# Inspection Report

## 19 November 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/ The Independent Health Care Regulations (Northern Ireland) 2005 and Minimum Care Standards for Independent Healthcare Establishments (July 2014)

## 1.0 Service information

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| **Organisation/Registered Provider:**<br>Northern Ireland Hospice<br><br>**Responsible Individual:**<br>Mrs Gemma Aspinall | **Registered Manager (Acting):**<br>Ms Fiona Flynn<br><br>**Date Acting:**<br>28 August 2025 |
| **Person in charge at the time of inspection:**<br>Acting Deputy Head of Adult Services for Northern Ireland Hospice | **Number of registered places:**<br>18 |
| **Categories of care:**<br>Hospice Adult – H(A)<br>Private doctor - PD | **Number of patients accommodated on the day of this inspection:**<br>18 |

**Brief description of the accommodation and how the services operate:**
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. The in-patient unit (IPU) service supports patients, their families and provides ongoing bereavement support.

**The NI Hospice Adult Community Services**

Hospice adult community services are available for adults with life limiting, life-threatening illnesses and palliative care needs. The community hospice service consists of seven specialist 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. The 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 teams for South and East Belfast, and North and West Belfast are based in the hospice. The specialist triage and response team are based in a Belfast Health and Social Care Trust facility which is in close proximity to the hospice.

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 19 November 2025 from 10.00 am to 5.00 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 a 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); 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 by the hospice staff 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

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 26 November 2025 for review.

The onsite components of our inspection were completed on 19 November 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 with 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 services

The inspectors had the opportunity to speak with two patients in the in-patient unit 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. One patient and six staff questionnaires were submitted to RQIA prior to or following the inspection.

One patient submitted a response. The patient's response indicated that they felt their care was safe and effective, that they were treated with compassion and that the service was well led. The patient indicated that they were very satisfied with each of these areas of their care and commented positively on the quality of services and the compassionate approach of staff and volunteers.

Six staff submitted questionnaire responses. Staff responses indicated that they felt patient care was safe, effective, that patients were treated with compassion and that the service was well led. All staff indicated that they were either satisfied or very satisfied with each of these areas of patient care. Four staff responses included positive comments regarding; a high level of job satisfaction; the provision of career development opportunities; positive relationships and culture between senior management and staff, and between the IPU and the community services teams: actions taken to raise the profile of hospice community teams; the quality of care delivery and impact of patient and family feedback.

One staff member provided an additional comment regarding communication arrangements with the Board of Trustees. This matter was discussed with Mrs Aspinall following the inspection, who confirmed that systems are in place to support communication and engagement with the Board of Trustees.

## 5.0 The inspection

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

The last inspection to NI Hospice and NI Hospice Adult Community Services was undertaken on 6 February 2025: no areas for improvement were identified.

## 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 within both the inpatient unit and the hospice community services was reviewed.

The IPU consists of a multi-professional team which 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 team; 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 services consists of specialist palliative care teams and a hospice at home service. There is an acting 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 staffing levels were sufficient and appropriately deployed across relevant roles to meet the assessed needs of patients. Staff consistently reported feeling supported in their roles and described positive working relationships across the hospice.

Staff demonstrated an understanding of the importance of effective communication and confirmed they had regular access to structured communication processes, including daily handovers, safety huddles and team meetings. Staff told us they were supported by management and had opportunities to contribute to decision making processes. There was evidence that staff were involved in quality improvement activities, including reviewing outcomes and learning from quality assurance audits.

Staff confirmed they could raise concerns openly and honestly with management. Staffing levels and staff morale were reported to be good, with evidence of effective multi-disciplinary working and clear communication systems in place.

Mrs Aspinall told us that the hospice was in the process of transitioning to a new electronic learning platform called SMARTLOG. Training and induction records for all staff and volunteers across all the NI Hospice services are being migrated to this new system. Managers and staff can monitor training compliance via corresponding dashboards, and the system includes audit functionality. Electronic systems provide staff with organisational charts and organisational information, as well as links to the Hospice Sentinal system and Elearning modules. Staff told us that teams across NI Hospice create short presentations which are available electronically as a means of sharing information about roles, responsibilities and work undertaken.

A recent audit of compliance regarding mandatory training for the IPU and community based staff was reviewed and it was confirmed that mandatory training was completed in line with RQIA training guidance.

