Unannounced Inspection Report
24 November 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

In respect of hospice services for the 2020/21 inspection year we are moving to a more focused, shorter inspection which will concentrate on the following key patient safety areas:

- review of areas for improvement identified during the previous care inspection;
- management of operations in response to COVID-19 pandemic;
- infection prevention and control (IPC);
- provision of palliative care;
- organisational and medical governance:
- medicine management;
- the environment; and
- patient and staff feedback.

The following additional areas were also inspected:

- safeguarding training; and
- management of emergency medicines and equipment.

Membership of the inspection team

Jo Browne	Senior Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Norma Munn	Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Carmel McKeegan	Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Catherine Glover	Senior Inspector, Medicines Management Team Regulation and Quality Improvement Authority
Gavin Doherty	Inspector, Estates Team Regulation and Quality Improvement Authority
Dr John Simpson	Senior Medical Advisor Regulation and Quality Improvement Authority

2.0 Profile of service

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. Due to the current pandemic, both day hospices have been temporarily suspended.

3.0 Service details

Organisation/Registered Provider: Southern Area Hospice Services **Responsible Individual:** Mrs Elizabeth Cuddy	**Registered Manager:** Mrs Eilish Courtney
Person in charge at the time of inspection: Mrs Elizabeth Cuddy	**Date manager registered:** 31 December 2020
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

An unannounced inspection was undertaken to St Johns House which commenced with an onsite inspection on 24 November 2020. We employed a blended multidisciplinary inspection approach. The onsite element of our inspection was completed on 24 November 2020 by two care inspectors and a senior inspector. A senior medical advisor was also onsite for a short period of time in the afternoon. We provided a list of specific documents to be submitted electronically to our pharmacist inspector and estates inspector on or before Tuesday 1 December 2020 for review remotely. Feedback of the inspection findings was delivered to Southern Area Hospice Services (SAHS) senior management team on 4 December 2020 via teleconference.

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 purpose of this inspection was to focus on the themes for the 2020/21 inspection year. Our multidisciplinary inspection team examined a number of aspects of the establishment including the management of operations in response to COVID-19 pandemic; infection prevention and control (IPC); the provision of palliative care; medicine management; maintenance of the premises and the management and oversight of governance across the organisation. We met and spoke with various staff members, reviewed care practice and reviewed relevant records and documentation used to support the governance and assurance systems.

We determined that the premises were maintained to a high standard of maintenance and décor and confirmed that robust arrangements were in place with regards to 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.

One area for improvement made against the regulations during the previous inspection has not been addressed and will be stated for a second time in relation to the overview of staff training.

Three areas for improvement made against the regulations during the previous inspection were partially met and have been stated for the second time in relation to the review of the role and function of the Medical Director, medical governance and practising privileges.

One new area for improvement against the standards was identified in relation to formalising the role of the Medical Advisory Committee.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	4	1

The four areas of improvement against the regulations comprises one area in relation to training which was not met and three areas which were partially met regarding the review of the role and function of the Medical Director, medical governance and practising privileges. These areas for improvement are stated for the second time within this report.

One new area for improvement against the standards was identified in relation to formalising the role of the Medical Advisory Committee.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Elizabeth Cuddy, Responsible Individual; Mrs Eilish Courtney, Manager; the previous Acting Manager; the Corporate Services Director; and the Chair of Clinical Governance Committee and Board Member; during the feedback session on 4 December 2020 via teleconference, as part of the inspection process. Findings of our inspection are outlined in the main body of the report.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent unannounced inspection dated 5 and 6 January 2020

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 5 and 6 January 2020.

5.0 How we inspect

In response to the COVID-19 pandemic we reviewed our inspection methodology 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 establishments are providing services in keeping with the minimum standards and relevant legislation.

In order to meet with best practice guidance we reduced the number of inspectors and employed a blended multidisciplinary inspection approach. Two care inspectors and a senior inspector undertook an unannounced onsite inspection on 24 November 2020 from 10:15 to 17:45. A senior medical advisor attended the inspection in the afternoon. Prior to the onsite inspection we had determined the information we would require to confirm compliance with the legislation and minimum standards for the areas inspected and were satisfied that this information could be provided to us electronically and reviewed remotely.

