The Regulation and Quality Improvement Authority

Inspection Report

6 March 2025

Southern Area Hospice Services

Type of Service: Independent Hospital (IH) – Adult Hospice
Address: Courtenay Hill, Newry, BT34 2EB
Tel No: 028 3026 7711

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/; The Independent Health Care Regulations (Northern Ireland) 2005 and the Minimum Care Standards for Independent Healthcare Establishments (July 2014)

1.0 Service information

Organisation/Registered Provider: Southern Area Hospice Services Limited **Responsible Individual:** Mrs Elizabeth Cuddy	**Registered Manager:** Ms Bridget Lynch **Date registered:** 5 October 2023
Person in charge at the time of inspection: Mrs Elizabeth Cuddy	
Categories of care: Independent Hospital (IH) – Adult Hospice PD – private doctor	
Brief description of how the service operates: Southern Area Hospice Services Limited is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital providing in-patient hospice services for up to 14 adults with life-limiting, life-threatening illnesses and palliative care needs. The registration also includes day hospice services for adults with life-limiting, life-threatening illnesses and palliative care. The day hospices operate from two sites, one based in the same site as the inpatient unit in Newry and one based in Dungannon.	

2.0 Inspection summary

An announced inspection was undertaken to the Southern Area Hospice Services which commenced on 6 March 2025 from 10.00 am to 5.30 pm by five care inspectors.

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

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

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

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

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

3.0 How we inspect

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

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

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

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

One week prior to the onsite inspection the hospice was provided with a list of specific documents requesting items to be reviewed remotely in respect of the maintenance of the premises and grounds. These items were to be sent electronically to our estates inspector on or before 14 March 2025 for review remotely.

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

4.0 What people told us about the service?

Posters were issued to the hospice by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire. No completed patient questionnaires were submitted to RQIA following the inspection.

One staff questionnaire was received following the inspection. The respondent indicated that they felt patient care was safe, effective, that patients were treated with compassion and that the service was well led. The respondent also indicated that they were very satisfied with each of these areas of patient care. They also included an additional comment stating they felt the hospice provided a very high standard of care where patients were made to feel very welcome.

All staff spoken with during the inspection spoke about the hospice in positive terms.

During the inspection the inspectors had the opportunity to speak with three patients who stated that they had experienced a very high standard of care delivery and were very pleased with all aspects of the services they received. The patients described the care as excellent, praised the high level of care provided by the staff and described staff as being very prompt to respond to their needs, very respectful and they felt very involved in decisions made regarding their care. They also stated that the hospice provides a very good environment.

Patient feedback was also assessed by reviewing the hospice's most recent patient satisfaction report. Patients were invited to complete a survey via survey monkey and comment on something the hospice was doing well and something that could be improved on. Respondents commented positively on the high standard of care; the quality of the food; the friendliness of staff and being involved in decisions about their care.

5.0 The inspection

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

There were no areas for improvement identified at the last inspection undertaken on 22 February 2024.

5.2 Inspection outcomes

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

The staffing arrangements in respect of the day hospices, the community outreach services and the inpatient unit (IPU) were reviewed.

A multidisciplinary team works in the hospice IPU and comprises of consultants; doctors; nurses; healthcare assistants; occupational therapists; physiotherapists; and social workers with specialist palliative care expertise.

In addition, there is a team of ancillary staff; administrative staff; complimentary therapists and a chaplaincy team supported by volunteers in providing a variety of services.

The hospice community outreach service provides a service to patients and their families in their own home and also in two hospice hubs, one based in Newry and the other in Dungannon. The team is led by a hospice community service manager and a hospice patient and family support manager and staff skills mix includes community hospice nurses, social workers, a counsellor, chaplains, physiotherapist. The community outreach service also includes counselling, bereavement support and an out of hours nursing care at home service. The out of hours nursing care at home is designed to help patients, their families and carers who need end-of-life support in their own home at night-time. The service is available all year round between the hours of 10.00pm and 8.00am to patients living in the Newry city and BT35 postcode area.