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 told us that bespoke training opportunities also exist for those in health care assistant, administrative and human resource roles. Furthermore a number of external partnerships had been developed by the hospice to strengthen the accessibility of training opportunities for staff. Mrs Aspinall discussed a number of training inputs including training in Human Factors and Sage and Thyme.

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 IPU and for patients receiving community services.

### 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.

The hospice has a policy and procedure for the recruitment and selection of staff in keeping with legislation and best practice guidance. The policy and procedure was not reviewed during this inspection. Discussion with Mrs Aspinall confirmed that no changes had been made to this policy and procedure since the previous inspection.

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.

The 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 HSCT 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.

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 IPU, as recommended by the Resuscitation Council (UK) guidelines.

An emergency trolley was located and equipment was stored appropriately. A daily check list of emergency equipment and expiry dates was in place. Emergency medicines were stored in their original packaging and expiry dates were visible. Staff had immediate access to the medicines stored in the emergency trolley 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. Mrs Aspinall confirmed that arrangements are in place with a local training provider regarding the provision of basic life support training for all staff across the NI Hospice services, and that a number of face to face training sessions had been provided over recent months.

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

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 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 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 IPC issues and the completion IPC audits. 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 undertaken in clinical areas that include environmental and hand hygiene audits were reviewed and evidenced good compliance and oversight in IPC practices.

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 and demonstrated a comprehensive understanding of this.

A policy was in place regarding aseptic non-touch technique (ANTT) and 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 and were able to describe the ongoing arrangements regarding cleaning audits. The cleaning records reviewed were up-to-date and indicated that areas were cleaned regularly. We observed staff cleaning high touch surfaces and other areas during the inspection visit.

Good compliance with IPC practices was observed in relation to hand hygiene, use of personal protective equipment (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.

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

The provision of palliative care delivered both within the hospice and the hospice at home service 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 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.

Staff confirmed that they were provided with information regarding admissions and that arrangements were in place to ensure that staffing levels were sufficient to meet the needs of the service.

On admission, patients and/or their representatives are provided with information regarding various assessments that may be undertaken by members of the multi-professional team. It was confirmed that information can be provided to patients in alternative formats if required and is communicated in a language and manner that is appropriate to patients' understanding and wishes.

Discussion with staff confirmed that on admission, a comprehensive, holistic assessment of patient's care needs is completed using a variety of evidence based tools. The results of these assessments are used to develop and implement individualised, person-centred care plans for patients. It was confirmed that care plans are reviewed with the patient in keeping with their changing care needs. Arrangements were in place to refer patients to specialised services and members of the multi-disciplinary team (MDT) to ensure patients' needs are met.

We identified a strong commitment to multidisciplinary working. Patients had access to a full range of allied health professionals (AHP) and therapists. AHP team members described effective and collaborative practice at the hospice. We observed a multidisciplinary team meeting in progress; this was clinician led with input from a range of staff including nurses, AHPs, social workers and chaplain representatives. Discussions were found to be thorough and staff demonstrated a clear understanding of the patient's needs.

A review of a sample 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. Staff and patients confirmed that care was patient centred with ongoing review and adapted according to the assessed need of each patient.

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 manner 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 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).

Arrangements are in place for good pain management and control. Staff confirmed that patients' pain levels are assessed daily and prior to routine practices being performed for example: wound dressing and movement, with various pain assessment tools in place. Medical staff are available if further pain relief is required and arrangements are in place for pain relief to be prescribed out of hours, if needed.

Staff confirmed that there are adequate syringe drivers in place to meet the needs of patients. A robust system is in place to manage the availability and return of syringe drivers when a patient is being discharged. Staff confirmed that alternative methods of pain relief is 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, evidenced that the assessment tools were completed consistently. A patient centred approach to pressure area care was demonstrated and staff had good knowledge of wound management and the use of ANTT. There is an adequate supply of pressure relieving equipment, which can be ordered and delivered in a timely manner to meet the needs of patients. Staff discussed the roles of the tissue viability nurse, occupational therapist and physiotherapist in relation to pressure area care and highlighted the valuable support that these services provide to patients.

The hospice specialist community team demonstrated a strong commitment to enabling patients to remain in their own homes, supported by experienced, competent, and skilled staff. There was clear evidence of holistic assessments being undertaken, effective advanced care planning in place and a strong focus on pain and symptom management to ensure patients' comfort and dignity.