At the outset of our inspection on 24 November 2020 we provided SAHS with a list of documents to be sent electronically to our senior pharmacist inspector and estates inspector who were available offsite. Our senior pharmacist inspector and estates inspector reviewed the submitted documents and also held discussions with Mrs Cuddy, Responsible Individual; the previous Acting Manager; and the Support Service Manager by telephone in the days following the onsite inspection.

At the onsite inspection we advised SAHS that any outstanding issues could be followed up by email or teleconference following the on-site inspection in effort to minimise time spent in the premises.

We agreed that formal feedback would be provided to the SAHS senior management team at a mutually agreeable date and time upon completion of our inspection process.

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

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

We were unable to meet with patients on the day of the inspection and we assessed patient feedback by reviewing the most recent patient satisfaction survey completed by SAHS. We invited staff to complete an electronic questionnaire, however, no completed staff questionnaires were submitted to us. Staff and patient feedback is further discussed in section 6.12 of this report.

A poster informing patients that an inspection was being conducted was displayed during the inspection.

During the onsite inspection we met and spoke with Mrs Cuddy; Mrs Courtney; the previous Acting Manager; the Corporate Services Director; nursing staff; healthcare assistants; allied health professionals (AHPs); and housekeeping staff. Following the inspection we also spoke with the Medical Director, the Chair of the Clinical Governance Committee and Board Member, a palliative care Consultant and the Support Services Manager.

We were informed that the day hospice elements of the SAHS were temporarily closed to patients due to the impact of the COVID-19 pandemic.

We undertook a tour of St Johns House in-patient unit including the staff rest areas and examined a sample of records in relation to the areas inspected.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 5 and 6 January 2020

The most recent inspection of the establishment was an unannounced care inspection on 5 and 6 January 2020. The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 5 and 6 January 2020

Areas for improvement from the last care inspection		
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)		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 17 **Stated:** First 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; • 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.	**Partially met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as partially met and is stated for the second time, further detail is provided in section 6.9.2.	
Area for improvement 2 **Ref:** Regulation 19 **Stated:** First 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.	**Partially met**

	Action taken as confirmed during the inspection: This area for improvement has been assessed as partially met and is stated for the second time, further detail is provided in section 6.9.2.	
Area for improvement 3 **Ref:** Standard 12.7 **Stated:** First time	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; and • the introduction of debriefing sessions for the multi-disciplinary team to attend in the aftermath of incidents or deaths occurring.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.6.1.	
Area for improvement 4 **Ref:** Regulation 19 (1) **Stated:** First 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.	**Partially met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as partially met and is stated for the second time, further detail is provided in section 6.9.3.	
Area for improvement 5 **Ref:** Regulation 17.1 **Stated:** First time	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; and • when issues are identified an action plan should be developed and embedded into practice to address any shortfalls identified.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.10.1.	
Area for improvement 6 **Ref:** Standard 9.3 **Stated:** First time	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; • 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.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.9.5.	

Area for improvement 7 **Ref:** Standard 7.6 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.9.6.	
Area for improvement 8 **Ref:** Regulation 18 (2) **Stated:** First 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.	**Not Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as not met and is stated for the second time, further detail is provided in section 6.4.	
Area for improvement 9 **Ref:** Standard 3.9 **Stated:** First time time	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.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.10.1.	
Area for improvement 10 **Ref**: Standard 28 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.7.	

Area for improvement 11 **Ref**: Standard 27 **Stated:** First time	The Registered Person shall ensure that controlled drugs reconciliation checks are completed when responsibility for safe custody is transferred at the shift handover.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.7.	
Area for improvement 12 **Ref**: Standard 18.3 **Stated:** First time	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 day hospice located in South Tyrone Hospital.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.10.2.	
Area for improvement 13 **Ref:** Regulation 15 (7) **Stated:** First time time	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	**Met**

	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.	
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 6.5.	

6.3 Inspection findings

6.4 Management of operations in response to the COVID-19 pandemic

COVID-19 has been declared as a public health emergency resulting in the need for healthcare settings to assess and consider the risks to their patients and staff. We sought assurance of effective governance arrangements in the planning and delivery of IPC measures by reviewing the key areas of collaborative working; COVID-19 risk assessments; the monitoring of staff practices; work patterns; and staff training.

We were informed how the hospice had developed a working group, involving senior management, nursing and medical staff to review and implement measures to promote a COVID-19 safe environment for staff, patients and visitors.

