Unannounced Inspection Report
6 and 7 January 2020

St Johns House

Type of Service: Independent Hospital (IH) – Adult Hospice
Address: Courtenay Hill, Newry BT34 2EB
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Assurance, Challenge and Improvement in Health and Social Care

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

1.0 What we look for

Membership of the Inspection Team

Lynn Long	Assistant Director Regulation and Quality Improvement Authority
Dr John Simpson	Senior Medical Advisor Regulation and Quality Improvement Authority
Jo Browne	Senior Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Norma Munn	Lead Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Carmel McKeegan	Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Steven Smith	Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Catherine Glover	Acting Senior Inspector, Medicines Management Team Regulation and Quality Improvement Authority
Gavin Doherty	Inspector, Premises Team Regulation and Quality Improvement Authority
Dr Ruth Carville	ADEPT Fellow Regulation and Quality Improvement Authority
Richard Gamble	Lay Assessor/Peer Reviewer Regulation and Quality Improvement Authority
Gary McMaster	Inspection Coordinator Regulation and Quality Improvement Authority

2.0 Profile of the services

Southern Area Hospice Services is the registered provider for St John's House and two day hospices. St Johns House is a registered independent hospital providing in-patient hospice services for up to 14 adults with life limiting, life-threatening illnesses and palliative care needs. This service also supports patients' families and provides ongoing bereavement support.

Southern Area Hospice Services also provides nurse led services for adults with life limiting, life-threatening illnesses and palliative care needs in two day hospices and these are currently included in the registration of St Johns House. One day hospice service is based in the St Johns House, Newry, site and operates four days per week from 9.30 to 15.30 and the other day hospice service is based at the South Tyrone Hospital, Dungannon and operates on Tuesday and Wednesday each week from 9.30 to 15.30.

3.0 Service details

Organisation/Registered Provider: Southern Area Hospice Services **Responsible Individual:** Mrs Elizabeth Cuddy	**Registered Manager:** Ms Roberta Wilson (Acting)
Person in charge at the time of inspection: Mrs Elizabeth Cuddy	**Date manager registered:** Acting from 16 December 2019
Categories of care: Independent Hospital (IH) – Adult Hospice	**Number of registered places:** 14 inpatients Day Hospice, Newry - 10 Day Hospice, Dungannon - 7

4.0 Inspection summary

We undertook an unannounced inspection to St Johns House over two days, commencing on Monday 6 January 2020 and concluding on Tuesday 7 January 2020. We employed a multidisciplinary inspection methodology during this inspection. Feedback of the inspection findings was delivered to the Southern Area Hospice Services (SAHS) senior management team on 13 January 2020.

We would like to thank Mrs Liz Cuddy, Chief Executive Officer/Responsible Individual, Ms Roberta Wilson, Acting Manager and all of the SAHS staff for being welcoming, open and transparent, and for providing the inspection team with all information and documents required in a timely manner.

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

The multi-disciplinary inspection team examined a number of aspects of the hospice, from front line care and practices, to management and oversight of governance across the organisation. The inspection team met with various staff groups, spoke with several patients, observed care practice and reviewed relevant records and documentation to support the organisational governance and assurance systems.

No immediate concerns were identified in relation to patient safety and the inspection team noted multiple areas of strength, particularly in relation to the delivery of front line care in the hospice. In general, we found the delivery of patient care was excellent and all feedback received by the team from patients and relatives was very positive. All patients and relatives spoken with advised they felt safe, felt they were being well cared for and we observed compassionate care being provided.

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

The senior management team informed us of improvements made and planned for the hospice in relation to their governance systems. Whilst we acknowledge the ongoing work in this regard we identified several areas for further development which will strengthen their current arrangements. These included the overarching management and governance arrangements; the registration of the establishment; the role and function of the Medical Director position; practising privileges; communication between nursing and medical staff; the management of incidents and complaints; the arrangements in respect of audits; and the overview of staff training.

Other areas requiring improvement were identified in relation to safeguarding training; the prescribing of medicines; the management of controlled drugs; the management and storage of medical emergency equipment; and the arrangements in relation to Infection Prevention and Control (IPC).

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	6	7

We identified six areas for improvement against the regulations in relation to:

- the role and function of a Medical Director position;
- medical governance;
- practising privileges;
- quality indicators and audit programme;
- the overview of staff training; and
- the arrangements in relation to IPC.

We identified seven areas for improvement against the standards in relation to:

- communication between nursing and medical staff;
- the management of incidents;
- the management of complaints;
- safeguarding training;
- the prescribing of medicines;
- the management of controlled drugs; and
- emergency equipment and medication.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Elizabeth Cuddy, Chief Executive Officer/Responsible Individual, Ms Roberta Wilson, Acting Manager, the Corporate Services Director and a Non-Executive Board Member/Vice Chair during the feedback session on Monday 13 January 2020. The Medical Director was unable to attend the feedback meeting due to planned leave.

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

At the conclusion of the inspection, Mrs Cuddy provided some feedback to the inspection team with respect to the multidisciplinary inspection methodology. Mrs Cuddy stated that the hospice considered the multidisciplinary approach beneficial for the organisation as it produced a detailed assessment of the hospice. We thanked Mrs Cuddy for this feedback.

This inspection did not result in enforcement action.

4.2 Action/enforcement taken following the most recent inspection

No further actions were required following the most recent inspection on 27 March 2019.

5.0 How we inspect

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

- notifiable events since the previous care inspection;
- the registration status of the establishment;
- written and verbal communication received since the previous care inspection; and
- the previous care inspection reports.

Questionnaires were provided to patients and/or their representatives during the inspection on behalf of RQIA. Returned completed patient questionnaires were analysed following the inspection. We invited staff to complete an electronic questionnaire during the inspection. No staff questionnaires were received by RQIA.

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

We met and spoke with the following staff: Mrs Cuddy, Ms Wilson, the Corporate Services Director and a Non-Executive Board Member/Vice Chair, the Medical Director, medical staff, nursing staff, healthcare assistants, allied health professionals (AHPs), the Estates and Facilities Manager, catering staff, housekeeping staff and volunteers.

The inpatient unit and both day hospices were inspected and we were provided with a tour of the three facilities.

A sample of records was examined in relation to the areas inspected.

We provided detailed feedback on our inspection findings as described in Section 4.1 of this report.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection

The most recent inspection of the establishment was an announced care inspection undertaken on 27 March 2019. There were no areas for improvement made as a result of that inspection.

6.2 Inspection findings

6.3 Is the service well led?

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

6.3.1 Clinical and Organisational Governance

We reviewed documentation and discussed the inpatient unit and day hospice services governance arrangements with a number of staff including: Mrs Cuddy, Ms Wilson, Corporate Services Director, the Medical Director, medical staff and nursing staff. We undertook a detailed review of the current arrangements for governance and managerial oversight and identified a number of areas which required to be strengthened relation to the overarching governance structure and the medical governance arrangements within the hospice.

