March 2022.

At the last two inspections, the level of pharmacist support available to the hospice had been discussed. Given that there could be a different prescriber each day of the week, due to the medical rota, it was agreed that the support of a pharmacist on a daily basis would greatly enhance the continuity of care for patients and would make an important contribution to safe and effective care. The responsible individual advised that she has been working with Health and Social Care Board (HSCB) and the Southern Health and Social Care Trust (SHSCT) to progress this, however to date resources have not been secured and recruitment has been unsuccessful. The senior leadership team in the hospice were keenly aware of the benefits that a pharmacist could bring to the multi-disciplinary team and are endeavouring to appoint a pharmacist in the near future.

The management of medicine-related incidents was also discussed. There had been a slight rise in the number of incidents in the weeks before the inspection which the management team were aware of. The responsible individual and registered manager advised that this was being closely monitored and a full review of each incident was completed. The inspector advised that incidents should be monitored to identify any trends or patterns that may be emerging and it was agreed that this would be done.

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

5.2.5 Does the service ensure the environment is safe?

Discussion with staff demonstrated that suitable arrangements are in place for maintaining the environment in accordance with current legislation and best practice guidance. The following documentation was reviewed in relation to the maintenance of the premises including the mechanical and electrical installations:

- the Fire Risk Assessment
- service records for the premises fire alarm and detection system
- service records for the premises emergency lighting installation
- service records for the premises portable fire-fighting equipment

- records relating to the required weekly and monthly fire safety function checks
- records relating to staff fire safety training
- records of fire drills undertaken
- Lifting Operations and Lifting Equipment Regulations (LOLER) 'Thorough Examination' reports of the premises' passenger lift and patient hoists
- condition report for the premises' fixed wiring installation
- report for the formal testing of the premises' portable electrical appliances
- the Legionella Risk Assessment
- Gas Safe Certification for the premises heating boilers and catering equipment
- water safety scheme control measures
- records, validation checks and audits for the premises' piped medical gas systems
- records, validation checks and audits for the premises' air conditioning systems

The most recent Legionella Risk Assessment was undertaken in August 2019 and all required remedial works have been undertaken and signed-off. Suitable temperature monitoring of the premises' hot and cold water systems was in place with records being maintained as recommended. Regular bacteriological sampling of the hot and cold water systems most recently undertaken on 23 August 2021 confirmed that legionella bacteria were not detected.

The most recent Fire Risk Assessment was reviewed on 28 October 2021. The overall assessment was assessed as 'tolerable' and no significant findings were identified. An audit undertaken by the Northern Ireland Fire and Rescue Service on 25 August 2021, found the premises to be 'Broadly Compliant' and no areas for improvement were identified. The most recent fire drill for the premises had been completed on 8 September 2021.

The premises' fixed electrical installation and emergency standby electrical generator continue to be serviced and maintained in accordance with current best practice guidance. The passenger lift and patient hoist undergo regular thorough examination with the most recent examination being on 26 January 2022.

The premises' specialised ventilation systems and medical gas pipeline services are serviced in accordance with current best practice guidance and suitable validation is undertaken in accordance with the current health technical memoranda. Records and validation reports were available and reviewed at the time of the inspection.

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

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

The governance structures were reviewed to include a review of committee minutes and discussion with Mrs Cuddy, Responsible Individual and members of the senior leadership team (SLT). Discussions were held with the chairperson of the Board of Trustees and an additional board member, via Zoom teleconference on 4 March 2022. The member of the Board of Trustees who attended the Zoom teleconference is also the chairperson of the Medical Advisory Committee (MAC).

It was confirmed that a robust organisational structure was in place with clear lines of accountability, defined structures and visible leadership and staff were aware of these.

Staff who spoke with us were able to describe their roles and responsibilities and how they fitted into the overarching governance structures and committees. All staff that we spoke with were highly respectful towards the Board of Trustees and the senior management team.

The Board of Trustees meet approximately seven times a year and will arrange an extraordinary meeting if required. Terms of reference for the operation of the Board were in place. Mrs Cuddy is the company secretary for the Board. It was confirmed that Board members have recently completed training on their roles and responsibilities. It was good to note that each subcommittee is chaired by a member of the Board and that Board members are furnished with all minutes of sub-committee meetings and relevant papers that had been prepared for those meetings.