We reviewed a selection of documentation including minutes of meetings; COVID-19 risk assessments; audits of the environment; and staff practices. We confirmed good governance measures were in place for the establishment and maintenance of a COVID-19 safe environment.

We discussed the management of operations in response to the COVID-19 pandemic with the nurse in charge on the day of inspection. We found COVID-19 policies and procedures were in place in keeping with best practice guidance. We reviewed the governance systems and we were informed that communication regarding COVID-19 guidance was provided in a timely manner to all staff at daily staff safety briefs. In addition, we found a COVID-19 file was provided on both in-patient wards for staff reference and staff informed us they could access minutes of IPC meetings online.

We found the IPC leads had developed strategies to incorporate COVID-19 training into IPC training. Discussion with the nurse-in-charge and other staff members indicated that all staff had completed IPC mandatory training. Staff also told us they had completed additional training in donning and doffing of personal protective equipment (PPE) and training on the completion of risk assessments in the workplace had also been facilitated by IPC lead. In relation to the

previous area for improvement 8 outlined in section 6.2 we reviewed staff training records in relation to IPC and found a training matrix was in place to provide an overview of all staff training. However, the training matrix reflected that a low percentage of staff had completed IPC training which was contrary to the information provided to us by staff. We discussed this with the senior management team and were informed the training matrix had not yet been updated to detail of all the IPC training completed.

We advised that training records should be updated and a robust system should be developed to provide the senior management team with an overview of all staff training undertaken. This area for improvement has not been addressed and has been stated for a second time. We were assured by observations of staff application in good hand hygiene practices and in the management and use of PPE that IPC training had been embedded into practice.

During discussion staff demonstrated good knowledge surrounding PPE requirements; environmental cleaning; hand hygiene; and COVID-19 risk assessments. Staff told us that increased frequency of hand hygiene audits and environmental audits were ongoing. We reviewed completed environmental risk assessments and found these to be in line with best practice.

We were informed all patients admitted to the hospice are swabbed for COVID-19 and asked to isolate pending their result. We observed one way systems and social distancing by staff were well adhered to in both clinical and non-clinical areas. We evidenced mechanisms in place at ward level to challenge non-adherence when social distancing measures were breached. Staff told us they would feel confident to challenge anyone not compliant with any aspect of COVID-19 precautions.

We were told visiting arrangements have been reviewed and facilitated in line with the most recent DoH guidance. We confirmed that patients and their family are advised of the visiting arrangements on admission. We observed that the detail of all persons visiting the in-patient unit are logged and retained to enable Public Health Agency (PHA) track and trace if required. We noted PPE was provided to visitors prior to entering the in-patient unit and all visitors were directed to wash their hands by reception staff before entering the ward areas.

We observed staff changing facilities, staff rest areas and nurses stations and found these areas had been included in the COVID-19 risk assessment. Notices were clearly displayed to remind staff the maximum number of staff personnel permitted in each area in accordance with social distancing guidance.

Areas of good practice: Management of operations in response to COVID-19 pandemic

We found that staff were knowledgeable on COVID-19 pandemic restrictions. We confirmed 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 visiting guidance.

Areas for improvement: **Management of operations in response to COVID-19 pandemic**

One area for improvement against the regulations was stated for the second time in relation to developing a robust system to provide the senior management team of the hospice with an overview of all staff training undertaken.

	Regulations	Standards
Areas for improvement	1	0

6.5 Infection prevention control (IPC)

We reviewed arrangements for IPC procedures throughout the hospice to evidence that the risk of infection transmission to patients, visitors and staff was minimised. We found that an infection control committee has been established within the hospice to support development and implementation of best practice and the IPC team lead had established links with the local HSC Trust.

We undertook a tour of the premises and found all areas to be clean, tidy and well maintained. We observed that environmental cleanliness in all areas, clinical and communal, was of a high standard and the environment was well maintained and clutter free. We found that cleaning schedules were in place that included all areas of the hospice and clearly detailed daily, weekly and monthly cleaning protocols. All records had been completed and were up to date.

We observed IPC information was displayed on notice boards in both clinical and non-clinical areas; providing assurance of audit compliance to visitors and staff of a good standard of environmental cleaning. We were provided with evidence and assurance of actions taken if environmental standards were to fall below the expected standard. We observed staff performing best practice in relation to hand hygiene, the use of PPE and adhering to the uniform policy. Hand hygiene posters were displayed for patients, visitors and staff regarding good hand hygiene and hand washing techniques.

