Inspection Report

27 March 2025

Marie Curie Hospice

Type of Service: Independent Hospital (IH) – Adult Hospice
Address: 1a Kensington Road, Belfast, BT5 6NF
Tel No: 028 9088 2000

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: Marie Curie **Responsible Individual:** Mrs Paula Heneghan	**Acting Registered Manager:** Mr Thomas Hughes **Date registered:** Application to be submitted
Person in charge at the time of inspection: Mr Thomas Hughes	
Categories of care: Independent Hospital (IH) Hospice Adult – H(A) Private Doctor - PD	
Brief description of how the service operates: Marie Curie Hospice is a registered independent hospital providing in-patient hospice services for up to 18 adults with life-limiting, life-threatening illnesses and palliative care needs. The Marie Curie community and outpatient's facility operates Monday to Friday 9.00 am – 5.00 pm providing patients and their families with a full range of multi-disciplinary services including visits to patient's own homes by members of team. The Marie Curie community services include Urgent Hospice Care at Home and Hospice Care at Home, these are generalist palliative nursing services which are commissioned in all five Northern Ireland Health and Social Care Trusts. The services provide care and support to adults over the age of 18 years, facilitating choice in where the patient wishes to be cared for at the end of life. The services operate over a 24-hour period with care being delivered by both Marie Curie registered nurses and healthcare assistants who have enhanced training and skills in palliative and end of life care. The Marie Curie community and outpatient services are consultant led providing physical and psychological support including symptom management to patients with palliative care needs from diagnosis to end of life. Since the previous inspection the outpatient service has been further enhanced to facilitate blood transfusion and infusion services for symptom management. The community and outpatient service is provided by a team of palliative care consultants, speciality doctors, physiotherapy, occupational therapy, social work and nursing support and is commissioned for the Belfast and South Eastern Health and Social Care Trust areas.	

2.0 Inspection summary

An announced inspection was undertaken to the Marie Curie Hospice on 27 March 2025 from 10.00 am to 5.00 pm by five care inspectors and a medical adept fellow. The care inspection was followed up with the electronic submission of additional documentation in relation to the premises aspect of the inspection and was reviewed remotely by a RQIA estates inspector. Feedback was provided to the hospice at the conclusion of the inspection.

The purpose of the inspection was to assess compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and the Minimum Care Standards for Independent Healthcare Establishments (July 2014).

Examples of good practice were evidenced in respect of: staffing; staff training; recruitment and selection of staff; safeguarding; management of medicines; infection prevention and control; adherence to best practice guidance in relation to minimising the transmission of respiratory illnesses; the provision of palliative care and the management of the patients' care pathway; engagement to enhance the patients' experience; 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 management team (SMT) 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

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 for review remotely.

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

4.0 What people told us about the service?

Posters were provided to the hospice by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire.

One relative response 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 and included positive comments pertaining to the staff's knowledge, dedication and excellent communication skills and also the high standards of care provided by staff.

No completed staff or patient questionnaires were submitted following the inspection.

Within the hospice patients and/or their representatives are offered the opportunity to provide feedback through a questionnaire and if required, assistance can be provided to complete this. Marie Curie has a national patient experience team that gathers feedback about all services offered. The hospice's patient satisfaction feedback was reviewed which evidenced that patients indicated very positively on the high standard of care; the quality of the food; the friendliness of staff and being involved in decisions about their care.

During the inspection the inspectors had the opportunity to speak with a number of patients who shared how 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, respectful and they felt involved in decisions made regarding their care. They also stated that the hospice provides a very good environment.

Staff spoken with during the inspection spoke about the hospice in very positive terms and indicated that they felt patient care was safe, effective, and that patients were treated with compassion.

Staff spoke in a complimentary manner regarding the support they receive from the SMT.

5.0 The inspection

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

There were no areas for improvement identified at the last inspection undertaken on 6 March 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 Marie Curie inpatient unit (IPU), community and outpatients and the Hospice Care at Home services were reviewed.

The community and outpatient services are staffed by a multi-disciplinary team consisting of specialist doctors, nurses and healthcare assistants who are supported by occupational therapists, physiotherapists, and social workers with specialist palliative care expertise. A bespoke five-week occupational therapy led programme to assist patients to manage fatigue, anxiety and breathlessness has been developed by the service.