Discussions with staff and a review of the duty rotas confirmed that there were sufficient staff in various roles to meet the assessed needs of patients. Staffing levels and morale was good with evidence of effective multi-disciplinary working arrangements and communication between staff. Staff spoke positively about relationships with management and reflected overall a high level of staff morale.

Staff told us they were happy, felt supported and there were good working relationships throughout the hospice. Staff discussed the benefits of effective communication within the hospice and confirmed that they have the opportunity to attend weekly multi-disciplinary meetings; daily handovers; staff de-briefs and team meetings. Staff from community outreach services also outlined methods of communication including monthly staff governance meetings, weekly multi-disciplinary meetings, quarterly staff meetings, staff de-briefs, the recently developed in patient services community meeting, lunch and learn reflective sessions, and spoke of a culture of peer support and learning. Staff noted a number of well received health and wellbeing initiatives including a wellbeing App; complementary therapy ‘re charge you’ sessions for staff; a staff walking group; and the recently introduced ‘office vibe’, a weekly electronic mechanism for staff feedback and recognition.

Discussions with human resources (HR) staff confirmed that the hospice has implemented an electronic HR portal system, which was made available to inspectors during the inspection. This portal records staff mandatory training, continuing professional development (CPD) activities and other learning activities. HR staff advised that the new system provides staff and their line managers with robust ongoing oversight of training uptake enabling management to monitor staff compliance against mandatory training targets.

Staff confirmed that arrangements were in place to ensure they receive appropriate training to fulfil the duties of their role in keeping with the RQIA training guidance. It was confirmed that staff training in basic life support and safeguarding adults and children is organised in conjunction with the Clinical Education Centre (CEC) and the Southern Health and Social Care Trust (SHSCT). Arrangements are in place to secure places on these courses for hospice staff and it was confirmed that this matter is monitored during clinical governance meetings.

The hospice affords staff opportunities to undertake specialist qualifications in palliative care. Additional training options for staff were discussed such as: elder care bereavement; palliative care case studies; the Princess Alice award, programmes to develop communication and therapeutic relationship skills, Postgraduate Diploma in Palliative Care Specialist Award in Social work, Advanced Nurse Practitioner, Acceptance and Commitment Therapy, Shapes of Grief, various one day training courses accessible through the Irish Hospice Foundation, and managerial and leadership training via the Institute of Leadership and Management (ILM).

An induction programme had been developed for each new member of staff which was relevant to their roles and responsibilities. Discussion with a newly recruited member of staff confirmed they felt very well supported throughout their structured induction programme by other staff and managers. The staff member also stated they had opportunity to shadow other team members to further develop an understanding of their role and responsibilities.

A review of a sample of records and discussion with staff evidenced that supervision has been completed on a regular basis and appraisals had been completed on an annual basis. Staff reported they were well supported and fully involved in discussions about their personal and professional development.

It was determined that there were sufficient staff in various roles to meet the assessed needs of patients throughout the hospice services.

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

The arrangements for the recruitment and selection of staff were reviewed.

A recruitment policy and procedure was in place in keeping with legislation and best practice. A staff register was available to review and was found to be up to date and contained staff details in keeping with legislation.

The Southern Area Hospice Services HR department is responsible for collating the required recruitment documents as outlined in the legislation and uploading these to an online HR portal.

A review of a random sample of four personnel files of newly recruited staff included all documentation as outlined in Regulation 19, Schedule 2 of The Independent Health Care Regulations (NI) 2005, as amended.

HR team members confirmed that arrangements are in place to monitor the professional indemnity of relevant staff and the professional registration status of all clinical staff.

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

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

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

Staff spoken with were aware of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified.

The safeguarding lead confirmed she had completed formal training in safeguarding adults in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016) and minimum standards.

Discussion with the safeguarding lead confirmed that arrangements are in place with the Clinical Education Center (CEC) to ensure that staff are enrolled and receive training in safeguarding adults and children, as outlined in the Minimum Care Standards for Independent Healthcare Establishments July 2014.

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

It was confirmed that a copy of the regional guidance document entitled 'Adult Safeguarding Prevention and Protection in Partnership' and regional policy entitled Co-operating to Safeguard Children and Young People in Northern Ireland (October 2024) were available for staff reference.