We found evidence that regular IPC audits are undertaken. We reviewed a range of IPC audits undertaken in clinical areas including environmental and hand hygiene audits which confirmed good compliance and oversight in these areas. Action plans are developed and implemented to affect change and improve practice, as applicable.

We reviewed a range of IPC policies and procedures and staff confirmed that they have been provided with IPC training commensurate with their role. We were informed that due to the impact of the COVID-19 pandemic the ANTT policy had not been completed within the planned timescale, however, this policy was nearing completion and a copy would be provided to RQIA. On 3 December 2020, RQIA received a copy of the hospice's first draft of the ANTT policy. In addition, we received written confirmation that arrangements had been made for nursing staff to attend training in relation to ANTT procedures. This addresses the previous area for improvement 13 outlined in section 6.2.

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.

Areas of good practice: IPC

We reviewed the current arrangements with respect to IPC practice and evidenced areas of good practice. We were assured of strong governance mechanisms and collaborative working across the hospice. We observed risks being assessed and managed with training and robust auditing measures in place in clinical areas.

Areas for improvement: IPC

No areas for improvement were identified in relation to IPC arrangements.

	Regulations	Standards
Areas for improvement	0	0

6.6 Provision of palliative care

6.6.1 Care pathway

We reviewed the patient care pathway and noted a good multi-disciplinary system for the review of referrals and triage/assessment of patients referred to SAHS. Since the previous inspection, staff advised us that the hospice had reviewed the admission procedure to include consultation with the entire multi-disciplinary team and that this was having a positive effect for patients and staff. We confirmed that staff receive relevant information about the patient prior to their admission.

Referrals can be received from the palliative care team, hospital Consultant, nurse specialist or General Practitioners (GP). Multi-disciplinary assessments are furnished with the referral information through the regional referral arrangements. These systems were found to be robust.

We found patients and/or their representatives are provided with relevant information, either prior to admission or on admission, regarding the hospice and the various assessments that may be undertaken by members of the multi-disciplinary team. This includes medical, nursing, physiotherapy, occupational therapy, social work and spiritual assessments.

We met with staff, reviewed relevant records and confirmed that multi-disciplinary daily safety briefs had been introduced since the previous inspection. These meetings are 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 the provision of services. We confirmed that debriefing sessions had also been introduced for the multi-disciplinary team to attend in the aftermath of incidents or deaths occurring. This addresses the previous area for improvement 3 outlined in section 6.2.

6.6.2 Person centred care

We reviewed two patients' care records and found evidence of 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. We found that care was patient centred.

Accessible facilities were provided to accommodate patients and their family to enable them to spend as much time together, as permissible, in the hospice in keeping with current visiting guidance issued by the DoH.

The hospice has a call system in place for patients to request assistance. We observed the system in operation as staff responded to patients to meet their needs in a timely manner.

We observed compassionate and positive interactions between staff and patients as staff entered and exited patients' rooms.

We found staff introduced themselves to patients and requested permission to enter the patient's room and then went on to explain why they were there in a kind and caring manner.

6.6.3 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. We confirmed that the staff who deliver bereavement care services are appropriately trained and skilled in this area. We found this to be an excellent service which is offered at the time of the bereavement and provides 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. Since the previous inspection, staff debriefing sessions have been undertaken for the multi-disciplinary team to attend in the aftermath of incidents or deaths occurring. Staff told us that this provided a beneficial additional layer of support, when needed.

6.6.4 Breaking bad news

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

We 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, consent must be obtained from the patient, where possible, and is documented in the patient's records. Following a patient receiving bad news, future treatment options are discussed fully with the patient and documented within their individual care records. Staff provide support to the patient and/or their representatives to help them to process the information shared. We reviewed patient records and found that the delivery of bad news is fully reflected in the care records. With the patient's consent, information is shared with the patient's GP.

6.6.5 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 an electronic questionnaire or comment cards. Where required, assistance can be provided from staff to complete the questionnaire.

The information received is made available to patients and other interested parties to read as an annual report. Patient's and/or their representative's feedback is also considered by the senior management team and informs the ongoing quality improvement of services provided.

