The Regulation and Quality Improvement Authority

Inspection Report

6 February 2025

Northern Ireland Hospice and Northern Ireland Hospice Adult Community Services

Type of service: Independent Hospital (IH) – Adult Hospice
Address: 74 Somerton Road, Belfast, BT15 3LH
Telephone number: 028 9078 1836

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Northern Ireland Hospice **Responsible Individual:** Mr Trevor McCartney, acting	**Registered Manager:** Mrs Gemma Aspinall **Date registered:** 18 October 2019
Person in charge at the time of inspection: Deputy Head of Adult Services for Northern Ireland Hospice	**Number of registered places:** 18
Categories of care: Independent Hospital (IH) Hospice Adult – H(A) Private doctor - PD	**Number of patients accommodated on the day of this inspection:** 18

Brief description of the accommodation/how the service operates:
The Northern Ireland (NI) Hospice and the NI Hospice Adult Community Services are located in Belfast and share a large site on the Somerton Road. They are purpose built facilities which opened in May 2016.

The NI Hospice
This 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. This service supports patients, their families and provides ongoing bereavement support.

The NI Hospice Adult Community Services
This is a registered day hospice and community based hospice service for adults with life limiting, life-threatening illnesses and palliative care needs. The community hospice service consists of seven specialists palliative care nursing locality teams which operate within the Belfast, Northern and South Eastern Health and Social Care Trusts (HSCT). In addition, there is a Hospice at Home service which operates within the Northern, Belfast and South Eastern HSCTs. It was confirmed by Mr McCartney and the Deputy Head of Adult Services that day hospice services (Hospice HUB) had not resumed since the last inspection, and alternative arrangements for the use of the HUB are under review with the relevant commissioners. The community based and Hospice at Home services had subsequently seen an increase in uptake by patients who appeared to have a preference for localised as opposed to day hospice service provision.

The community teams for South and East Belfast, and North and West Belfast are based in the hospice along with a specialist triage and response team.

Hospice Outreach Services are a multidisciplinary team of medical staff, social workers, physiotherapists and occupational therapists who support the hospice community nurses in family homes. Individualised patient treatment programmes are identified via physiotherapy or occupational therapy assessment, and emotional support can be provided either face to face or remotely by social workers.

Bereavement support services are available via one to one sessions or group programmes, a monthly bereavement drop in café, and tailored bereavement programmes for children and young people.

2.0 Inspection summary

A short notice inspection took place on 6 February 2025 from 10.00 am to 5.30 pm followed by a request for the submission of information electronically.

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; recruitment and selection of staff; safeguarding; infection prevention and control (IPC): 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; clinical and organisational governance; engagement to enhance the patients experience and the maintenance of the environment.

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
- the returned QIP from the previous care inspection

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 RQIA's estates inspector on or before 13 February 2025 for review.

The onsite components of our inspection was completed on 6 February 2025. The onsite inspection team examined a number of aspects of the hospice services as outlined in section 2.0 of this report. The care team undertook a tour of the premises and met with various staff members, talked to two patients, observed care practices and reviewed relevant records and documentation.

Feedback regarding the onsite inspection findings were delivered to the deputy head of adult services and members of the hospice management team on the day of the inspection.

4.0 What people told us about the service

The inspectors had the opportunity to speak with two patients during the inspection who stated that they had experienced a high standard of care delivery and were very pleased with all aspects of the services they received.

Patient feedback was also assessed by reviewing the most recent patient satisfaction surveys completed by the hospice.

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

5.0 The inspection

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

Areas for improvement from the last inspection on 6 and 7 December 2023		
Action required to ensure compliance with Minimum Care Standards for Independent Healthcare Establishments (July 2014)		**Validation of compliance**
Area for improvement 1 **Ref: Standard 25** **Stated: First time**	The responsible individual shall ensure that the management of patients' own medicines which are no longer required, is reviewed, to ensure that they are disposed of in a timely manner.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was confirmed as addressed by the pharmacy inspector following the last inspection.	