We were informed by Mrs Cuddy that the hospice had undertaken a organisational review including their governance arrangements and had developed an action plan which was being brought before the hospice Board of Trustees for approval at their next meeting.

Mrs Cuddy advised that the hospice had completed a review of its governance capabilities at Board level. After completing a skills audit and identification of potential skill areas needing improvement the hospice completed a publicly advertised recruitment process for new Board Members. The result was, that at the time of the inspection, four Board members had stepped down and six new members had been appointed with a further three new members joining in January 2020.

Mrs Cuddy told us a new committee structure had been agreed and the terms of reference for each committee were going to the Board of Trustees later in January 2020. The new Committees were Clinical Governance, Resources, Audit and Risk, Remuneration and Nominations. Mrs Cuddy informed us that the terms of reference for each committee were in the process of being completed.

6.3.2 Management of Operations

The SAHS is the registered provider and St Johns House is registered to include the in-patient hospice service and two day hospice services for adults. One day hospice service is based in the St Johns House on the Newry site and operates four days per week and one day hospice service is based at the South Tyrone Hospital, Dungannon and operates on a Tuesday and Wednesday.

We discussed the operational management arrangements of SAHS with the senior management team. We confirmed that currently one registered manager is responsible for both the inpatient service and day hospice services within SAHS. Having considered the complexity of the services, we recommended that a change in registration is considered in relation to the current hospice service provision. We advised that one registration should be in respect of the in-patient service and a separate registration applied for in respect of the two day hospice services. This arrangement would enable the hospice management team to strengthen the management structure and provide a better oversight of governance issues.

We advised that the services would be expected to have a separate registered manager coming forward for registration. Mrs Cuddy agreed with our determination and advised that the hospice had already considered splitting the registration of SAHS and increasing the Registered Managers as part of their organisational review. Mrs Cuddy agreed to submit an application to RQIA to separate the registration of the inpatient and day hospice services.

We discussed with the senior management team the variation application which had been submitted previously in relation to opening a further day hospice service in Lurgan. We advised that the application was no longer current and we highlighted that the hospice needed to focus on strengthening the governance arrangements within the services currently provided before consideration is given to expansion of the SAHS. Mrs Cuddy agreed with our determination and advised that they had already considered withdrawing this application. Following the inspection we received confirmation from the hospice that this application had been withdrawn.

6.3.3 Clinical Governance

We reviewed the role and function of the Board of Trustees in relation to the governance structures of the hospice. We reviewed information sent to and from the Board of Trustees. We could not evidence agile or relevant reporting and no evidence that Key Performance Indicators have been developed and shared with the Board of Trustees.

We advised that this reporting structure should be reviewed and further developed. Information provided to the Board of Trustees should be shared with RQIA for a period of three months following the inspection.

As previously outlined in section 6.3.1 the hospice had restructured their Board of Trustees to strengthen their governance arrangements.

We reviewed the medical governance arrangements within the hospice and met with some members of the senior management team including the Medical Director. Through these discussions we were unable to identify how role of a Medical Director was being utilised at an operational level and how it was incorporated into the overall governance, quality improvement and assurance systems of the hospice. We found that due to clinical committments the Medical Director was not involved in overseeing medical staff working in the hospice, or had oversight of their annual appraisals. We also identified that role of the Medical Director did not include the analysing of incidents/notifiable events that should be reported to RQIA or to the hospice Board of Trustees. We highlighted that having oversight of incidents/notifiable events from the Medical Director would strengthen governance arrangements and the learning outcomes for the hospice.

We discussed the role of a Medical Director with the hospice and agreed that the role and function of a Medical Director position needs to include responsibility for medical staff working in the hospice, patient safety, oversight of annual appraisals for medical staff, oversight of incidents/notifiable events and for reporting quality of care and patient safety issues to the hospice Board of Trustees. We discussed the importance of a Medical Director's role in providing strong medical leadership and advising the Board of Trustees and executive team regarding best practice. We highlighted the importance of this type of role providing a key link between the hospice and the Health and Social Care (HSC) Trust. An area for improvement against the regulations in relation to medical governance has been made.

All medical practitioners working within the hospice must have a designated Responsible Officer (RO). In accordance with the General Medical Council (GMC) all doctors must revalidate every five years.

The revalidation process requires doctors to collect examples of their work to understand what they're doing well and how they can improve. Experienced senior doctors (called Responsible Officers) work with the GMC to make sure doctors are reviewing their work. As part of the revalidation process RO's make revalidation recommendations to the GMC. Where concerns are raised regarding a doctors practice information must be shared with their RO who then has a responsibility to share this information with all revelant stakeholders in all areas of the doctors work.

We established that all medical practitioners working within the hospice have a designated external RO due to their prescribed connection with another health care organisation. We discussed with Mrs Cuddy how concerns regarding a doctor's practice are shared with the wider HSC. We advised that the hospice should strengthen their links with the external RO's and the regional RO network.

We were advised that currently two Consultants work in the hospice, one of which is a Medical Director and one is an employee of the Southern Health and Social Care Trust (SHSCT) along with a range of General Practitioners (GPs) with palliative care experience. We were informed that there was a vacant position for one Palliative Care Consultant (also employed by the SHSCT) and currently the two Consultants were providing medical cover every day between them. We were informed that the SHSCT had tried on more than one occasion to recruit Consultants for the hospice and so far had been unsuccessful in this endeavour.

The Medical Director described to us the challenges faced, due to the clinical commitments, by the Consultants under the current medical model e.g. lack of flexibility, unable to participate in meaningful audit, unable to attend meetings, as their focus is on delivering patient care. We advised that the hospice needed to review the sustainability of the current medical model. Mrs Cuddy informed us that the structure of all care services within the hospice was being examined as part of the organisational review which had been presented to the Board of Trustees for consideration. As previously reported the purpose and aim of the organisational review was to ensure the structures in place facilitate good governance arrangements.

We reviewed the medical staff rota and identified gaps in the General Practitioner (GP) rota and Consultant cover. Mrs Cuddy advised that the hospice were able to fill any gaps internally and at no time did the hospice operate without appropriate medical cover in place.

We reviewed the personnel documentation in relation to the Consultants. Senior management informed us that over time the hospice have inherited a number of different employment arrangements for both Consultants and Medical Officers who work in the hospice. We were advised that some were employed directly by the hospice, some by the HSC Trust and some worked in both the hospice and the HSC Trust. We advised that the arrangements relating to the bi-directional sharing of information about medical staff, between the HSC Trust and the hospice should be reviewed and strengthened.