It was determined that the hospice had appropriate arrangements in place to manage a safeguarding issue should it arise.

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

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

The hospice had undertaken a risk assessment to determine the emergency medication and equipment to be retained on site and as per Resuscitation Council (UK) guidelines.

An up to date management of medical emergencies and resuscitation policy and procedure was in place.

An emergency trolley for the storage of emergency equipment and medicines was provided on level one and level two of the IPU. The equipment was noted to be readily available and in good working order. A daily check list of emergency equipment was available which detailed the emergency equipment and medicines provided. Discussion with staff confirmed that robust arrangements were in place to ensure that emergency medicines are always available in sufficient quantities and within their expiry dates.

It was good to note that protocols for the management of anaphylaxis, hypoglycaemia and tracheostomy management were readily available for staff.

Review of training records and discussion with staff confirmed that resuscitation and the management of medical emergencies is included in the induction programme. As discussed in section 5.2.1 it was confirmed that arrangements are in place with the SHSCT for any hospice staff to attend annual refresher training in basic life support.

Discussion with staff demonstrated that they have a good understanding of the actions to be taken in the event of a medical emergency and the location of medical emergency medicines and equipment.

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

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

The arrangements for IPC procedures throughout the hospice to evidence that the risk of infection transmission to patients, visitors and staff was minimised were reviewed. It was confirmed that the hospice had an overarching IPC policy and associated procedures in place.

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

Dedicated IPC leads were available to advise staff on the management of infection control issues and the completion of IPC audits. Staff confirmed there was good communication between the hospice staff and the IPC leads.

As previously discussed, staff compliance with mandatory IPC training was monitored and kept up to date. Staff who spoke with us demonstrated a good understanding of IPC measures in place.

A range of IPC audits undertaken in clinical areas including, environmental and hand hygiene audits were reviewed and evidenced good compliance and oversight in IPC practices. Staff told us about the actions that would be taken if environmental standards were to fall below the expected standard. Staff were also able to describe the actions they would take to address areas requiring improvement. Staff demonstrated a comprehensive understanding of this.

Excellent standards of environmental and equipment cleaning were also observed. There was a regular programme of environmental auditing and equipment cleaning schedules in place. Discussion with support service staff demonstrated that they were knowledgeable about the daily, weekly and monthly cleaning schedules and records to be completed. They were able to describe the ongoing arrangements concerning cleaning audits.

Good compliance with IPC practices was observed in relation to hand hygiene, equipment cleaning, appropriate use of PPE and donning and doffing. The collaborative approach by all staff in relation to IPC ensured efficiency and consistency in upholding the high standard of IPC practices evidenced throughout the hospice. It was noted that areas of IPC risks were being assessed and managed appropriately with robust auditing measures in place in clinical areas. Arrangements are in place to ensure the all staff adhere to IPC best practice guidance.

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

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

In relation to the provision of palliative care, areas reviewed consisted of the referral process; the admission process; applicable risk assessments; discharge planning; bereavement services; care of the dying; breaking bad news and a review of a sample of care records.

Well established referral procedures were evidenced to be in place. There was a robust multi-disciplinary system for review of referrals and triage/assessment of referrals received by the hospice. Patients and their families/carers are given information in relation to the hospice which is available in different formats, if necessary. Referrals can be received from healthcare professionals such as the palliative care team, hospital consultants, nurse specialists or general practitioners (GP). Multidisciplinary assessments are completed with the referral information through the regional referral arrangements and admission processes are in place to ensure holistic needs of patients are addressed.

On admission, patients and/or families/carers are provided with information regarding the various assessments that may be undertaken by members of the multi-disciplinary team. Staff told us that patients are given time to settle in with the opportunity provided for family members to be involved in the holistic care of the patient. Assessments are undertaken to include medical; nursing; physiotherapy; occupational therapy; complimentary therapy and spiritual assessments within 24 hours when possible.

Staff spoke with great empathy and passion regarding the care they deliver to patients and families involved with the hospice services. Discussion with staff demonstrated an emphasis on addressing patient needs, promoting patient choice and considered involvement of the patient and their families/carers in keeping with best practice guidance. Staff reported a supportive environment with opportunity for growth and development. Staff spoke about good support available regarding multi-disciplinary team meetingsand debriefing.