5.2 Inspection findings

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 the inpatient unit of the hospice were reviewed. The multi-professional team includes consultants; doctors; nurses; healthcare assistants; occupational therapists; physiotherapists; social workers with specialist palliative care expertise; a pharmacist; and an advanced nurse practitioner. In addition, there is an administrative and an ancillary team; a chaplaincy service; a complimentary therapy service and music therapy all of which support the staff in providing holistic care along with volunteers who provide a variety of services.

The hospice community based service consists of specialist palliative care teams and a hospice at home service. There is a head of adult hospice services who is responsible for the day to day management of the community services. The seven specialist palliative care nursing locality teams and specialist triage and response team are staffed by hospice nurse specialists and hospice community nurses who are supported by consultants in palliative medicine. Community adult services also include bereavement support and hospice outreach services which include specialisms provided by social workers, physiotherapists and occupational therapists.

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 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 daily handover meetings, safety huddles, team meetings and feel supported by management. Staff have the opportunity to be included in decision making and are involved in quality improvement such as reviewing the outcome and learning from quality assurance audits.

Staff agreed that they can raise concerns openly and honestly with management. Staffing levels and morale was good with evidence of effective multi-disciplinary working arrangements and communication between staff.

A recent audit of compliance regarding mandatory training for the inpatient unit and community based staff was reviewed and it was confirmed mandatory training was completed in line with RQIA training guidance. Mandatory training compliance rates were all within acceptable parameters with the exception of annual basic life support training for all staff which was just outside of the compliance parameters. This was acknowledged by management who provided assurance that the identified training sessions were underway and that an increase in compliance had already been noted.

Staff confirmed that a system was in place to ensure they receive appropriate training to fulfil the duties of their role in keeping with the RQIA training guidance. The hospice affords staff opportunities to undertake specialist qualifications, such as the Specialist Practice Qualification, the European Certificate in Essential Palliative Care (in-house) and the Post Graduate Diploma in Palliative Care, a specialist award within social work.

Staff reported they felt supported and are fully involved in discussions about their personal and professional development.

Review of personnel files and discussion with staff confirmed that medical practitioners had appropriate professional indemnity insurance in place and had received the required annual appraisals. A system was also in place to review the registration details of all health and social care professionals.

A review of a medical practitioner's personnel file evidenced the following documents were in place in keeping with legislation and best practice guidance:

- confirmation of identity
- current registration with the General Medical Council (GMC)
- appropriate professional indemnity insurance
- experience in palliative care
- ongoing professional development and continuing medical education that meets the requirements of the Royal Colleges and GMC
- ongoing annual appraisal by a trained medical appraisee
- an appointed responsible officer

It was determined that there was sufficient staff in various roles to meet the assessed needs of patients in the inpatient unit and community.

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

The arrangements in respect of the recruitment and selection of staff were reviewed.

A review of the policy and procedure for the recruitment and selection of staff found that the policy was in accordance with legislation and best practice guidance.

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 two 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.

The NI Hospice has a human resources department which is responsible for gathering and collating the required recruitment documents as outlined in the legislation.

When a new member of staff is recruited they complete an induction and undertake training commensurate with their role and responsibilities. An induction programme had been developed for each new member of staff which was relevant to their roles and responsibilities.

It was determined that robust recruitment and selection procedures were in place to ensure 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.

Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm. 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.

Review of records demonstrated that all staff had received training in safeguarding adults as outlined in the Minimum Care Standards for Independent Healthcare Establishments July 2014.

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 identified safeguarding leads had completed safeguarding training at the level required in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016) and minimum standards. The safeguarding leads are identified to all staff members on a daily basis during the daily safety brief.

It was confirmed that a copy of the regional guidance document entitled Adult Safeguarding Prevention and Protection in Partnership (July 2015) was available for reference.

It was demonstrated that appropriate arrangements were 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. Emergency medicines and equipment were retained in the inpatient unit, as recommended by the Resuscitation Council (UK) guidelines.

An emergency trolley was located in the inpatient unit. The emergency equipment was stored appropriately. A daily check list of emergency equipment and expiry dates was completed. Emergency medicines were stored in their original packaging and expiry dates were visible. Immediate access to the medicines on the emergency trolley, by any member of staff, was possible in the event of a medical emergency occurring.

Review of training records and discussion with staff confirmed that resuscitation and the management of medical emergencies is included in the induction programme. As previously discussed basic life support training for all staff was being monitored by management and assurance was provided that training sessions are underway to ensure all staff received this training on an annual basis.