We found that the annual appraisals of medical staff were mainly undertaken in the HSC Trust. We advised that the hospice should have oversight of the full appraisal documents and revalidation for all medical staff working in the hospice and this information should be reviewed by the Medical Director. This would enable the hospice to have a greater degree of assurance in relation to the medical staff roles and responsibilities. An area for improvement against the regulations has been made to strengthen the medical governance arrangements; to consider becoming a designated body and appointing a Responsible Officer; develop a system to review medical staff annual appraisals and revalidation; and develop a system to share information in respect of medical staff between the HSC Trust and the hospice.

We reviewed the structures in place for the different teams that work in the hospice and the lines of communication between staff. We observed the weekly multi-disciplinary meeting taking place which was attended by various members of the team including doctors, nurses, social workers and allied health professionals. The meeting demonstrated a holistic approach was taken by the hospice in their endeavour to maintain patients in the place of their choice and provide bespoke medical and nursing interventions to support patients and their families.

Outside of the weekly multi-disciplinary meeting to discuss individual patient cases we found little evidence of good multi-disciplinary working. Staff informed us that there was a disconnect between the nursing and medical leadership. Staff reported to us they felt they were working in isolation, particularly in relation to the arrangements for the admission of patients to the inpatient unit by medical staff. We advised that arrangements should be put in place to improve communication between nursing and medical staff and should include the introduction of multi-disciplinary daily safety brief. This safety brief should be incorporated into handovers, held at an agreed time and place and focus on the patients most at risk; as well as all other emerging issues that may have the potential to impact on the provision of services. We also suggested that debriefing sessions should be arranged for the multi-disciplinary team to attend to support staff in the aftermath of incidents or deaths occurring. An area for improvement against the standards has been made in relation to improving communication between nursing and medical staff.

6.3.4 Practising Privileges

As outlined in section 6.3.3, the hospice has varied arrangements in place regarding how they engage the services of medical practitioners. In line with the legislation a medical practitioner can only work in the hospice under a direct contract of employment or under a practising privileges agreement. We confirmed that a number of medical practitioners were working in the hospice however we were not able to evidence if these staff had direct contracts of employment or practising privileges agreements in place.

Where a medical practitioner does not have a direct contract of employment with the hospice, robust arrangements must be in place for the application, granting, maintenance and withdrawal of practising privileges.

The hospice must undertake a full review of how each medical practitioner is employed to determine if any staff member requires to have a practising privileges agreement in place as outlined in Standard 11 of Minimun Care Standards for Independent Healthcare Establishments, July 2014. An area for improvement against the regulations has been made in this regard.

We were able to evidence that the hospice retains a personal file for each medical practitioner That contains all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005.

6.3.5 Quality Assurance

We reviewed the arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals. We found evidence of some audits being carried out to review working practices, mainly in relation to IPC, to ensure that they are consistent with legislation, best practice guidance and the hospice policies and procedures. We found that action plans were not always developed to address shortfalls identified during the audit process or reaudits scheduled and there was a lack of involvement from the medical staff in the audit programme.

We highlighted that an important aspect of auditing is escalation through the hospice's governance system and to the Board of Trustees and dissemination of learning arising from the audit to staff to influence care and practice.

We found that the audit programme needs to be revised and strengthened to be more meaningful in identifying and addressing issues. As previously discussed the Medical Director and medical staff should be involved the audit programme.

A core set of key quality indicators should be developed and evidenced through the audit programme. These key quality indicators must be embedded throughout the hospice's governance structures to allow the oversight and assurance of good and best practice throughout the hospice.

Where issues are identified through audit an action plan must be developed and embedded into practice to address any shortfalls identified. The key quality indicators and outcomes of audits and actions required should be shared with staff, governance committee, the senior management team and the Board of Trustess and a record retained of the action taken to address ay shortfalls. An area for improvement against the regulations has been made.

We discussed how data is collected through audit and how this can be analysed using a statistical model and its usefulness as comparative data.

6.3.6 Management of Notifiable Events/Incidents

We reviewed the arrangements in respect of the management of notifiable events/incidents and the notifications submitted to us since the previous inspection. We confirmed that a system was in place to ensure that notifiable events/incidents were investigated and reported to RQIA and other relevant bodies, as appropriate, within a timely manner.

We examined the internal management of some of the incidents and found that these were being dealt with in isolation with little evidence of trend analysis or learning in a multi-disciplinary way that would affect change or influence practice.

We recommended that incidents are reviewed and audited in a meaningful way and the data used to identify trends and themes. Systems should be developed to escalate notifiable events/incidents through the hospice's governance structures and ensure any learning is shared with the multi-disciplinary team. As previously reported under section 6.3.3 we highlighted that having oversight of incidents/notifiable events from a Medical Director would strengthen governance arrangements and the learning outcomes for the hospice. An area for improvement against the standards has been made.

6.3.7 Management of Complaints

We reviewed a copy of the complaints procedure and found this, in general, to be in line with the relevant legislation and DoH guidance on complaints handling. We advised that the complaints procedure should include the contact details of RQIA in line with the legislation. We were informed that a copy of the complaints procedure is made available for patients and/or their representatives. Patients who spoke with us confirmed that they were aware how to raise concerns and staff demonstrated good awareness of complaints management.

We were advised by the senior management team that all complaints were investigated and responded to appropriately. We reviewed a recent complaint and while the complaint had been resolved, records of all communications with the complainant, the result of the investigation, the outcome and any action taken had not been retained. An area for improvement against the standards has been made.

We were informed that any information gathered from complaints was used to improve the quality of services provided.

Areas for improvement – Is Care Well Led?

Areas for improvement were made in relation to strengthening the role and function of the Medical Director; medical governance; communication between nursing and medical staff, practising privileges, the development of key quality indicators and the audit programme, the management of notifiable events/incidents; and the management of complaints.

	Regulations	Standards
Areas for improvement	4	3

6.4 Is care safe?

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

6.4.1 Staffing

We reviewed the staffing arrangements and found that, in general, staffing levels in the inpatient hospice and day hospices services were good and there was sufficient staff in various roles to meet the assessed needs of patients. We observed staff responding to patients in a timely and caring manner.

We found that staff were easily identifiable as they each wore a name badge with their name and profession/designation. Uniforms were also colour coded and identified different professionals and their level of responsibility.

The multi-professional team, included doctors and nurses with specialist palliative care expertise, health care assistants, physiotherapists and social workers. In addition, there was a chaplaincy team who supported the patients and their families by providing holistic and spiritual care and a team of volunteers who provide a variety of non-direct care services.

Staff feedback was generally positive however, staff told us that they would feel better supported by the availability of senior nursing cover on duty at weekends. This was discussed with the senior management team and we were informed that senior management cover is available at weekends however in light of our findings, the availability of senior nursing cover at the weekends would be reviewed.