Staff informed us that a daily multi-disciplinary huddle meeting and a main weekly multi-disciplinary meeting take place. During these meetings patients' admissions, transfers, care and discharge planning are discussed; the needs and wishes of patients' families/carers are also acknowledged and considered. Staff felt these meetings ensure there was good communication and enable the multi-disciplinary team to be fully informed and up to date regarding the individual plan of care for patients.

Three patients' care records were reviewed and were found to be legible and comprehensive. Care plans demonstrated meaningful patient involvement in planning care and treatments and interventions met the expressed wishes and assessed needs of individual patients and their families/carers.

Observation of care practices and discussion with staff evidenced that there was a high standard of care being provided to patients in relation to the management of pain, pressure area care and nutritional needs. Staff had a good knowledge in relation to patient pain assessments and wound management tools in use and the various referrals and interventions which can be made for specialist care when necessary. Staff also demonstrated good knowledge of the various nutritional needs of patients, including alternative methods of hydration and when this is appropriate. It was observed that staff communicated in a kind and respectful manner with patients and treated them with kindness and courtesy.

There was evidence of good practice in the management of syringe drivers and discussion with staff confirmed that there was an adequate number of syringe drivers in place to meet the needs of patients. Discussion with staff confirmed that staff are adequately trained in the management of syringe drivers.

Staff were observed to be prompt in responding to patient needs. Good team work was observed when attending to patient care and responding to patient needs.

The provision of the Hospice Community Outreach Services was discussed with relevant managers and staff. Referrals for the community outreach services, as outlined in section 5.2.1, are all managed by the Patient and Family Support Manager and presented at weekly multi-disciplinary meetings which include Newry and Dungannon hub staff. At this meeting, referrals are triaged and allocated for a holistic needs assessment by a named case lead, and patients care planning is reviewed. An individualised programme of care and support is provided for the patient which is based on the outcome of their needs assessment. Patients can access one to one consultations with a hospice community outreach nurse, physiotherapist, social worker or chaplain as well as complementary therapies and counselling. Community Outreach staff will also assist with accessing a range of relevant external services as required. The community outreach service offers programmes including; creative and memory making workshops; art therapy; living well drop in café; and reflexology sessions. Bereavement services include access to the aforementioned programmes as well as a walking group, a bereavement drop in café, counselling, varied courses of group work throughout the year such as the 7-week Bereavement Journey programme, as well as a monthly family night, for families with children and young people aged under 18 years.

Programmes of care have been developed to help patients understand their illness and prepare for the future, and to support family /carers to share their experiences, build confidence and learn new skills in the caring role. Staff discussed walking groups, the drop-in café, family nights, art therapy and reflexology services that have been developed to support patients, families and carers, as well as the wide range of patient information booklets and practical support provided by the team. Patient information is currently being reviewed to improve readability and the approach to this work has been shaped by learning identified by a member of staff whilst attending the Advance Nurse Practitioner course.

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

There was a policy and procedure for delivering bad news to patients and/ or their families/carers which was in line with best practice guidance. The hospice retains a copy of the guidelines which are accessible to staff. A review of the policy and discussion with staff evidenced that bad news is delivered by professionals who have experience in delivering bad news in a sensitive and compassionate manner. Where news is shared with others, staff confirmed that consent must be obtained from the patient and this is documented in the patient records. Following a patient receiving bad news future treatment options are discussed fully with the patient and documented within their individual care records. Staff spoken with were very aware of the importance of being available to provide support to the patient and families/carers to help them to process the information shared.

The arrangements in relation to discharge planning were reviewed and this evidenced that there was full engagement with patients and/or their families/carers. Discussion with staff demonstrated that there was multi-disciplinary involvement in discharge planning that included daily and weekly meetings to ensure the patient’s needs were at the centre of discharge planning. A comprehensive discharge summary and plan is completed prior to the patient leaving the hospice. A letter is provided to the patient's GP outlining the care and treatment which has been provided.

Robust systems were in place ensuring that agreed discharge arrangements are recorded and co-ordinated with all services that are involved in the patient's ongoing care and treatment.