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.

The arrangements for patients with a “do not attempt resuscitation” (DNAR) order were discussed. It was confirmed that DNAR decisions are taken in line with the NI Hospice policy and procedures, by a consultant in palliative medicine. The decision is fully documented and the patient’s record includes a date for review of the decision.

It was demonstrated that arrangements are in place to ensure the hospice is fully equipped and staff are trained to manage medical emergencies.

5.2.5 Are arrangements in place to minimise the transmission of risk of respiratory illnesses?

We reviewed governance arrangements to seek assurance that effective procedures were in place to minimise the transmission of respiratory illnesses.

There is a nominated infection prevention and control lead who ensures the hospice respiratory illnesses policy, procedures and continuity plans are in place and updated in keeping with best practice guidance. Mitigating actions in relation to the management of respiratory illnesses policies were documented and implemented as necessary to continue to keep the risk of infection and transmission to a minimum in clinical areas and throughout the patient pathway.

The governance arrangements in place were discussed with senior management who stated that timely communications were provided to staff updating them regarding respiratory illness guidance and any issues arising locally via reports, IPC audits, safety briefs, and IPC meetings.

Discussion with staff confirmed they were knowledgeable and aware of current best practice guidance.

It was determined that satisfactory arrangements were in place to minimise the transmission of respiratory illnesses.

5.2.6 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.

During a tour of the premises all areas were found to be clean, tidy and well maintained. Hand hygiene posters were displayed for patients, visitors and staff regarding good hand hygiene and handwashing techniques.

There was a dedicated IPC lead nurse available to advise staff on the management of infection control issues and the completion IPC audits. Staff confirmed there was good communication between the hospice staff and the IPC lead nurse.

As previously discussed, overall staff mandatory IPC training had been audited recently. Areas for improvement identified during any IPC audits were being actioned.

Staff who spoke with us demonstrated a good understanding of IPC measures in place. A range of audits are undertaken in clinical areas that include environmental and hand hygiene audits were reviewed. A review of these audits confirmed good compliance and oversight in IPC practices.

A range of IPC audit scores were displayed to provide assurance of audit compliance to visitors and staff of a good standard of environmental cleaning and IPC practices. This information was displayed on notice boards and discussed at the daily safety briefs. Staff told us about the action 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.

It was confirmed that a policy was in place regarding aseptic non-touch technique (ANTT) and that staff had undertaken both training and competency-based training assessments. Through discussion, staff demonstrated good knowledge and understanding of the application of ANTT into clinical practices and the management of invasive devices.

A system of audit had been implemented regarding the management of invasive devices, with audit results being disseminated to staff through the hospice's governance systems.

Environmental cleanliness was of a high standard and there was a regular programme of environmental auditing of equipment cleaning records and 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 regarding cleaning audits.

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

Review of the current arrangements with respect to IPC practices evidenced areas of good practice. It was noted that areas of IPC risks were being assessed and managed appropriately with robust auditing measures in place in clinical areas.

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.

5.2.7 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. 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, observation of care practices and a review of documentation evidenced that palliative care was delivered in accordance with best practice guidance.

Well established referral procedures were evidenced to be in place. There was a robust multi-disciplinary system for review of referrals and triage/assessment of cases referred to the NI Hospice. Patients and/or their representatives are given information in relation to hospice services 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.

On admission, patients and/or their representatives are provided with information regarding the various assessments that may be undertaken by members of the multi-professional team.

Staff told us that patients are given time to settle in with the opportunity provided for family members to be involved in the holistic care of the patient. Assessments are undertaken to include medical; nursing; social work; physiotherapy; occupational therapy; complementary therapy and spiritual assessments.

A review of patient care records evidenced meaningful patient involvement in plans of care, and treatment was provided in a flexible manner to meet the expressed wishes and assessed needs of individual patients and their families. Patient care records evidenced staff introducing themselves to patients and seeking consent to provide care and treatment on an active basis. Staff and patients confirmed that care was very patient centred with ongoing review to ensure care is adapted according to the assessed need of each patient.