We were informed that agency staff had been required over the weekend prior to the inspection, due to staff absences at short notice. Staff told us that issues had been identified in relation to the competency and capability of some agency staff employed during this period and their skills in relation to the provision of palliative care. We were advised that this these concerns were raised with the agency providing the staff.

We discussed how the hospice manage staff absences and vacancies with senior management team at the conclusion of the inspection. We were informed that an active recruitment plan was in place to address future staff shortages, as necessary.

Individual training records were available that confirmed that mandatory training is provided and staff, in general, felt content with their levels of training to fulfil the duties of their roles in keeping with the RQIA training guidance. However, we identified deficiencies regarding the oversight and ownership of staff training. We were unable to evidence that a robust system was in place to provide the hospice with an overview of staff training that would clearly identify any training gaps. We were informed that the Human Resource (HR) department have a system in place to record training undertaken. We advised that a more robust system should be developed to provide the senior management team of the hospice with an overview of staff training undertaken. An area for improvement against the regulations has been made.

We confirmed that there are specialist palliative care nurses working in the hospice who have completed a Nursing and Midwifery Council (NMC) recordable specialist practice qualification and other nurses who had completed shorter palliative care courses. We were informed by the senior management team that they will be encouraging and supporting staff to undertake specialist palliative care qualifications in the future.

We reviewed appraisal records for nursing and health care staff and found that appraisals had been completed on an annual basis. Staff reported they were well supported and fully involved in discussions about their personal and professional development.

We found a robust process was in place to review the registration details of all health and social care professionals.

6.4.2 Recruitment and selection

We were told that a number of staff had been recruited since the previous inspection. We reviewed the personnel files for five of these staff members. We confirmed that all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 had been sought and retained.

We reviewed the personnel file of a medical practitioner appointed since the previous inspection and evidenced the following:

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

6.4.3 Safeguarding

We reviewed the arrangements in place for safeguarding of children and adults in accordance with the current regional guidelines. We confirmed that appropriate policies and procedures were in place in relation to safeguarding and protection of adults and children. We advised that the relevant contact details for onward referral to the local HSC Trust should be included in the policies in case a safeguarding issue arise.

We discussed safeguarding with staff and found good general awareness of the types and indicators of abuse along with the actions to be taken in the event of a safeguarding issue being identified. We found that some of the staff were not able to identify who the nominated safeguarding lead was and we advised that the name of the safeguarding lead should also be included in the policies and shared with staff. Staff confirmed that training in safeguarding children and adults had been provided however we were not able to evidence that all staff had undertaken training in safeguarding, at the appropriate level, in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy and the Safeguarding Board for Northern Ireland training and development strategy. An area for improvement against the standards has been made.

We spoke with volunteers in each facilitiy who demonstrated a good awareness of their safeguarding responsibilities. Volunteers were supportive of the initial induction training provided and confirmed that there was a process in place to ensure they attend refresher training sessions.

We discussed the new Mental Capacity Act (Northern Ireland) 2016 with staff and found that staff were not fully aware of the Deprivation of Liberty Safeguards (DOLs) code of practice devised in November 2019 and had not undertaken training in DOLs.

We advised that a policy should be developed in relation to the implementation of new DOLs legislation, staff should be trained in DOL's and any new admissions of patients that lacked capacity should be subject to the new DOLs legislation and protocols. We were advised that the acting manager was undertaking training in DOLs legislation and this training would be subsequently rolled out to other staff.

6.4.4 Management of Medicines

We reviewed the arrangements in place of the management of medicines within the hospice to ensure that medicines are safely, securely and effectively managed in compliance with legislative requirements, professional standards and guidelines.

We observed satisfactory systems for the following areas of the management of medicines: staff training and competency assessment; the majority of medicine records; and the management of the medicines on admission.

We were informed that policies and procedures for the management of medicines were in the process of being reviewed.

We reviewed the completion of the medicines kardex which contained all of the medicines prescribed and administered to patients. We were informed that this document was still in draft form and staff advised that it had been in draft form for a considerable period of time. We advised that a final version of the medicines kardex should be approved and implemented. We recommended that consideration should be given to adopting the regional medicine kardex used by the HSC Trusts.

We found that records of medicines prescribed were generally well completed however, when medicines were prescribed on a "when required" basis the minimum dosage intervals and maximum daily dosages were not always specified. This included Schedule 2 and 3 controlled drugs prescribed for analgesia. As this information is required to enable nurses to make appropriate clinical decisions for administering these medicines an area for improvement against the standards has been made in this regard.

We reviewed the stock control for medicines and the arrangements for ordering and disposing of medicines.

We found that the order form was signed by the prescriber on duty and sent to the pharmacy for dispensing. We reminded staff that any section not completed on the order form should be cancelled out to prevent additional entries being made after the form has been signed.

We reviewed the management of controlled drugs and found that the controlled drugs registers had been fully and accurately completed. Staff advised us that controlled drugs reconciliation checks are completed mid way through the shifts at 03.00 hours and 15.00 hours each day. We advised that these checks should be completed at the end of the shift during handover when responsibility for the safe-keeping of these medicines is passed over to another nurse. An area for improvement against the standards has been made.

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

Due to the complexity of drug regimes for patients admitted to the hospice, we discussed the level of pharmacist support available to the hospice.

We were informed that historically the hospice availed of a pharmacist one day per week but that this service provision had ceased in recent months due to staff changes within SHSCT. Given that there could be a different prescriber each day of the week, due to the medical rota, we highlighted 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. We advised that the pharmacist should also participate in the daily safety briefs when this role has been established.

We outlined that increased pharmacist support could ensure that there are robust medicines audit and review processes in place for medicines management and that reconciliation of medicines is completed on admission and discharge. This would aid the safe management of medicines for patients.

We found that the senior management team of the hospice were very receptive to this advice and advised that they had identified this as an area which required to be addressed and they were in negotiations with the HSCB in relation to increasing the pharmacist support.

6.4.5 Resuscitation and Management of Medical Emergencies

We reviewed the arrangements for the management of medical emergencies and resuscitation in the inpatient unit and found that medical emergency equipment was provided as recommended by the Resuscitation Council (UK) guidelines. However, the emergency equipment was observed to be stored in different areas throughout the hospice and not centralised in one place for easy accessibility.

We advised that the management and storage of medical emergency equipment should be reviewed to ensure that it is easily accessible in the event of a medical emergency.
The revised arrangements should be shared with all staff and included in the resuscitation and management of medical emergencies policies and procedures. An area for improvement against the standards has been made.

We also reviewed the arrangements for the management of medical emergencies and resuscitation in both day hospice sites and spoke with staff at each site. Staff working in the Newry based day hospice told us that in the event of a medical emergency they can access the medical emergency medicines and equipment located in the inpatient unit and summon 999 emergency services, if required.