The directors (Director of Corporate Services; Director of Care and the Director of Development) produce a monthly report concerning their respective areas of responsibility. These monthly performance reports are used to generate the quarterly reports that are presented at the subcommittee meetings. Reports include information about the inpatient and community services being provided. Mrs Cuddy advised that the directors are in the process of reviewing and further developing the key performance indicators (KPI's) that are detailed within these reports. The refreshed KPIs will be outcome focused.

Review of the minutes of various committees that sit within the governance structure, Clinical Governance Committee; Resources Committee; Audit and Risk Committee; Remuneration and Nomination Committee and Capital Development and Infrastructure Committee demonstrated that these committees were functioning well and provide the required level of assurance to the Board. The membership of the various committee meetings was representative of the governance structures. It was confirmed that the Board are able to interrogate the data provided to them and provide appropriate challenge to the SLT, where required. Organisation learning is discussed at Board and subcommittee meetings and shared with heads of department for dissemination with staff.

It was observed that arrangements were in place to develop, implement and regularly review risk assessments. The active risk register was reviewed and there was evidence of risks being reviewed with the overarching risk grading being amended following mitigations being put in place.

The arrangements concerning medical governance were reviewed. In relation to the previous area for improvement 2 outlined in section 5.1, Mrs Cuddy confirmed that the role and function of the medical director was reviewed as part of the overall review of the structure of care services. In the new structure, the medical director and nursing director roles have been replaced by one role which has responsibility for care, the director of care. This role is supported by a lead consultant who has responsibility for all medical practitioners and attends the MAC. This area for improvement has been addressed.

The MAC had been formalised within the Clinical Governance Committee. 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). This addresses the previous area for improvement 3 outlined in section 5.1. The MAC is chaired by a Board member and its membership includes board members and medical practictioners from outside the hospice. The lead consultant attends MAC meetings. The minutes of MAC meetings held during May and September 2021 were reviewed; practising privileges is a standing agenda item for MAC meetings. Mrs Cuddy confirmed that going forward the MAC will separate from the Clinical Governance Committee and will be meet separately.

In relation to the previous area for improvement 4 outlined in section 5.1, RQIA are aware that there are issues with the system used within the HSC sector to record the appraisals of medical staff. Namely medical staff cannot print or share an electronic version of their full appraisal outside of the Trust, they can however access and print a PDF summary document confirming that their appraisal has taken place. As a result of this, the hospice requires all medical staff to provide this PDF.

In addition the hospice is developing a proforma to be signed by the relevant responsible officer (RO) confirming that no issues were identified during the appraisal/revalidation that would impact on the medical practitioner's ability to perform their role and responsibilities in the hospice. This proforma will include all KPIs (incidents, complaints, training etc). Following the inspection guidance documents to support the development of this proforma and a Letter of Good Standing (LOGS) was emailed to the chair of the MAC. This addresses the area for improvement 4.

In relation to the previous area for improvement 5 outlined in section 5.1, it was confirmed that staff are either directly employed by the hospice or the SHSCT, and therefore are not subject to a practising privileges agreement. This area for improvement has been addressed. Mrs Cuddy advised that the hospice is giving consideration to employing private doctors under a practising privileges agreement in the future. In preparation for this ,the hospice has a practising privileges policy and supporting documentation in place. Following the inspection guidance in relation to practising privileges and becoming a designated body with the General Medical Council (GMC) was shared with Mrs Cuddy by email.

It was noted that the minutes of the hospice governance meetings referenced debrief meetings held following the sudden death of a patient. These debrief meetings (Multidisciplinary Morbidity and Mortality (M&M) 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 leadership team through the governance structures. M&M meetings provide a unique opportunity for health professionals to improve the quality of care offered through the review of case studies. They also provide clinicians and members of the healthcare team with a routine forum for the open examination of individual events surrounding a patient's death, with a view to sharing any learning and improving practice. Feedback received from staff regarding these meetings was very positive.