It was noted that facilities were accessible and provided to accommodate patients and their families to enable them to spend as much time together, as permissible, in keeping with current visiting guidance issued by the DoH. Examples of patient centred practice were shared with the inspectors by patients and these were recognised as examples of good practice by the inspection team.

Staff were observed to be compassionate and positive interactions were observed between staff and patients as staff entered and exited patients' 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 and patients, it was evident that patients' needs were being attended to in a timely manner and that patients were exercising choice regarding how their care needs were being met.

The service of the lunchtime meal was well co-ordinated, with patients receiving their meals in a timely way and being assisted as needed.

Feedback from two patients was positive in relation to the availability of food and fluids, menu choices and the quality of food served. The patients noted how staff actively sought to provide a range of menu choices based on patients' preferences. Discussion with staff evidenced good choice of nutritious meals being offered that included specific meals for patients requiring specialised diets, and meal times that were flexible and tailored according to the patient's wishes and needs. It was also confirmed that alternative methods of nutrition are available when required. 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).

Discussion with patients and staff confirmed that arrangements were in place for good pain management and control. Discussion with two patients confirmed that when they experienced pain, staff responded in a compassionate way and in a timely manner. Discussion with staff confirmed that patients' pain levels were 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 medical staff were available if further pain relief was required. Discussion with staff confirmed that arrangements were in place for pain relief to be prescribed out of hours, if required. It was confirmed that pain medication is administered as prescribed in the medicine kardex.

There was evidence of good practice in the management of syringe drivers and discussion with staff confirmed that there were 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 complimentary therapies. Discussion confirmed that nursing staff are adequately trained in medicines management and are competent in the administration of controlled drugs.

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, confirmed that the assessment tools were completed consistently. Discussion with staff confirmed 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 good knowledge of wound management and the use of aseptic non touch techniques. It was also confirmed that there was an adequate supply of pressure relieving equipment, which is ordered and delivered in a timely manner to meet the needs of patients. Staff also discussed the role of the tissue viability nurse and dietician in relation to pressure area care and highlighted the valuable support that these services provide to 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 bereavement support services and group based support 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. Discussion confirmed that staff who deliver bereavement care services are appropriately trained and skilled in this area.

The hospice has a policy and procedure for delivering bad news to patients and/or their representatives which is 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 have experience in communication skills and who act in accordance with the hospice's policy and procedure.

Where this news is shared with others, staff confirmed that consent must be obtained from the patient and this is documented in the patient records. Following a patient receiving bad news, future treatment options are discussed fully with the patient and documented within their individual care record. Staff spoken with were very aware of the importance of ensuring support is provided to patients and/or their representatives to help them to process the information shared.

The arrangements to engage with patients and/or their representatives were reviewed and found to be an integral part of the services delivered. Patients and/or their representatives are offered the opportunity to provide feedback through a questionnaire or feedback / suggestion comment cards. The information received from these questionnaires is collated and made available to patients and other interested parties to read as an annual report. This report is also used by the hospice SMT and informs the ongoing quality improvement of services.

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 multidisciplinary involvement. Daily and weekly meetings take place to ensure the patients' 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 patients 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.

5.2.8 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, in the main, to be in line with legislation and best practice. A range of policies and procedures were in place for the management of records and 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) and EpicCare Link which will enhance communication between the hospice and the Health and Social Care (HSC) sector leading to better continuity of care for patients.

A sample of patients' notes completed by medical staff and nursing staff were reviewed. In the main, there was evidence of an up to date review of each patient, as well as clear decision making by the multidisciplinary team involved in delivery of the patient's care. Review of care records evidenced a multidisciplinary, holistic and empathetic approach to patients care. The multidisciplinary 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 cardiopulmonary resuscitation (DNACPR) orders
- records pertaining to previous admissions and community care team, if applicable.

A sample of medical records were reviewed and it was evidenced that the staff had signed and dated these however in one entry the medical practitioner's GMC registration number was not documented. Some of the nursing care records reviewed evidenced that further development was required in relation to completing fluid balance charts, clinical observation charts and peripheral cannula observations charts. It was also noted that not all patient records were appropriately labelled with the patient's details. These matters were discussed with the SMT members who were receptive to our findings and provided assurances that these matters would be reviewed.