6.6.6 Discharge

We reviewed the discharge policy and procedure and found robust 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. Daily and weekly multi-disciplinary meetings take place to ensure the patient's individual needs are at the centre of discharge planning.

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: provision of palliative care

We found examples of good practice in relation to care delivery; the management of clinical records; the care pathway including admission and discharge arrangements; patient engagement; and the provision of information to patients.

Areas for improvement: provision of palliative care

No areas for improvement were identified in relation to the provision of palliative care.

	Regulations	Standards
Areas for improvement	0	0

6.7 Medicines Management

We completed the medicines management section of the inspection remotely. The senior management team of the hospice were provided with a self-assessment questionnaire to complete and were requested to submit documents to support the information provided.

We reviewed the arrangements in place for 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 found that appropriate policies and procedures for the management of medicines were in place.

We reviewed a sample of the completion of the medicines kardex which contained all of the medicines prescribed and administered to patients. At the previous inspection, this document was still in draft form. We noted that a final version of the medicines kardex has now been approved and implemented and feedback received on the new style has been positive.

We found that records of medicines prescribed were well completed. The new medicines kardex highlights when medicines are prescribed on a "when required" basis and the minimum dosage intervals and maximum daily dosages are specified. This enables nurses to make appropriate clinical decisions for administering these medicines and addresses the previous area for improvement 10 outlined in section 6.2.

We reviewed the management of controlled drugs. Reconciliation checks for Schedule 2 and 3 controlled drugs are completed at the end of the shift during handover when responsibility for the safe-keeping of these medicines is passed over to another nurse. This addresses the previous area for improvement 11 outlined in section 6.2.

We reviewed the medication audits completed by the previous Acting Manager and found that audits are scheduled to be completed on a six-monthly basis. The last audits were completed in February 2020 and good outcomes were observed.

The frequency of the audits was discussed and it was suggested that smaller and more frequent audits could be completed to give the senior management team the required assurance that medicines are safely managed.

Antimicrobial guidelines have been drafted by the previous Acting Manager; however, an antimicrobial audit has not yet been implemented. We discussed this with the previous Acting Manager and assurances were given that an audit would be developed and implemented.

At the last inspection, we discussed the level of pharmacist support available to the hospice. 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 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. We advised that the pharmacist should also participate in the daily safety briefs when this role has been established and this would aid the safe management of medicines for patients.

We were informed that the Responsible Individual has been working with Health and Social Care Board (HSCB) and the Southern Health and Social Care Trust (SHSCT) to progress this. We were advised that there was an unsuccessful recruitment process undertaken and a pharmacist has not yet been appointed. The senior management team of the hospice are endeavouring to appoint a pharmacist in the near future.

Areas of good practice: medicines management

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

Areas for improvement: medicines management

No areas for improvement were identified in relation to medicines management.

	Regulations	Standards
Areas for improvement	0	0

6.8 Environment

We completed the environment section of the inspection remotely and the senior management team of the hospice were requested to electronically submit relevant documents to our estates inspector. We reviewed building services documents and spoke with the Support Service Manager. We found that satisfactory 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. Regular bacteriological sampling of the hot and cold water systems is also undertaken. The most recent results sampled on 29 June 2020 confirmed that legionella bacteria were not detected.

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. This risk assessment was reviewed on 12 October 2020 by the Service Support Manager and no changes or remedial actions were identified. A further review of the Fire Risk Assessment will be undertaken by the fire risk assessor once the current Covid-19 safeguarding measures are no longer required.

Through discussion with the Service Support Manager and review of the records we confirmed suitable fire safety training was being delivered and the most recent fire drill had been completed on 12 October 2020.

We reviewed records and validation reports which were available at the time of the inspection and evidenced that the premises' piped medical gas systems were serviced in accordance with current best practice guidance. Suitable planned preventative maintenance was undertaken on 21 July 2020, in accordance with the current health technical memoranda.

Areas of good practice: environment

We observed satisfactory systems were in place for all areas of estates management, with suitable contracts in place for the provision of necessary specialist services.

Areas for improvement: environment

No areas for improvement were identified as a result of this inspection.