The current arrangements with respect to specialist palliative care were noted to be of an extremely high standard and adhered to current best practice guidance.

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

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

Staff confirmed that the hospice maintains both electronic and paper records and that all records are stored safely and securely.

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

The multi-disciplinary care records reviewed contained the following:

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

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

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

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

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

5.2.8 How does the hospice ensure the environment is safe?

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

- the fire risk assessment
- service records for the premises fire alarm and detection system
- service records for the premises emergency lighting installation
- service records for the premises portable fire-fighting equipment
- records relating to the required weekly and monthly fire safety function checks
- records relating to staff fire safety training
- records of fire drills undertaken
- Lifting Operations and Lifting Equipment Regulations (LOLER) 'Thorough Examination' reports of the premises' passenger lift and patient hoists
- condition report for the premises' fixed wiring installation
- service records for the emergency backup generator
- report for the formal testing of the premises' portable electrical appliances
- the legionella risk assessment
- water safety scheme control measures
- gas safe certification for the premises heating boilers and catering equipment
- records, validation checks and audits for the premises piped medical gas systems
- records, validation checks and audits for the premises air conditioning systems

The most recent legionella risk assessment was undertaken in October 2023 and all required remedial actions are being addressed within the stipulated timescales. Suitable temperature monitoring of the premises' hot and cold water systems continues in-house with records being maintained as recommended. Regular bacteriological sampling of the hot and cold water systems, most recently undertaken on 6 December 2024, confirmed that legionella bacteria was not detected within the hot or cold water systems.

The most recent review of the fire risk assessment was undertaken on 21 November 2024. The overall assessment was assessed as 'tolerable' and no significant findings were identified. The most recent audit undertaken by the Northern Ireland Fire and Rescue Service on 25 August 2021, found the premises to be 'Broadly Compliant' and no areas for improvement were identified. The most recent fire drill for the premises had been completed on 4 February 2025.

The premises' fixed electrical installation and emergency standby electrical generator continues to be serviced and maintained in accordance with current best practice guidance. The most recent electrical installation condition report was undertaken on 11 July 2024. The passenger lift and patient hoists undergo regular thorough examination with the most recent examination being on 4 January 2024.

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

It was determined that procedures are in place for maintaining the premises, grounds, engineering services and equipment in line with legislation, current standards of best practice and manufacturers' and suppliers' guidance, and that these are regularly reviewed and updated.

5.2.9 Are robust arrangements in place to regarding clinical and organisation governance?

The governance structures were reviewed to include a review of minutes of Board and Clinical Governance Committee meetings and discussion with Mrs Cuddy, chief executive officer (CEO) of Southern Area Hospice Services and responsible individual, and with Ms Lynch, director of care services of Southern Area Hospice Services and registered manager.

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

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

The Board meets approximately seven times a year and will arrange an extraordinary meeting if required. Terms of reference for the operation of the Board were in place. Mrs Cuddy is the company secretary for the Board. It was good to note that each subcommittee is chaired by a member of the Board and that Board members are furnished with all minutes of sub-committee meetings and relevant papers that had been prepared for those meetings. At every Board meeting, the CEO report and the reports for all subcommittees are reviewed and discussed and there is a set agenda for the Board meetings. Review of the Board meeting minutes confirmed that they detail the reports reviewed by Board members and action taken, where necessary.

There are three directors, who are the director of corporate services; the director of care and the director of development, who produce a monthly report concerning their respective areas of responsibility. These monthly performance reports are used to generate the quarterly reports that are presented at the subcommittee meetings. Reports include information about the IPU and community services being provided. These reports include key performance indicators (KPI's) in relation to both the IPU and community services.

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

It was confirmed that policies and procedures are saved on a shared folder that can be accessed from any hospice computer. Access can be restricted to identifiable individuals if necessary, depending on roles and responsibilities. Each of the directors is responsible for the review of identified policies and arrangements were in place to ensure the policies due for review would be prioritised. Where a policy/protocol is amended an email is sent to all staff members to notify them of any changes or updates made to the respective document and staff members must confirm by email that they have read and understood the relevant documents.