Staff working in the South Tyrone Hospital based day hospice informed us that in the event of a medical emergency they will immediately summon 999 emergency services, if required. The hospice should review and risk assess the need for the provision of emergency equipment and medication in the day hospice located in South Tyrone Hospital. Staff in both sites stated they have a next of kin contact number for each service user, should a patient become unwell or require emergency medical assistance.

Staff told us that resuscitation procedures and the management of medical emergencies is included in the induction programme and training is updated on an annual basis in keeping with best practice guidance. As previously discussed in section 6.4.1 of this report we found that there was no overarching system in place to identify gaps in training. An area for improvement was made to address this in section 6.4.1.

Staff demonstrated to us that they had a good understanding of the actions to be taken in the event of a medical emergency and the location of medical emergency medicines and equipment.

We discussed the arrangements for patients with a “do not attempt resuscitation” (DNAR) order. Staff confirmed that DNAR decisions are taken by a Consultant in palliative medicine; in line with the hospice policy and procedures. The decision is fully documented in the patient’s care records and includes a date for review of the decision.

6.4.6 Interventional procedures

We were informed that clinical interventional procedures such as blood transfusion, paracentesis and the management of hypercalcaemia are only undertaken in the inpatient unit by Medical Practitioners and not undertaken at either of the day hospice sites.

6.4.7 Infection Prevention Control (IPC) procedures

We found the hospice inpatient unit and day hospices to be generally clean, tidy and well maintained. We reviewed cleaning schedules and cleaning records and found some gaps in the recording of cleaning undertaken. We advised that cleaning schedules should be more robust to include all areas of the environment and the recording of daily, weekly and monthly cleaning should be improved.

We observed IPC information was displayed on notice boards throughout the hospice. In general, good practice was observed in relation to infection prevention and control. However, we observed a member of staff who was wearing jewellery and with finger nails that were not in keeping with best practice.

We advised that staff should adhere to the hospice's hand hygiene and uniform policy and any deviance from this should be identified and addressed by senior staff.

We could not evidence that there were clear lines of accountability for IPC or identify a designated infection control nurse within the hospice. Advice was given on developing links with the local HSC Trust in relation to IPC to ensure that staff remained up to date with current best practice. We advised that the hospice should have clearly identifable lead IPC nurse or obtain expert advice in this area from an experienced IPC practitioner/nurse to support development and implementation of best practice.

We reviewed a range of IPC policies and procedures and staff confirmed that they have been provided with IPC training commensurate with their role.

However, an aseptic non touch technique (ANTT) policy had not been developed and training and competency based assessment on ANTT had not been undertaken by relevant staff. We advised that a policy should be developed in line with best practice and all nursing staff should attend training in relation to ANTT procedures to ensure that current clinical practices in relation to IPC are being implemented.

We were informed that arrangements were in place to ensure the decontamination of equipment and reusable medical devices in line with manufacturer's instructions and current best practice. Staff confirmed single use equipment is used where possible.

We confirmed that IPC audits were being conducted. As previously outlined in section 6.3.5 more robust audit requires to be developed to affect change and influence practice.
We emphasised the importance of evidencing appropriate clinical practices through audit, to provide assurance to the senior management team and the Board of Trustees that clinical practices are being implemented to required standards. An area for improvement against the regulations in relation to IPC has been made.

6.4.8 Environment

We reviewed the environment and found it to be very peaceful and conducive to the delivery of care. We were informed that an ongoing refurbishment program was in place and found this was well advanced.

This included the refurbishment of the premises bathrooms, the in-patient bedrooms and a complete redecoration of the overall premises. We found that, in general, the décor and cleanliness of the premises was to a high standard. In addition, the Newry based day hospice had been repainted during the Christmas break and was commented on favourably by patients and volunteers in that area.

We reviewed building services documents and spoke with the Estates and Facilities Manager. We found that arrangements were in place for maintaining the premises' building services and the environment.

We reviewed the following documents:

- 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;
- LOLER 'Thorough Examination' reports of the premises' stair lifts;
- condition report for the premises' fixed wiring installation;
- condition report for the formal testing of the premises' portable electrical appliances;
- the Legionella Risk Assessment; and
- service records and validation checks for the premises' specialist ventilation systems and piped medical gas systems.

We found that the Legionella Risk Assessment had been undertaken during August 2019 and all required remedial works were subsequently completed and signed off accordingly.

Suitable temperature monitoring of the premises hot and cold water systems was in place with records being maintained as recommended. A full chemical treatment of the premises hot and cold water systems was undertaken on 27 November 2019. Regular bacteriological sampling of the hot and cold water systems was also undertaken and the most recent results on file confirmed that legionella bacteria were not detected. The thermostatic mixing valves throughout the premises were serviced on 13 November 2019.

We reviewed the Fire Risk Assessment and found that it had been undertaken by a suitably accredited fire risk assessor on 19 July 2019. The overall assessment was assessed as 'tolerable' and no significant findings were identified. Through discussion with staff and review of the records we confirmed suitable fire safety training was being delivered and the most recent fire drill had been completed on 2 July 2019. Staff who spoke with us demonstrated that they were aware of the action to be taken in the event of a fire.

We found that the premises' specialised ventilation systems were serviced in accordance with current best practice guidance and suitable validation was undertaken in accordance with the current health technical memoranda. We reviewed records and validation reports which were available at the time of the inspection and found that the kitchen mechanical ventilation ductwork was subject to 'thorough examination' and cleaning on 11 July 2019.

We reviewed records and validation reports which were available at the time of the inspection and evidenced that the premises' piped medical gas systems was serviced in accordance with current best practice guidance and suitable validation was undertaken in accordance with the current health technical memoranda.

We observed that windows throughout the premises were fitted with robust window restrictors in accordance with the current care standards and best practice guidance. However, we recommended that 'tamper-proof' fixings are used to secure these restrictors. We advised that further details in relation to this could be found in the following:

- Health Services Information Sheet No 5 - Falls from windows or balconies in health and social care (https://www.hse.gov.uk/pubns/hsis5.pdf).

The Estates and Facilities Manager gave assurances that this would be acted upon without further delay. We were advised at the conclusion of the inspection that the new 'tamper-proof' fixings had been ordered.

We also observed that several pull cords in the bathrooms were not easily cleaned. We suggested that new anti-microbial pull cords could be implemented and agreed to forward details of these pull cords to the hospice for consideration.

6.4.9 Specialist palliative care team

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

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

We were informed that multi-disciplinary meetings are held weekly to discuss the patient's progress and multidisciplinary records are retained within the patient's care records. Arrangements were in place for ethical decision making and patient advocacy where this is indicated or required.

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

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

Areas of good practice: Is Care Safe?

Areas of good practice were found in relation to staffing, recruitment and selection, the environment and the provision of specialist palliative care.