Addressing the issues identified regarding patient care records will enhance the systems in place to ensure that record keeping is in line with legislation and best practice guidance.

5.2.9 How does the hospice ensure the environment is safe?

The review of the environment and building engineering services was completed remotely. A range of building engineering maintenance assurance documents was submitted by the premises maintenance manager, and reviewed by the RQIA estates inspector.

The water safety/legionella risk assessment document was completed by the hospice`s water safety consultant. Control measures and improvements listed in the risk assessment action plan have been implemented to ensure the risk is as low as is reasonably practicable.

The Medical Gas Pipework System HTM 02:01 Authorising Engineer (AE) audit report was dated 19 November 2024. The report action plan recommendations are currently being completed in accordance with AE guidelines.

Lifting equipment was maintained in compliance with the Lifting Operations and Lifting Equipment Regulations (LOLER) and manufacturer`s instructions.

The BS7671 periodic inspection report for the electrical installation was completed on 15 March 2021, was deemed satisfactory and valid for five years.

The 12 December 2024 fire risk assessment was listed as tolerable and reduced too trivial after implementation of the report action plan recommendations. The hospice estates manager confirmed that the 12 December 2024 report action plan items will be addressed.

There were no areas for improvement listed in the environment/estates management review, satisfactory assurances were received confirming that suitable and sufficient controls are being implemented.

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

The governance structures and arrangements were reviewed, and included a review of minutes of meetings of the Board of Trustees. Discussions which took place with the chair of the Board of Trustees and with Mr McCartney included; an overview of governance arrangements; building on an organisational culture of 'patient first'; stakeholder engagement to promote, sustain and develop NI Hospice services; methods of staff engagement including drop in 'let's connect' face to face sessions for staff facilitated by a member of the Board of Trustees or Mr McCartney; volunteer recognition mechanisms; development of the Belfast Community Palliative Hub with Belfast Trust and other palliative care providers.

It was demonstrated that the overall governance structures within the hospice provide the required level of assurance to the SMT and Board of Trustees. The Board of Trustees includes personnel who have expertise in areas of relevance to govern the services provided by NI Hospice. There are defined governance committees in place each of which have a Board member within its quorum. All Board members are furnished with all minutes of sub-committee meetings and relevant papers that had been prepared for those meetings. Board members are committed to be a driving force for continued improvement.

The NI Hospice has implemented an electronic governance system called 'Sentinel'. Sentinel is available on the hospice intranet and is accessible to all staff. Sentinel operates as a live dashboard and can display data in relation to the inpatient unit and the community service. Information in relation to complaints; incidents and corporate policies and procedures are now available on the Sentinel system. Sentinel can generate reports and 'red flag' areas that require SMT review. Data from Sentinel concerning incident; mortality and morbidity (M&M) meetings and complaints and other key performance indicators (KPI's) is used to generate the monthly quality indices report. The dashboard system continues to provide a useful tool for the review of information, comparative data analysis and to share relevant information with all staff and patients, as necessary.

Review of the minutes of various committees that sit within the governance structure (Finance and Business; People and Culture; Care Quality Committee), demonstrated that these committees were functioning well and provide the required level of assurance to the SMT and Board of Trustees. The membership of the various committee meetings was representative of the governance structures.

The Board of Trustees are able to scrutinise the data provided to them and provide appropriate challenge to the SMT, where required. The Board of Trustees review the monthly quality indices reports with relevant information regarding KPI's as well as audit findings.

It was confirmed that organisational learning is discussed at Board of Trustees and subcommittee meetings and shared with heads of department for dissemination to staff. The hospice uses a variety of means to share organisational learning with staff to include; power point presentations; discussion at safety briefs and handovers; emails, memorandums; posters; and hot topic educational events.

It was confirmed that an 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. Through conversations with staff at ward level we were able to see a live governance system working from ward/community team to the SMT and Board of Trustees. A review of the Board of Trustees minutes confirmed that they detail the reports and documents reviewed by them and the action taken.

It was observed that arrangements were in place to develop, implement and regularly review risk assessments. It was confirmed that each of the three directorates have a risk register that feeds into the corporate risk register. These are live documents that are actively reviewed. Plans are in place to migrate the risk assessments to Sentinel.