	Regulations	Standards
Areas for improvement	0	0

6.9 Organisational and Clinical governance

6.9.1 Organisational and clinical governance

We met with Mrs Cuddy, Mrs Courtney, the previous Acting Manager, and the Director of Corporate Services to review and discuss the organisational and clinical governance of the hospice and to assess the progress made in relation to the governance review. We spoke with the Medical Director, the Chair of the Clinical Governance Committee (CGC) and Board member and a palliative care Consultant following the inspection.

We found an organisational structure was in place with clear lines of accountability, defined structures and visible leadership. Staff who spoke with us were able to describe their roles and responsibilities and how they fitted into the overarching governance structures and committees.

The Chair of the CGC spoke positively regarding the new governance systems and confirmed the committee is given robust assurances on safety and is seeing tangible evidence of quality improvement.

We reviewed the new structures and the terms of reference and minutes of the various committees and found that these were functioning well to provide an organisational and multidisciplinary clinical governance system and the required level of assurance to the Board of Trustees. We were advised that the Trustees are able to interrogate the data provided to them and offer appropriate challenge to the senior management team.

Through our conversations with staff at ward level, we were able to see the live governance system working from ward to Board. Overall, we have found an improving picture in relation to organisational and clinical governance, however further work is required to further develop and embed the new systems.

We found that a key development has been the new appointments to the Board of Trustees which have been of great assistance to Mrs Cuddy and the senior management team in refreshing the organisation as a whole and enabling the governance review to progress. We would like to recognise the work undertaken by the senior management team to progress this work during the difficult time of a global pandemic while ensuring that safe, effective and compassionate palliative care continues to be delivered to patients and their families.

We confirmed that the Statement of Purpose and Patient's Guide were kept under review, revised and updated when necessary and available on request.

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

6.9.2 Medical Governance

We examined the medical governance arrangements within the hospice and spoke with the Medical Director; the Chair of the CGC and Board Member; and one of the recently appointed palliative care Consultants. We were unable to meet with other medical staff during the inspection as they were involved in providing direct patient care. We were told that the medical staff were involved in the governance structures of the hospice and felt supported in their role. Feedback received was positive in relation to the safety and quality of care provided, while acknowledging that work is still ongoing in relation to developing and embedding the governance structures.

We found that the CGC is currently undertaking the role and function of a Medical Advisory Committee (MAC) and it was agreed that this would be formalised within the governance structures in line with the legislation and standards. An area for improvement in relation to the standards has been made.

In relation to the previous area for improvement 1 outlined in section 6.2, we were informed SAHS is reviewing the role and function of the Medical Director within the hospice and work is ongoing to progress this. This area for improvement was partially met and is stated for the second time.

However, we found that medical leadership has been strengthened within the hospice since the previous inspection and the Medical Director is fully involved in the governance arrangements including the review of safety and quality information, incidents, complaints and KPIs through attendance at the CGC. Copies of the reports of quality of care and patient safety issues submitted to the hospice Board of Trustees were forwarded to RQIA for February, March and April 2020.

We established that there is a system in place to share information in respect of medical staff with the HSC; however, a system to review the full appraisal of medical staff is still to be developed. Review of the full appraisal should be delegated to a senior medical practitioner within the hospice who scrutinises the document and records this before providing assurance to the MAC that this has been undertaken. Any issues identified as part of this process should be escalated to the MAC to agree next steps and determine any action to be taken. The appraisal sign off sheet only enables the hospice to confirm that the appraisal has taken place. Review of the full appraisal document will provide an additional level of assurance; enable the hospice to develop appropriate scope of practice for practising privileges; will identify the personal development plan (PDP) of the doctor and where the hospice can link in with any further development required, e.g. in relation to the provision of palliative care. The previous area for improvement 2 in relation to medical governance outlined in section 6.2 has been partially met and is stated for the second time.

All medical practitioners working within the hospice must have a designated Responsible Officer (RO). In accordance with the General Medical Council (GMC) all doctors must revalidate every five years. The revalidation process requires doctors to collect examples of their work to understand what they are doing well and how they can improve. Experienced senior doctors (called Responsible Officers) work with the GMC to make sure doctors are reviewing their work. As part of the revalidation process RO's make revalidation recommendations to the GMC. Where concerns are raised regarding a doctor's practice information must be shared with their RO who then has the responsibility to share this information with all relevant stakeholders in the areas of the doctor's work. We established that all medical practitioners working in the hospice have a designated RO. We discussed how concerns would be raised regarding a doctor's practice with the MAC and wider HSC and found that good internal arrangements were in place and the hospice was linked in with the regional RO network.