Experienced senior doctors (called Responsible Officers) work with the GMC to make sure doctors are reviewing their work. All medical practitioners working within the hospice must have a designated RO. 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. A discussion was held around how concerns would be raised regarding a doctor's practice with the MAC and within the wider HSC sector. It was established that internal arrangements were in place and the hospice was linked in with the regional RO network, should any issues emerge.

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

The arrangements for the provision of medical practitioners within the hospice were reviewed to ensure that patients had access to appropriate medical intervention as and when required.

This review evidenced that robust arrangements were in place to meet the needs of the patients accommodated. A rota of medical practitioners was easily accessible to inform staff of the doctors working in the hospice and also arrangements for out of hours cover.

It was confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care and treatment delivered to patients at appropriate intervals. There is a rolling audit programme in place.

It was observed that the results of audits are analysed and actions plans developed to address any areas for improvement, including the name of the person responsible for implementing the action plan and the timeframe. It is commendable that all grades of staff including medical staff are involved in the completion of audits as this increases ownership and accountability amongst staff. Timeframes had been updated to show when action points had been completed. Staff told us that the senior leadership team use this information to drive quality improvement within the hospice.

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.

It was confirmed that any learning from notifiable events/incidents that occurred were reviewed through the governance structures of the hospice, in a meaningful way, to identify trends and learning that could be used to affect change or influence practice. A trend analysis report is generated on a quarterly basis. A multidisciplinary approach is applied to the review of notifiable events/incidents and the hospice ensures the dissemination of learning to all staff. Staff described to us that the reporting of incidents is encouraged in an open and transparent way which leads to a no blame culture within the organisation and enhanced learning outcomes.

The hospice has a complaints policy and procedure in place in accordance with the relevant legislation and DoH guidance on complaints handling. A copy of the complaints procedure is made available for patients/and or their representatives. It was suggested that the complaints policy is further developed to include the contact details of RQIA.

The management of complaints within the hospice was reviewed. 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. Staff who spoke with us demonstrated good awareness of how to deal with a complaint, if received.

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. Mrs Cuddy, Responsible Individual, was in day to day control of the hospice however, Mrs Cuddy can delegate the task of undertaking the unannounced visits to one of the directors or a member of the Board of Trustees. Mrs Cuddy receives a copy of the reports generated for review and sign off. The most recent unannounced quality monitoring visit report dated 29 November 2021 was reviewed.

It was confirmed that should these unannounced visits identify issues an action plan would be developed to address any deficits; including timescales and persons responsible for completing the actions.

During the Zoom meeting with the chairperson and the member of the Board of Trustees, on 4 March 2022, the role and responsibilities of the Board and the governance structures were discussed.

It was good to note that the Board members were actively reviewing their membership; identifying skill sets or areas of expertise that would further enhance the Board for the benefit of the hospice and were actively recruiting new members with the desired skills and knowledge, where appropriate. A discussion took place concerning the further development of the strategic plan and provision of services.

Mrs Cuddy advised that the Board and SLT are reviewing the strategic plan and that a greater emphasis will be placed on the further development of community services. A discussion took place about the further development of the community services and if this would require to be registered with RQIA. Following the inspection a written proposal was submitted to RQIA and it was decided that a separate registration was not required and that all services offered by the hospice would be registered and regulated under the one registration.

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 current insurance policies were in place.

We would like to recognise the work undertaken by the Trustees, the SLT and staff of the hospice to progress the strengthening of the governance structures during a difficult time of a global pandemic while ensuring that safe, effective and compassionate palliative care continues to be delivered to patients and their families.

Overall, the governance structures within the hospice provided the required level of assurance to the senior leadership team and Board of Trustees. It was good to note the involvement of Trustees on all committees and their commitment to driving continued quality improvement. Our discussions with the chairperson of the Board of Trustees and the SLT established that they continued to have a shared vision and strategy for the hospice coupled with a cohesive and productive way of working together.

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

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

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

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Cuddy, Responsible Individual; the Chair of the Board of Directors; the Director of Corporate Services and the Director of Care during a zoom teleconference on 26 April 2022, as part of the inspection process and can be found in the main body of the report.

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