Areas for improvement: Is Care Safe?

Areas for improvement were identified in relation to managerial oversight of staff training, undertaking the appropriate level of safeguarding training, some aspects of medicines management, the management and storage of medical emergency equipment, and some aspects of the arrangements in relation to IPC.

	Regulations	Standards
Areas for improvement	2	4

6.5 Is care effective?

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

6.5.1 Clinical Records

We reviewed a sample of patients' notes completed by a Consultant and a sample of nursing care records. 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 delivery of the patients' care. We noted a multi-disciplinary, holistic and empathetic approach to patients' care. Care records were found to be contemporaneous, well documented and up to date.

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; and
- records pertaining to previous admissions and community care team, if applicable.

We did not evidence systems in place to audit patient care records. However, we were advised that an audit template has been developed and audits of care records would be implemented in the future.

The senior management team advised that the hospice had read only access to the Northern Ireland Electronic Care Record (NIECR) system. The hospice is considering moving to an electronic care record system.

6.5.2 Records Management

We found the management of records within the hospice to be in line with legislation and best practice.

We reviewed a range of policies and procedures for the management of records which included the arrangements for the creation, use, retention, storage, transfer, disposal of and access to records. Discussion with staff confirmed they had a good knowledge of effective records management.

We reviewed information available for patients on how to access their health records in keeping with the General Data Protection Regulations (GDPR) and confirmed the hospice is registered with the Information Commissioner's Office (ICO).

6.5.3 Care Pathway

We were informed that on admission patients and/or their representatives are given information in relation to the hospice which is available in different formats, if necessary. Referrals can be received from the Palliative Care Team, Hospital Consultant, Nurse Specialist or GP. Patients are provided with information regarding the various assessments that may be undertaken by members of the multi-professional team; this included medical, nursing, physiotherapy, social work and spiritual assessments.

We reviewed the procedure for admissions of patients and through discussion with staff identified that this is currently a medical led model. We were informed by nursing staff that they were not always consulted in relation to admission decisions and as previously reported in section 6.3.3, it was evident that there was a lack of connectivity between the medical staff and nursing staff in relation to the admission of patients and ensuring that the hospice has the ability to adequately meet the needs of the patients. It was suggested that the hospice reviews the admission procedure to ensure a clear pathway for admission to hospice services includes consultation with the entire multi-disciplinary team. An area for improvement was previously made under section 6.3.3 to improve the lines of communication between medical and nursing staff.

6.5.4 Nutrition and Hydration

In the inpatient unit we observed that the meal service was well co-ordinated, with patients receiving their meals in a timely way and being assisted as needed. Nursing staff were responsible for the recording and monitoring of food and fluid intake for each patient.

Feedback from patients was positive in relation to the availability of food and fluids, menu choices and the quality of food served.

We reviewed a sample of menus and found a good choice of nutritious meals offered that included specific meals for patients requiring specialised diets. Meal times were flexible and tailored according to the patient's wishes and needs. Nursing and catering staff in the inpatient unit who spoke with us were familiar with best practice guidance regarding nutrition and the specialised dietary descriptors outlined in the International Dysphagia Diet Standardisation Initiative (IDDSI).

We observed patients attending day hospice at both sites were provided with tea, coffee and scones on arrival and were also provided with lunch before being collected for home.

Meals and snacks are overseen by hospice staff and are served by volunteers. Staff in both sites told us they are informed if a patient has a special dietary requirement and confirmed that on occasion patients with specialised diets would attend day hospice. We found that not all staff in the Newry based day hospice were familiar with IDDSI specialised dietary descriptors and further training may be needed in this area. The senior management team agreed to address this.

6.5.5 Pain Management

We observed evidence of good pain management and control with a holistic approach being applied. Patients and their representatives confirmed that when patients experienced pain, staff responded in a compassionate and timely manner.

6.5.6 Communication

In the inpatient unit and both day hospice sites we observed good communication between staff and patients with patients being treated with dignity and respect. We found that patients were well supported to make decisions about their own care and treatment.

We were informed by staff that there were good relationships between staff and the volunteers in the hospice and found that the volunteer service was being well managed.

Communication between medical and nursing staff was previously discussed in section 6.3.3.

6.5.7 Discharge Planning

We reviewed the discharge policy and procedure and found well developed discharge planning arrangements were in place that required full engagement with patients and/or their representatives.

We were informed that a discharge summary and plan is completed prior to the patient leaving the hospice. A letter is provided to the patient's GP outlining the care and treatment provided within the hospice.

We found that robust systems were in place to ensure that agreed discharge arrangements were recorded and co-ordinated with all services that were involved in the patient's ongoing care and treatment.

Areas of good practice: Is Care Effective?

Areas of good practice were found in relation to the completion of multi-disciplinary care records; the management of nutrition and hydration; pain management; communication between patients, their families and staff; volunteers; and discharge planning.

Areas for improvement: Is Care Effective?

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

	Regulations	Standards
Areas for improvement	0	0

6.6 Is care compassionate?

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

6.6.1 Person Centred Care

We found that excellent care was delivered to the patients which was very patient centred. Patients and their families advised us that they were very happy with the care provided. Compassionate and positive interactions between staff and patients were observed throughout the inspection in all sites. We observed staff introducing themselves to patients and explaining procedures to patients in a kind and caring manner.

We found evidence of meaningful patient involvement in plans of care and treatment, provided in a flexible manner to meet the expressed wishes and assessed needs of each individual patient and their families.

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

6.6.2 Bereavement Care Service

We reviewed the provision of bereavement care within the hospice and found that they have a range of information and support services available. The bereavement services offered by the hospice are managed by the Social Work Team. Staff who spoke with us confirmed that the staff who deliver bereavement care services are appropriately trained and skilled in this area. We found this was an excellent service which provides support at the time of the bereavement and ongoing bereavement care and support as necessary. The multi-denominational Chaplaincy Service available within the hospice provides spiritual support and we found that this was well utilised.

We were informed that counselling and support services are also available for staff. Staff confirmed to us that they are made aware of these services and other support mechanisms in place. As previously reported we suggested that debriefing sessions should be arranged for the multi-disciplinary team to attend in the aftermath of incidents or deaths occurring to provide an additional layer of support to staff, when needed.

6.6.3 Breaking Bad News

We reviewed the policy and procedure for delivering bad news to patients and/or their representatives which is accordance with the Breaking Bad News Regional Guidelines. The hospice retains a copy of the Breaking Bad News Regional Guidelines 2003 and these are accessible to staff.

We spoke with staff who confirmed that bad news is delivered to patients and/or their representatives by professionals who have experience in communication skills and act in accordance with the hospice's policy and procedure. Where this news is shared with others, staff confirmed that consent must be obtained from the patient, where possible, and 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.