Referrals for the service are accepted from general practitioners (GP), hospital palliative care teams, district nurses and other relevant nursing / hospital teams such as lung disease nurses who refer patients to the aforementioned five-week occupational therapy led programme. Staff were particularly keen to comment on a new physiotherapy lead initiative; grant funding has been secured to run three courses of a seven week Positive Parkinson's Programme, which seeks to assist symptom management for patients with Parkinson's disease through group sessions which combine intensive circuit based exercise and education. The education element includes input from hospice occupational therapist, social workers and the Belfast Trusts movement disorder nurses. Arrangements are in place to measure corresponding patient outcomes through measurement tools specific to Parkinson's disease and physical impact.

A multi-disciplinary team works in the IPU of the hospice and comprises of consultants; doctors; nurses; healthcare assistants; occupational therapists; rehabilitation assistant; physiotherapists; complimentary therapists and social workers with specialist palliative care expertise. In addition, there is a team of ancillary staff; administrative staff; and a chaplaincy team. The IPU is supported by volunteers in providing a variety of services.

Discussions with staff and a review of the duty rotas confirmed that there was sufficient staff in various roles to meet the assessed needs of patients.

Staff who spoke with us, told us that they enjoy working in the hospice and that they felt supported in their roles.

Clinical and ancillary staff confirmed that there were good working relationships throughout the hospice. Evidence demonstrated that all members of the multi-disciplinary teams have the opportunity to attend weekly multi-disciplinary meetings; daily handovers; staff de-briefs; team meetings; supervisions and appraisals.

A review of records and discussion with the recently appointed clinical educator confirmed that staff receive appropriate training to fulfil the duties of their role in keeping with the RQIA training guidance and the Marie Curie training and development programme.

The hospice has an online learning and development portal offering a range of training modules. This system can be used to provide hospice staff, and their line managers with robust oversight of training status and will enable the medical director and Mr Hughes to monitor staff compliance with mandatory training.

Discussion with managers in the IPU and community nursing services confirmed the arrangements in place to monitor compliance with mandatory training, noting that it is a standing agenda item on the monthly SMG group meetings and that staff compliance can also be monitored via the Marie Curie learn and develop electronic system. Senior management confirmed that all matters in relation to training compliance is reported to the SMT on a monthly basis.

The hospice affords staff opportunities to undertake specialist qualifications in palliative care. Additional training options for staff were discussed such as: specialist practice in palliative care, the Princess Alice award, level three diploma in health and social care with palliative care modules, advanced nurse practitioner, advanced communication, post graduate diploma in health education, non-medical prescribing and specialist courses relating to loss and bereavement, as well as a two day in-house course for health care assistants on conversation and communication.

An induction programme had been developed for each new member of staff which was relevant to their roles and responsibilities, and which includes shadow shifts and the allocation of a mentor for three months. Appraisals had been completed on an annual basis and a number of group clinical supervision dates are available to nursing staff throughout the year, with community nursing managers reporting a good uptake of same. Nursing staff are required to attend two supervision sessions per year.

Discussion with staff evidenced that there is governance oversight with regards to the regular supervision, revalidation and annual appraisal of medical staff.

Staff reported they were well supported and fully involved in discussions about their personal and professional development.

It was determined that there was 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 policy and procedure was in place in keeping with legislation and best practice.

A staff register was available to review which was up to date and included the names and details of all staff who are and have been employed, in keeping with legislation. The staff register evidenced that a number of staff had been recruited since the previous inspection. A review of a random sample of three personnel files of newly recruited staff evidenced that all the relevant information as listed in Regulation 19, Schedule 2 of the Independent Health Care Regulations (NI) 2005, as amended had been sought and retained.

Recruitment and selection is managed centrally through an electronic system called Oracle. RQIA are aware that Mr Hughes, as the acting registered manager, has oversight of all pre-employment recruitment documentation via the Oracle system.

When a new member of staff is recruited they take part in an induction and undertake training commensurate with their roles and responsibilities. An induction programme had been developed for each new member of staff which was relevant to their roles and responsibilities and a review of records demonstrated that robust arrangements are in place to monitor the professional registration status of all clinical staff.

It was determined that the recruitment and selection of staff is in compliance with legislation and best practice guidance to ensure suitably skilled and qualified staff work in the practice.

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

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

Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm 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 (HSC) Trust should a safeguarding issue arise.

A review of records demonstrated that all staff had received training in safeguarding adults and children as outlined in the Minimum Care Standards for Independent Healthcare Establishments July 2014. Review of records demonstrated that clinical nurse leads, senior managers and the senior social worker had all completed formal level three training in safeguarding adults in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016) and minimum standards.

There was a nominated safeguarding lead. All staff spoken with were knowledgeable about adult and child safeguarding, the types and indicators of abuse, and the actions to be taken in the event of a safeguarding issue being identified.