The Medical Advisory Committee (MAC) is a sub-committee held within the clinical leads forum and areas of focus for the MAC are also discussed within the weekly clinical leads meeting. The terms of reference for the MAC were reviewed and these have been developed in accordance with the Minimum Standards for Independent Healthcare Establishments (July 2014). The MAC has an identified quorum. MAC meetings are minuted and minutes of the most recent MAC meetings held were reviewed and noted to be a detailed account of the topics discussed and decisions made.

Multidisciplinary morbidity and mortality (M&M) meetings are held on a monthly basis and are formally documented within the monthly quality indices report. It was confirmed that any learning from the M&M meetings would be shared with relevant staff and the SMT 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.

All medical practitioners working within the hospice must have a designated responsible officer (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 RO's) 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 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.

We discussed how concerns would be raised regarding a doctors practice with the MAC and within the wider Health and Social Care (HSC) sector and found that good internal arrangements were in place and the hospice was linked in with the regional RO network.

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

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

It was confirmed that medical practitioners are either directly employed by the NI Hospice or have a joint contract between the Hospice and the Belfast Health and Social Care Trust (BHSCT).

An audit programme and audit recording templates are in place. The progression and results of audits are analysed by the clinical audit and quality improvement group which meets quarterly. Action plans are developed to address any deficits, including the name of the person responsible for implementing the action plan and the timeframe. It was good to note that audit schedules, include the various professional disciplines and topics specific to the inpatient unit and adult community services; chaplaincy, pharmacy, social work, allied health professionals, nursing, as well as staff of various grades being involved in the completion of audits, as this increases ownership and accountability amongst staff. Completion dates of action points were documented as well as forward planning of audit programmes. Arrangements are in place that ensure audit findings are shared with relevant staff and committees.

It was established that the quality indices reports (inpatient unit & community services), includes all key quality indicators and these reports are shared with the relevant governance committees.

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

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

Discussion with staff and review of records demonstrated that all subsequent 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 multidisciplinary approach is applied to the review of notifiable events/incidents and the hospice ensures the dissemination of learning to all staff.

Staff described to us that the reporting of incidents is encouraged in an open and transparent way which leads to a no blame culture within the organisation and enhanced learning outcomes.

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

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

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 is used to improve the quality of services provided. All members of the senior management team are trained in complaints handling and all staff undertake complaints training via the Learning Matters portal; the complaints policy is available to staff via Sentinal.

Patients and their relatives / carers are made aware of how to make a complaint via admissions information and can provide feedback on the quality of services provided via various other pathways such as feedback surveys and comment cards. Complaints audits are undertaken routinely and are formally discussed and analysed at Clinical Leads meetings, with learning recorded on Sentinal and shared with relevant members of staff.

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. Mr Trevor McCartney, is not in day to day operational management of NI Hospice inpatient unit or the NI Hospice Adult Community Services. It was confirmed that Mr McCartney undertakes the six monthly monitoring unannounced visits in line with the legislation. Separate unannounced visits are undertaken to the inpatient unit and the community services. A review of the most recent reports evidenced that the unannounced visits were thorough and conducted in a meaningful way. Mrs Aspinall receives a copy of the reports generated for review and sign off.

The role and responsibilities of the Board of Trustees and the governance structures were discussed with the chair of the Board of Trustees and another Board of Trustees member on the day of inspection. We were informed that the Board of Trustees actively review their membership; identifying skill sets or areas of expertise that would further enhance the function of the Board of Trustees, for the benefit of all NI hospice services. The Board of Trustees members informed us that the SMT have an open door policy and make themselves available to Board of Trustee members and staff when required. They also felt the governance structures were effective and that the Board of Trustees were fully assured about the quality and standard of services delivered by the NI Hospice.

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

Our discussions with the chairperson of the Board; Board member and the SMT established that they continued to have a shared vision and strategy for the hospice coupled with a cohesive and productive way of working together.

We would like to recognise the work undertaken by the Board of Trustees, the SMT and staff of the hospice to continue to strengthen the governance structures to promote the delivery of safe, effective and compassionate palliative care to patients and their families.

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

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with the deputy head of adult community services as part of the inspection process and can be found in the main body of the report.

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