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

We reviewed the provision of medical practitioners within the hospice to ensure that patients had access to appropriate medical intervention as and when required and determined that the hospice had arrangements in place to meet the needs of the patients accommodated. We found that 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.

6.9.3 Practising Privileges

In line with the legislation medical practitioners can only work in the hospice under a direct contract of employment or under a practising privileges agreement. We confirmed that two medical practitioners were working in the hospice under a joint contract with the Trust.

We found that a practising privileges policy and application form had been developed, however, the policy required further development and where relevant, a practising privileges agreement must be developed and implemented as outlined in Standard 11 of the Minimum Care Standards for Independent Healthcare Establishments, July 2014 and signed by both parties. We were informed that a review of how other medical staff in the hospice are contracted for their services is ongoing. We provided advice and support on the development of practising privileges arrangements, the policy and the agreement. The previous area for improvement 4 outlined in section 6.2 has been partially met and is stated for the second time.

6.9.4 Quality assurance

We found that arrangements were in place to review risk assessments. A corporate risk register and departmental risk registers are maintained and reviewed on a regular basis through the appropriate governance committees.

We found that key quality indicators (KQI) had been developed and were being shared through the governance structures of the hospice and to the Board of Trustees. There was evidence of medical staff being involved in audit and quality improvement, e.g. redesign of the kardex and a review of hospice discharges.

We confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care and treatment delivered to patients at appropriate intervals. The results of audits are analysed and areas identified for improvement are developed into an action plan to ensure any required changes are shared with staff and embedded into practice.

We advised that the next stage would be to use the data from the KQI to target areas for improvement across the hospice and drive the audit programme. We discussed with the senior management team that the clinical audit programme should be formally developed, directed and ratified by the MAC with the results being scrutinised by the medical leaders within the hospice.

We found that 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.

6.9.5 Notifiable events/incidents

We reviewed notifiable events/incidents submitted to us since the previous inspection and found that they were recorded, investigated and reported to us or other relevant bodies, as appropriate, in a timely manner. All 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 affect change or influence practice. We confirmed that the Medical Director has oversight of notifiable events/incidents as a member of the CGC. This addresses the previous area for improvement 6 outlined in section 6.2.

A medical practitioner raised that the incident reporting system could be further developed across all aspects of clinical work so that it could be better used as an intelligence gathering mechanism on safety and quality.

They also highlighted that the quality improvement project on the processes around discharging patients should be helpful in that respect. This was discussed with the senior management team who agreed to take this information into account.

6.9.6 Complaints Management

We reviewed the management of complaints within the hospice and noted that no formal complaints had been received since the previous inspection.

A copy of the complaints policy and procedure was available in the establishment. We found this to be in line with the relevant legislation and DoH guidance on complaints handling. A copy of the complaints procedure is made available for patients/and or their representatives. Staff who spoke with us demonstrated a good awareness of complaints management.

We found that any complaints were investigated and responded to appropriately. Records were kept of all complaints and included details of all communications with complainants; the result of any investigation; the outcome and any action taken. Information gathered from complaints was used to improve the quality of services provided. This addresses the previous area for improvement 7 outlined in section 6.2.

Areas of good practice: Is the service well led?

We found improvements in relation to the organisational and clinical governance arrangements; aspects of medical governance; quality assurance; management of notifiable events/incidents; and complaints management.

Areas for improvement: Is the service well led?

Three areas for improvement against the regulations from the previous inspection were partially met have been stated for the second time in relation to the review of the role and function of the Medical Director, medical governance and practising privileges.

One new area for improvement against the standards was identified in relation to formalising the role of the Medical Advisory Committee.

	Regulations	Standards
Areas for improvement	3	1

6.10 Additional Areas Examined

6.10.1 Safeguarding training

We met with staff, reviewed relevant records and confirmed that the majority of staff had undertaken training in safeguarding adults and children, in keeping with NIASP training strategy and the Safeguarding Board for Northern Ireland training and development strategy respectively.

We were informed that further safeguarding training was arranged to take place during January 2021 and that any staff who had not attended recent training would be encouraged to attend.

This addresses the previous area for improvement 9 outlined in section 6.2.