It was confirmed that a copy of the regional guidance documents entitled ‘Adult Safeguarding Prevention and Protection in Partnership’ was 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.

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, arrangements are in place for hospice staff to attend refresher training in basic life support on an annual basis.

An emergency trolley for the storage of emergency equipment and medicines was provided in the IPU. A daily check list was available which detailed the emergency equipment and medicines provided, including the use of an automated external defibrillator **(**AED**).** The emergency equipment in place was noted to be readily available and in good working order.

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 was demonstrated that satisfactory arrangements were in place for the safe management of medical emergencies.

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

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

Good compliance with IPC practices was observed in relation to hand hygiene and appropriate use of personal protective equipment (PPE). 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.

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 that all staff adhere to IPC best practice guidance.

A range of IPC audits undertaken in clinical areas including hand hygiene and PPE audits were reviewed and evidenced good compliance and oversight with IPC practices. Staff were also able to describe the actions they would take to address areas requiring improvement.

Excellent standards of environmental and equipment cleaning were also observed. There was a regular programme of environmental auditing and 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.

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?

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

Discussion with staff confirmed that there was a robust multi-disciplinary system for review of referrals and triage/assessment of cases referred to the IPU, the community and outpatient team and the Urgent Hospice Care at Home and Hospice Care at Home teams. Referrals can be received from healthcare professions including the palliative care team, hospital consultant, nurse specialist or GP through the routine or urgent pathway. Discussions with staff provided assurances that the referrer is kept up to date with the progress of the referral and the referral is continually reassessed while the patient remains on the waiting list. Patients and/or their representatives are given information in relation to all of the services provided by the hospice which are available in alternative formats, if necessary. Multi-disciplinary assessments are completed with the referral information through the regional referral arrangements. These systems were found to be robust.

Staff spoken with in the IPU confirmed they always receive relevant information about the patient prior to their admission. On admission to the IPU, patients and/or their representatives are provided with information regarding the various assessments that may be undertaken by members of the multi-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, psychosocial, physiotherapy, occupational therapy, complimentary therapy and spiritual assessments.

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

Staff confirmed that care was patient-centred with ongoing review to ensure care is adapted according to assessed need. It was noted that facilities were accessible and visiting arrangements enabled patients and their family to spend as much time together as possible.

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

Discussion with staff evidenced a wide choice of nutritious meals being offered that included specific meals for patients requiring specialised diets, and meal times that were flexible and individually tailored according to the patient's wishes and needs. Patients were extremely complimentary of the quality of food provided and the selection on offer. Nursing and catering staff were familiar with best practice guidance regarding nutrition and the specialised dietary descriptors outlined in the International Dysphagia Diet Standardisation Initiative (IDDSI).

The inspection team observed evidence of good pain management and control. Patients confirmed that when they experienced pain, staff responded in a compassionate and timely manner. Patients also confirmed that symptoms were well managed. Discussion with staff confirmed that pain was assessed daily and prior to routine practices being performed for example: wound dressing and movement, with various pain assessment tools in place. It was also confirmed that the pain management of each patient was a priority and that medical staff were readily available if further pain relief prescriptions were required. Discussion with staff confirmed that pain medication is administered as prescribed in the medicine Kardex and arrangements are in place for pain relief to be prescribed out of hours, if required. Staff confirmed they are adequately trained in medicines management and are competent in the administration of controlled drugs.

There was evidence of good practice in the management of syringe drivers and discussion with staff confirmed that there was an adequate number of syringe drivers in place to meet the needs of patients. There was evidence of a robust system in place to manage the availability and return of syringe drivers when a patient was discharged. Staff also confirmed that alternative methods of pain relief were available to patients in the form of various complementary therapies and pressure relieving devices.

The management of pressure area care was discussed and it was confirmed that various pressure area care assessment tools were in place. A review of a sample of patient care records noted that these assessment tools were completed consistently. Discussion with staff confirmed that there was a patient-centred approach to pressure area care and advised of the various aims of wound care for patients with wounds and pressure sores. Staff had a sound knowledge of wound management and the use of aseptic non-touch technique (ANTT). It was also confirmed that there was an adequate supply of pressure relieving equipment.

Staff also discussed the process for sourcing expert tissue viability advice and dietetics from the local HSC trust when required for patients.

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 a link with external providers. Ongoing bereavement care is available for families and children coping with the loss of a loved one.

Discussion with staff confirmed that staff who deliver bereavement care services are appropriately trained and skilled in this area.

Discussion with staff confirmed there is procedure for delivering bad news to patients and/or their representatives. Conversations with staff confirmed that this procedure was in accordance with the Breaking Bad News regional guidelines 2003.