We reviewed patient records and found that the delivery of bad news is fully reflected in the care records. Staff confirmed that, with the patient's consent, information was shared with the patient's GP and/or other healthcare professionals involved in their ongoing treatment and care.

6.6.4 Patient Engagement

We reviewed how the hospice engages with patients and/or their representatives and found that this as an integral part of the service they deliver. Patients and/or their representatives are offered the opportunity to provide feedback through a questionnaire. Where required, assistance can be provided.

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

Patients who spoke with us were very positive about the efforts made to obtain their views.

Areas of good practice: Is Care Compassionate?

Areas of good practice were found in relation to the delivery of person centred care, the bereavement care service, breaking bad news and patient engagement.

Areas for improvement: Is Care Compassionate?

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

	Regulations	Standards
Areas for improvement	0	0

6.7 Equality data

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 were discussed. The equality data collected was found to be managed in line with best practice.

6.8 Patient and staff views

We spoke to some of the patients and relatives visiting the inpatient unit. We were told that they felt the care delivered was safe and effective, that they were treated with compassion and that the service was well led.

Four patients, who attend the Newry based day hospice met with us. These patients informed us that the centre allowed them the opportunity to interact with others who were experiencing a similar situation as themselves.

We observed that several activities are arranged within the day hospice each week and on the day of our inspection some of the patients were participating in a general knowledge quiz that had been organised by a volunteer, which they told us they enjoyed.

Patients also described a number of other services and activities they could avail of at the day hospice which included pastoral support and psychotherapy, however they explained the availability of the psychotherapist was influenced by inpatients' demand. If several inpatients requested therapy on one day, day hospice patients would have to reschedule their therapy appointments to another date/time. Overall. we found that the day hospice patients were happy and grateful with the opportunity, care and facilities provided by the hospice.

Questionnaires were provided to patients during the inspection on behalf of RQIA. Four returned completed patient questionnaires were analysed following the inspection. The patients or their relatives indicated that they felt their care was safe; effective; that they were treated with compassion; that the service was well led; and that they were very satisfied with each of these areas of their care.

We invited staff to complete an electronic questionnaire during the inspection. No staff questionnaires were received by RQIA.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Cuddy, Ms Wilson, the Corporate Services Director and a Non-Executive Board Member/Vice Chair during the feedback session on Monday 13 January 2020, as part of the inspection process. The timescales commence from the date of inspection.

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

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

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Independent Health Care Regulations (Northern Ireland) 2005 and The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health (DoH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

7.2 Actions to be taken by the service

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

Quality Improvement Plan	
Action required to ensure compliance with The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Independent Health Care Regulations (Northern Ireland) 2005 and The Minimum Care Standards for Independent Healthcare Establishments (2014)	
Clinical Governance	
Area for improvement 1 **Ref:** Regulation 17 **Stated:** First time **To be completed by:** 6 July 2020	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 scruitiny of medical staff annual appraisals; • have responsibility for reviewing and reporting quality of care and patient safety issues to the hospice Board of Trustees; • 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. **Ref:** 6.3.3
	Response by Registered Person detailing the actions taken: The Chief Executive Officer and Registered Person has reviewed the role and function of the Medical Director as part of the medical governance arrangements. An updating of medical information for each practitioner is underway for 2020/2. Medical management is closely linked to the Southern Health and Social Services Trust and NIMDTA depending on the individual practitioner status. The Hospice is continuing to explore the strengthening of medical governance requirements with the Trust and NIMDTA for all medical staff involved in the Hospice. The Hospice Medical Director provides clinical leadership to the

	Medical Officers. The Hospice Consultant model includes two Trust employed Palliative Care Consultants who also provide clinical support. The Medical Director is fully involved in the Hospice internal governance arrangements including the review of safety and quality information, incidents, complaints and KPIs. **Above partially completed.** A copy of reports regarding patient safety and care quality were forwarded to RQIA for February as part of the overall internal action plan submitted. There were no submissions for March and April due to the exceptional circumstances because of COVID-19 crisis. RQIA have considered action plans submitted by the Hospice since the Inspection and indicated their satisfaction with same. **Completed.**

Area for improvement 2 **Ref:** Regulation 19 **Stated:** First time **To be completed by:** 7 April 2020	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. **Ref:** 6.3.3
	Response by Registered Person detailing the actions taken: There are systems in place to record and review registration, appraisal, and revalidation details monthly. This is managed by the HR department. **Complete.** Medical information for each practitioner and sharing of information between Trust, Hospice and NMIDTA – See comments in 1 above. **Partially completed**
Area for improvement 3 **Ref:** Standard 12.7 **Stated:** First time **To be completed by:** 7 April 2020	The Registered Person shall ensure that arrangements are put in place to improve communication between nursing and medical staff to include the following: • the introduction of multi-disciplinary daily safety briefs incorporated into handovers, held at an agreed time and place and focused on the patients most at risk; as well as all other emerging issues that may have the potential to impact of the provision of services. • the introduction of de-briefing sessions for the multi-disciplinary team to attend in the aftermath of incidents or deaths occurring. **Ref:** 6.3.3
	Response by Registered Person detailing the actions taken: Daily multidisciplinary reviews are well established in addition to the weekly detailed Multidisciplinary Team meetings. There are appropriate mechanisms in place should staff need support following an incident depending on the level of severity with the incident. Debriefings are arranged following significant incidents/events or deaths as a result of an incident. There is also an opportunity to review the previous weeks activity including discharges, transfers and deaths at the weekly multidisciplinary meetings **All complete.**
Area for improvement 4	The Registered Person shall review how all they engage the services of all medical staff and implement a practising

Ref: Regulation 19 (1) **Stated:** First time **To be completed by:** 7 April 2020	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. **Ref:** 6.3.4
	Response by Registered Person detailing the actions taken: The Registered Person and Director of Corporate Services have reviewed the processes around engaging medical staff. A Practicing Privileges policy has been drafted. In addition to the current pre-employment checks, all new medical officers and Trust employees now sign a practicing privileges agreement. **Completed**