6.10.2 Management of emergency medicines and equipment

We reviewed the management of emergency equipment and found 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 has been reviewed to reflect the revised arrangements.

We were informed that the day hospice located in South Tyrone Hospital has been closed due to the COVID-19 pandemic. We discussed the arrangements in place in relation to the provision of emergency equipment and medication in this day hospice and we advised that a risk assessment should be undertaken regarding the need for the provision of emergency equipment and medication.

Following the inspection we received evidence that a risk assessment had been undertaken. We have advised that the arrangements for the provision of emergency equipment and medication within the day hospice are included in the day hospice's management of a medical emergency policy.

This addresses the previous area for improvement 12 outlined in section 6.2.

6.11 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. Review of information evidenced that the equality data collected was managed in line with best practice.

6.12 Patient and staff views

We were unable to meet with patients on the day of the inspection and we assessed patient feedback by reviewing the most recent patient satisfaction survey completed by SAHS.

We found the hospice undertakes patient satisfaction surveys on an annual basis. A review of recent patient satisfaction report demonstrated that the hospice pro-actively seeks the views of patients and/or their representatives about the quality of care, treatment and other services provided. The comments we reviewed were in the main extremely positive, however, patient feedback whether positive or raising issues, was observed to be included in the summary report and the feedback is used by the senior management to drive improvements across the service.

We invited staff to complete an electronic questionnaire, however, no completed staff questionnaires were submitted to us.

Total number of areas for improvement

	Regulations	Standards
Total number of areas for improvement	4	1

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; Mrs Courtney; the previous Acting Manager; the Corporate Services Director; and the Chair of Clinical Governance Committee and Board Member during the feedback session via teleconference on 4 December 2020. The timescales commence from the date of inspection.

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

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

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

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

Quality Improvement Plan

Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and The Minimum Care Standards for Independent Healthcare Establishments (2014)

Area for improvement 1 **Ref:** Regulation 18 (2) **Stated:** Second time **To be completed by:** 4 February 2021	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**
	Response by Registered Person detailing the actions taken: Review of Human Resources Information System has been undertaken. The HR System can produce the required reporting. MET
Area for improvement 2 **Ref:** Regulation 17 **Stated:** Second time **To be completed by:** 4 March 2021	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. **Ref: 6.9.2**
	Response by Registered Person detailing the actions taken: The organisation of care services at a senior level continues. Progress has been substanitally delayed due to the impact of the Covid-19 pandemic. The CEO is working with the Board on progressing this to completion over the next few months ensuring continued strong medical leadership is part of this. The Clinical Governance Committee is now well established and has incorporated a Medical Advisory Committee as part of it - see below. A copy of the reports of quality of care and patient safety issues submitted to the Board of Trustees for the period of February, March and April 2020 were submitted to RQIA at that time and no comment was received. Further on page 23 above RQIA reports that this is the

	case. Partially met.
Area for improvement 3 **Ref:** Standard 30.1 **Stated:** First time **To be completed by:** 4 February 2021	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. **Ref: 6.9.2**
	Response by Registered Person detailing the actions taken: The Clinical Governance Committee now incorporates the MAC and its terms of reference have been revised to clearly set out its function. The Board have approved this. RQIA ID: 10667 Inspection ID: IN037217 29 The MAC's terms of reference gives a specific remit for establishing and reviewing practicing priveledges, review of appraisals and revalidation of all medical staff. in addition the MAC considers medical service development, best practice and provides a review of adverse incidents. The MAC also provides medical advise to the Responsible Individual. MET

Area for improvement 4 **Ref:** Regulation 19 **Stated:** Second time **To be completed by:** 4 March 2021	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: 6.9.2**
	Response by Registered Person detailing the actions taken: - in relation point 1 above - Medical Practitioners are required to provide appraisal information. This is partially met. - In relation to point 2 above - as noted in Report findings above at page 23 this is well established. This is met.
Area for improvement 5 **Ref:** Regulation 19 (1) **Stated:** Second time **To be completed by:** 4 March 2021	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. **Ref: 6.9.3**
	Response by Registered Person detailing the actions taken: A Practising Privileges Policy has been developed as detailed in the report above. It has now been reviewed and considered by the Clinical Governance Committee (including the MAC) and the Board have approved it. It will now be implemented in full. Partially Met - will be fully met by end of April

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

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