Staff told us that bad news is delivered to patients and/or their representatives by professionals who are well informed and who act in accordance with the hospice's policy and procedure. Where this news is shared with others, staff confirmed that consent must be obtained from the patient. Following a patient receiving bad news, future treatment options are discussed fully with the patient and documented within their individual care records.

Staff spoken with were very aware of the importance of being available to provide support to the patient and/or their representatives to help them to process the information shared.

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

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

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

5.2.7 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. A range of policies and procedures were in place for the management of records however these were not reviewed during this inspection.

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

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

The multi-disciplinary care records reviewed contained the following:

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

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

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

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

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

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

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

5.2.8 How does the hospice ensure the environment is safe?

Documentation was reviewed in relation to the design, commissioning, validation and ongoing maintenance of the premises mechanical and electrical services.

Discussion with staff demonstrated that suitable arrangements are in place for maintaining the environment in accordance with current legislation and best practice guidance.

The most recent risk assessment, with regard to water borne pathogens in the premises' hot and cold water systems, was undertaken on 4 March 2024, and is currently being assessed and implemented by the service. A water safety audit was undertaken on 6 and 7 August 2024 and the required control measures are being maintained. 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 continues to confirm that legionella and pseudomonas bacteria are not detected.

The fire risk assessment had been undertaken by a suitably accredited fire risk assessor on 6 and 7 August 2024. Records reviewed confirmed that suitable maintenance of all fire safety systems was being maintained. Fire safety training is also being delivered and maintained at the required frequency. Fire drills have been undertaken throughout the year at various times of the day to ensure all staff attend at least one drill annually. The most recent fire drill for the premises was completed on 3 February 2025.

The premises' fixed electrical installation and emergency standby electrical generator continue to be serviced and maintained in accordance with current best practice guidance. The most recent Electrical Installation Condition Report was completed on 22 November 2024, and the installation was deemed 'Satisfactory'. The passenger lift and patient hoist undergo regular thorough examination with the most recent examination completed on 10 October 2024. No defects or observations were noted at this time.

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.

All gas appliances (boilers and kitchen equipment) are subject to regular 'gas safe' inspections in accordance with current legislation. The most recent inspections were undertaken on 7 February 2025.

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 regarding clinical and organisation governance?

The organisational governance structures of the hospice were reviewed. Marie Curie Hospice is part of a well-established UK wide organisation and has clear organisational structures in place and benefits from the support of robust local, regional and national governance structures.

Marie Curie has a clinical governance framework which details how Marie Curie manages clinical governance and defines executive accountabilities and other responsibilities for leading and managing clinical governance. This framework maps out the key governance meetings operating at Board and senior leadership level. Underneath are a series of place-based meetings which take place to address clinical quality and safety, finance, estates, IT, human resources and organisational issues at a local level.

The review of governance structures included a review of committee minutes. The structure of these meetings is agreed at the local leadership team to reflect the needs of the establishment. Each meeting has agreed terms of reference, which includes details on the purpose, membership, chair, secretary, quoracy, frequency, duration, aims and reporting.

The review of the current arrangements for governance and managerial oversight found the arrangements to be robust. Staff reported there were good working relationships and that management were responsive to any suggestions or concerns raised.

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 SMT; Local Advisory Board (LAB) members and the regional SMT.

Each devolved nation has a LAB with direct links to the Marie Curie UK Board. It was good to note that there is a strong emphasis within Marie Curie UK to ensure that each of the devolved nations is represented at corporate governance level.

The Northern Ireland (NI) LAB meets at least quarterly and will arrange an extraordinary meeting if required. Terms of reference for the operation of the LAB were in place.

The chairperson for the LAB is also a Trustee of Marie Curie UK and meets with Mrs Paula Heneghan, Responsible Individual, on a weekly basis; they also represent NI on national committees such as the policy and quality committee and the safety committee. It was good to note that the LAB members actively review their membership and identify skill sets or areas of expertise that would further enhance the LAB for the benefit of the hospice.

It was confirmed that the chief executive, Marie Curie United Kingdom (UK), regularly attends LAB meetings and undertakes sites visits. It was good to note that each local sub-committee provides minutes of sub-committee meetings and relevant papers that had been prepared for those meetings to the LAB members.

Trustees have strong links with the Marie Curie National Board and members of the local SMT report directly to the UK directors.

Review of the minutes of various committees that sit within the governance structure, for example: senior management and governance meetings.