Area for improvement 5 **Ref:** Regulation 17.1 **Stated:** First time **To be completed by:** 7 March 2020	The Registered Person shall address the following matters with respect to key quality indicators and the audit programme: • develop a set of key quality indicators that are evidenced by the audit programme and shared with the governance committee and Board of Trustees and record the evidence of action taken to address shortfalls; • involve the Medical Director and medical staff in the audit programme; • ensure that robust arrangements are established to escalate issues identified during the audit process through the hospice's governance structures; • develop a more robust procedure in relation to undertaking audits to ensure these are more meaningful in identifying issues to be addressed; • when issues are identified an action plan should be developed and embedded into practice to address any shortfalls identified. **Ref:** 6.3.5
	Response by Registered Person detailing the actions taken: Current key performance indicators have been enhanced. these now form part of the Acting Registered Manager's Report which is considered at Multidisciplinary Managers Team meetings, Senior Managers Team meeting, the Clinical Governance Committee and then at Board meetings. The Multidisciplinary Team Managers meeting enables clinical and non-clinical audit results to be discussed and actioned. Again audit findings are reported to the person in charge on the day of audit for action and are considered at the following meetings Multidisciplinary Managers Team, Senior Management Team, Clinical Governance Committee of the Board. Areas of concern are revisited and audited again to see if issues have been acted upon. **Completed**
Management of notifiable events/incidents	
Area for improvement 6 **Ref:** Standard 9.3 **Stated:** First time **To be completed by:** 7 April 2020	The Registered Person shall ensure that: • all notifiable events/incidents that occur are reviewed in a meaningful way to identify trends and learning that would affect change or influence practice; and • systems are developed to escalate notifiable events/incidents through the hospice's governance structures and ensure any learning is shared with the multi-disciplinary team; and • the role of the Medical Director includes the management of notifiable events/incidents.

	Ref: 6.3.6
	Response by Registered Person detailing the actions taken: All incidents and accidents including notifiable events to RQIA are reviewed at the time of the incident/event. These are also held on a register and reported on monthly. Monthly incident reports are considered at the Multidisciplinary Managers Team meeting, Senior Management Team meeting, Clinical Governance Committee of the Board. Lessons learned are discussed with any change in practice being agreed and implemented. **Completed**

Management of Complaints	
Area for improvement 7 **Ref:** Standard 7.6 **Stated:** First time **To be completed by:** 7 April 2020	The Registered Person shall ensure that a record is kept of all complaints which includes the details of the complaint, the result of any investigation undertaken, the outcome and the action taken. **Ref:** 6.3.7
	Response by Registered Person detailing the actions taken: The one complaint received in 2019 and examined on the day of inspection did not have the full details of the investigation available. The complaint had been addressed to the complainant in line with the Hospice Complaints Policy and procedures. All complaints are logged, and records held. Complaints are part of the Hospice monthly KPI recording and information shared to various groups and committees as identified above. **Completed.**
Staff Training	
Area for improvement 8 **Ref:** Regulation 18 (2) **Stated:** First time **To be completed by:** 7 April 2020	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. **Ref:** 6.4.1
	Response by Registered Person detailing the actions taken: A central register of all training is held in the HR Department. Each departmental line manager is updated when mandatory training requirements of relevant staff is due to expire. A monthly review by the Registered Manager was to be in place from 01 April 2020. Unfortunately, due to COVID-19 challenges these reviews had not been completed until September 2020. **Partially completed**
Safeguarding	
Area for improvement 9 **Ref:** Standard 3.9 **Stated:** First time time **To be completed by:** 7 April 2020	The Registered Person shall ensure that all staff undertake training in safeguarding adults and children, at the appropriate level, in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy and the Safeguarding Board for Northern Ireland training and development strategy respectively. **Ref:** 6.4.3
	Response by Registered Person detailing the actions taken: Safeguarding training has been reviewed. A small number of staff (4) plus 3 new staff members have to update their existing safeguarding training. All safeguarding training had been

	stepped down by CEC due to COVID – 19. This will be completed through CEC in September 2020 now that their services are fully up and running. **Partially completed**
Management of Medicines	
Area for improvement 10 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 7 February 2020	The Registered Person shall ensure that when medicines are prescribed on a "when required" basis, the minimum dosage intervals and maximum daily doses are clearly specified. **Ref:** 6.4.4
	Response by Registered Person detailing the actions taken: This has now been incorporated into the new medication prescription booklet. **Completed**

Area for improvement 11 **Ref**: Standard 27 **Stated:** First time **To be completed by:** 7 February 2020	The Registered Person shall ensure that controlled drugs reconciliation checks are completed when responsibility for safe custody is transferred at the shift handover. **Ref:** 6.4.4
	Response by Registered Person detailing the actions taken: Reconciliation checks of all schedule 2 controlled drugs have moved to shift handover time. **Completed**
Resuscitation and Management of Medical Emergencies	
Area for improvement 12 **Ref:** Standard 18.3 **Stated:** First time time **To be completed by:** 7 February 2020	The Registered Person shall ensure that: • all emergency equipment is stored in a centralised area of the hospice to ensure that it is readily accessible at all times; and • the medical emergency and resuscitation policy is reviewed to reflect the revised arrangements in relation to the management and storage of emergency equipment provided. • review and risk assess the need for the provision of emergency equipment and medication in the DayHospice located in South Tyrone Hospital. **Ref:** 6.4.5
	Response by Registered Person detailing the actions taken: All emergency equipment now stored in Nurse's station on Hospice Unit 1. Resuscitation Policy updated to reflect a range of emergencies in addition to cardiac arrest. Emergency equipment and medication is currently stored within the Out-Patients Department in South Tyrone Hospital and managed by the Trust. Hospice staff have access to this and are aware of where and how to access this in the event of an emergency. **Complete**
Infection Prevention Control (IPC)	
Area for improvement 13 **Ref:** Regulation 15 (7) **Stated:** First time time **To be completed by:** 7 April 2020	The Registered Person shall strengthen infection prevention and control (IPC) arrangements in the following areas: • cleaning schedules should be more robust to include all areas of the environment and the recording of daily, weekly and monthly cleaning should be improved; • staff adherence to the hand hygiene and uniform policy; • clearly identify a lead IPC nurse within the hospice or obtain expert advice from an experienced IPC

	practitioner/nurse to support development and implementation of best practice; • establish links with the IPC team in the local HSC Trust; • a policy and procedure should be developed and implemented in relation to Aseptic Non-Touch Technique (ANTT) in line with best practice; • all nursing staff should attend training in relation to ANTT procedures to ensure that current clinical practices in relation to IPC are being implemented; and • develop a more robust procedure in relation to undertaking IPC audits and ensure that action plans are developed and implemented which affect change and influence practice. **Ref:** 6.4.7
	Response by Registered Person detailing the actions taken: At inspection an old version of the cleaning schedule for one area was being used. This was resolved on the day of the inspection. One member of staff (who had just started employment on the day of the inspection) was noted to be non-compliant with the Hospice uniform policy. This was addressed at the time of the inspection. The Hospice has two link nurses and there is access to the IPC team at the Southern Trust. However, there have been no link nurse meetings arranged by the Trust for a number of years. In light of the COVID-19 crisis and management of the same, linkages with the Trust IPC team have significantly improved. IPC staff have visited the Hospice to view its arrangements for the management of COVID-19 as a non-acute community based service. The Hospice will continue to use the Regional Infection Control online manual as its source of infection prevention and control policies and procedures. This manual includes information on Aseptic Non-Touch Technique (ANTT) **Complete**

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

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