Staff were observed to work in a compassionate and responsive manner, respecting patients' privacy, dignity, values, and personal wishes. Patients and their families are informed of who to contact for support, and staff focus on providing timely advice, guidance and education, to patients and their families to help them feel informed and supported.

The hospice specialist community team was well led, with effective communication and a well-distributed caseload that allowed staff to respond promptly to changing needs. Multi-disciplinary working was embedded in practice, including active engagement with Gold Standards Framework meetings and close collaboration with external agencies to ensure patients received the right care at the right time.

Staff worked effectively alongside wider health and social care partners, providing coordinated and person-centred care. Overall the hospice at home service demonstrated a strong values-based approach, supporting not only patients but also their families, and ensuring care delivery was compassionate, coordinated, and responsive throughout the patient's journey.

The provision of bereavement care was reviewed and this evidenced a range of information and support services available.

The hospice can provide internal individual bereavement support services and group based support for patients and families or links with external providers. Chaplaincy and bereavement staff were available to provide support for families and carers. The team provided a dedicated service, including a multi-faith room, which supported people through the end of life process.

Bereavement staff confirmed that ongoing bereavement care is available for families and children coping with the loss of a loved one. It was good to note that exclusive resources have been developed to support the emotional, social and physical well-being of the children visiting loved ones in the hospice.

Staff in the IPU could provide examples where staff had considered the needs of the patient and relatives and were flexible around their wishes, taking into account people's religious beliefs and customs regarding end of life.

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

It was good to note that staff are being supported to deal with the emotional demands of their work, to build resilience and manage their overall wellbeing.

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 on a quarterly basis and as an annual report. Quarterly reports are displayed in the IPU in a 'You said / we did' format. These are also used by the hospice SMT and inform the ongoing quality improvement of services. Mrs Aspinall told us that plans are in place to implement a service user panel for patients and families by the end of March 2026. The implementation of this group will further enhance feedback mechanisms for patients and their families.

The arrangements concerning discharge planning were reviewed. Discussion with staff confirmed that discharge arrangements are agreed with the patient in keeping with the hospice discharge procedure that included multidisciplinary involvement. Daily and weekly meetings take place to ensure the patients' needs are at the centre of discharge planning.

It was confirmed that a comprehensive planned programme for discharge is in place and that patients are provided with written information regarding the discharge arrangements, future management of care including input of community services. A range of advice and support information leaflets are also available and provided to patients on discharge. Upon discharge, a letter is provided to the patients GP and other professionals and services involved in the patient's ongoing treatment and care. 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, 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 MDT 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 AHP's
- 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. This was discussed with the SMT who were receptive to our findings and provided assurances that this issue would be addressed.

Addressing the issue 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.

### 5.2.8 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 completed on 6 May 2025 was deemed satisfactory and valid for five years.

The fire risk assessment dated 12 December 2024 was listed as tolerable and reduced to trivial after implementation of the report action plan recommendations.

There were no issues to address in the environment/estates management review and satisfactory assurances were received confirming that suitable and sufficient controls are being implemented.

### 5.2.9 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 chief operating officer and the chief executive officer (CEX) included; an overview of strategic planning; approach to and methods of staff engagement; staff leadership training and opportunities; a patient centred approach.

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 the 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 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 IPU and the community service. Information in relation to complaints; incidents and corporate policies and procedures are 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. 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 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 doctor's practice with the MAC and within the wider 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 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 IPU and adult community services; chaplaincy, pharmacy, social work, AHP's, 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 (IPU & 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 Northern Ireland Public Ombudsman (NIPSO) 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 discussed with Mrs Aspinall and staff 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 SMT are trained in complaints handling and all staff undertake complaints training via the SMARTLOG platform which has replaced 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 monthly at Clinical Leads meetings, and quarterly by the Care Quality Committee 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. Mrs Aspinall, is not in day to day operational management of IPU or the community services. It was confirmed that Mrs Aspinall undertakes the six monthly monitoring unannounced visits in line with the legislation and separate unannounced visits are also undertaken to the IPU and the community services. A review of the most recent reports evidenced that the unannounced visits were thorough and conducted in a meaningful way. Ms Flynn receives a copy of the reports generated for review and sign off.

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 chief executive; Mrs Aspinall 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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