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

The MAC is managed by the director of care and the Hospice's lead consultant. Terms of reference for the MAC were reviewed and were found to be in accordance with the Minimum Standards for Independent Healthcare Establishments (July 2014). The minutes of MAC meetings held on 15 January 2025 were reviewed which confirmed that practising privileges is a standing agenda item for MAC meetings. The Clinical Governance Committee receives the minutes and other papers relation to the work of the MAC and recommends the appointment of practising privileges to the Board. The director of care presents the outcome of the MAC meetings at the Clinical Governance Meetings.

It was confirmed that medical staff are either directly employed by the hospice or the SHSCT and that any medical staff not directly employed by hospice are subject to a practising privileges agreement.

Experienced senior doctors, called Responsible Officers, (ROs) work with the GMC to make sure doctors are reviewing their work. All medical practitioners working within the hospice must have a designated RO. Mrs Cuddy confirmed that Southern Area Hospice Services has been approved by the GMC as a designated body and has appointed a RO.

In accordance with the GMC all doctors must revalidate every five years. The revalidation process requires doctors to collect examples of their work to understand what they are doing well and how they can improve. As part of the revalidation process, RO's make revalidation recommendations to the GMC. Where concerns are raised regarding a doctor's practice information must be shared with their RO who then has a responsibility to share this information with all relevant stakeholders in the areas of the doctor's work. It was established that all medical practitioners working in the hospice have a designated RO. A discussion was held around how concerns would be raised regarding a doctor's practice with the MAC and within the wider HSC sector. The hospice has established links with ROs of the doctors working in the organisation.

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

The arrangements for the provision of medical practitioners within the hospice were reviewed to ensure that patients had access to appropriate medical intervention as and when required. This review evidenced that robust arrangements were in place to meet the needs of the patients accommodated. A rota of medical practitioners was easily accessible to inform staff of the doctors working in the hospice and also the arrangements for out of hours cover.

It was noted that the minutes of the hospice governance meetings referenced debrief meetings and these can include patients if appropriate. Multidisciplinary Morbidity and Mortality (M&M) meetings are held regularly and are formally documented. The M&M meetings are open to all staff to discuss patients who received care and treatment/services within the IPU and community. It was confirmed that any learning from the M&M meetings would be shared with relevant staff and the senior leadership team through the governance structures. M&M meetings provide a unique opportunity for health professionals to improve the quality of care offered through the review of case studies.

They also provide clinicians and members of the healthcare team with a routine forum for the open examination of individual events surrounding a patient's death, with a view to sharing any learning and improving practice. Feedback received from staff regarding these meetings was very positive.

It was confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care and treatment delivered to patients at appropriate intervals. There is a rolling audit programme in place. Audit findings and any learning arising from audits are included in the care services report.

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

A system was in place to ensure that urgent communications, safety alerts and notices are reviewed and, where appropriate, made available to key staff in a timely manner.

The hospice has a policy and procedure in place for the management of notifiable events/incidents which includes reporting arrangements to RQIA. Notifications submitted to RQIA since the previous inspection were reviewed. It was confirmed that all notifiable events/incidents were recorded, investigated and reported to RQIA or other relevant bodies, as appropriate, in a timely manner. Incidents are reviewed on a weekly basis and a synopsis of incidents and any learning resulting from incidents is included in the care services report.

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

The hospice has a complaints policy and procedure in place in accordance with the relevant legislation and Department of Health (DoH) guidance on complaints handling. A copy of the complaints procedure is made available for patients/and or their representatives.

It was confirmed that the statement of purpose and patient's guide were kept under review, revised and updated when necessary and made available for all interested parties to read.

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

We would like to recognise the work undertaken by the Board, the SLT and staff of the hospice to progress the strengthening of the governance structures to ensure that safe, effective and compassionate palliative care continues to be delivered to patients and their families.

Overall, the governance structures within the hospice provided the required level of assurance to the SLT and the Board. It was good to note the involvement of Board members on all committees and their commitment to driving continued quality improvement.

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

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

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

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Cuddy, Responsible Individual and Ms Lynch, Registered Manager as part of the inspection process and can be found in the main body of the report.

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