NI oversight and performance group; quality committee; medicine management; and patient and client experience, demonstrated that these committees were functioning well and provide the required level of assurance to the SMT and LAB. The membership of the various committee meetings were representative of the governance structures. It was confirmed that LAB members are able to interrogate the data provided to them and provide appropriate challenge to the SMT, where required.

Organisation learning is discussed at LAB subcommittee meetings at local and regional level and shared with heads of department for dissemination with staff.

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

A team of consultants who have specialist qualifications and skills in palliative care work in the hospice. It was identified that three speciality doctors are considered to be wholly private doctors as they not affiliated with the HSC sector in NI and are not on the GP's performer list in NI. Review of the private doctors' details confirmed there was evidence of the following:

- confirmation of identity
- current GMC registration
- professional indemnity insurance
- qualifications in line with service provided
- ongoing professional development and continued medical education that meets the requirements of the Royal Colleges and GMC
- ongoing annual appraisal by a trained Medical Appraiser
- each doctor/surgeon has an appointed Responsible Officer (RO)
- arrangements for revalidation

Private doctors are required to complete training in accordance with RQIA's training guidance. As previously discussed a training matrix was in place to monitor the status of staff training requirements that included all staff who work in the establishment.

The arrangements concerning medical governance were reviewed. The terms of reference for the Medical Advisory Committee (MAC) were reviewed and these have been developed in accordance with the Minimum Standards for Independent Healthcare Establishments (July 2014). The MAC has an identified quorum and MAC meetings are minuted. The minutes of a MAC meeting held during March 2025 were reviewed and noted to be a detailed account of the topics discussed and decisions made. The medical director chairs the MAC meetings and provides feedback to the NI Caring Services Oversight and Performance group and to the Clinical Reference Group.

All medical practitioners working within the hospice must have a designated RO. In accordance with the GMC all doctors must revalidate every five years. The revalidation process requires doctors to collect examples of their work to understand what they are doing well and how they can improve. Experienced senior doctors (called an RO) 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.

It was confirmed that all medical practitioners working in the hospice have a designated RO. The arrangements for discussing how concerns would be raised regarding a doctor's practice, if applicable with the MAC and wider HSC system, was discussed with the medical director. It was noted that good internal arrangements were in place and the hospice was linked in with the regional RO network.

The medical director issues letters of good standing for medical practitioners whose appraisals are undertaken by GP appraisers. The medical director is actively involved in the recruitment of medical practitioners and reviews relevant recruitment records.

A review of a sample of personnel files held for medical practitioners 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.

Debrief meetings known as multi-disciplinary morbidity and mortality (M&M) meetings are held regularly and are formally documented. It was confirmed that any learning from the M&M meetings would be shared with relevant staff and the SMT through the governance structures at a local and regional level. 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.

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

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

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 actions had been completed. Staff told us that the SMT use this information to drive quality improvement within the hospice.

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

The hospice has a policy and procedure in place for the management of notifiable events/incidents which includes reporting arrangements to RQIA. Notifications submitted to RQIA since the previous inspection were reviewed. It was confirmed that all notifiable events/incidents were recorded, investigated and reported to RQIA or other relevant bodies, as appropriate and in a timely manner.

It was confirmed that any learning from notifiable events/incidents that occurred were reviewed through the governance structures of the hospice, in a meaningful way, to identify trends and learning that could be used to affect change or influence practice at both local and national levels. A trend analysis report is generated on a quarterly basis. A multi-disciplinary 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. The management of complaints within the hospice was reviewed.

It was evidenced that systems were in place to ensure that any complaints received would be fully investigated and responded to appropriately. Records are kept of all complaints and include details of all communications with complainants; the result of any investigation; the outcome and any action taken. Information gathered from complaints would be used to improve the quality of services provided, if applicable. Staff who spoke with us demonstrated good awareness of how to deal with a complaint, if received.

Where the entity operating a hospice is a corporate body or partnership or an individual owner who is not in day to day management of the service, Regulation 26 unannounced quality monitoring visits must be undertaken and documented every six months. Mrs Heneghan, Responsible Individual, was in day to day control of the hospice therefore Regulation 26 visits are not required.

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.

RQIA would like to recognise the work undertaken by the LAB members, the SMT and staff of the hospice to progress the strengthening of the governance structures while ensuring that safe, effective and compassionate palliative care continues to be delivered to patients and their families.

Overall, the governance structures within the hospice provided the required level of assurance to the SMT; LAB members and Marie Curie UK Board of Trustees.

5.3 Equality data

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

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

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Paula Heneghan, Responsible Individual; Mr Thomas Hughes, Acting Registered Manager and other members of the senior management team, as part of the inspection process and can be found in the main body of the report.

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