

Inspection Report

12 and 13 March 2026



Southern Area Hospice Services

Type of Service: Independent Hospital (IH) – Adult Hospice

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Assurance, Challenge and Improvement in Health and Social Care

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

1.0 Service information

Organisation/Registered Provider: Southern Area Hospice Services Ltd	Registered Manager: Ms Bridget Lynch
Responsible Individual: Mrs Elizabeth Cuddy	Date registered: 5 October 2023
Person in charge at the time of inspection: Mrs Elizabeth Cuddy	
Categories of care: Independent Hospital (IH) – Adult Hospice PD – private doctor	
Brief description of how the service operates: Southern Area Hospice Services Ltd is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital providing in-patient hospice services for up to 14 adults with life-limiting, life-threatening illnesses and palliative care needs. The registration also includes day hospice services for adults with life-limiting, life-threatening illnesses and palliative care. The day hospices operate from two sites, one based in the same site as the inpatient unit in Newry and one based in Dungannon. Since the last RQIA inspection on 6 March 2025, Southern Area Hospice Services have rebranded and are now operating under the name Evora Hospice. Southern Area Hospice Services senior management have assured RQIA that upon completion of the legal aspect of rebranding with associated name change, formal correspondence will be submitted to RQIA in accordance with legislation.	

2.0 Inspection summary

An announced inspection was undertaken to the Southern Area Hospice Services on 12 March 2026 from 10.00 am to 5.30 pm by four care inspectors and an ADEPT (Achieve Develop Explore Programme for Trainees) fellow and on 13 March 2026 from 9.30am to 3.00pm by two pharmacy inspectors.

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

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

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

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

3.0 How we inspect

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

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

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

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

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

4.0 What people told us about the service?

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

One staff questionnaire was received following the inspection. The respondent indicated that they felt patient care was safe, effective, that patients were treated with compassion and that the service was well led. The respondent indicated that they were either satisfied or very satisfied with each of these areas of patient care.

One questionnaire was received following the inspection from a relative/visitor. The respondent indicated that they felt patient care was safe, effective, that patients were treated with compassion and that the service was well led. The respondent indicated that they were very satisfied with each of these areas of patient care. The respondent left a very positive comment pertaining to the care and compassion of all the staff.

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

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

Patient feedback was also assessed by reviewing the hospice's most recent patient satisfaction report. Respondents commented positively on the high standard of care; the quality of the food; the friendliness of staff and being involved in decisions about their care.

5.0 The inspection

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

There were no areas for improvement identified at the last inspection undertaken on 6 March 2025.

5.2 Inspection outcomes

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

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

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

The hospice community outreach service provides a service to patients and their families in their own home and also in two hospice hubs, one based in Newry and the other in Dungannon. The team is led by a hospice community service manager and a hospice patient and family support manager. The staff skill mix includes community hospice nurses, social workers, a counsellor, chaplains, and physiotherapists. The community outreach service also provides counselling, bereavement support and an out of hours nursing care at home service. The out of hours nursing care at home is designed to help patients, their families and carers who need end-of-life support in their own home at night-time.

The service is available all year round between the hours of 10.00 pm and 8.00 am to patients living in the Newry city and BT35 postcode area.

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

Staff reported that they were happy, felt supported and experienced good working relationships throughout the hospice. They highlighted the benefits of effective communication and confirmed that they have opportunities to attend weekly multi-disciplinary meetings; daily handovers; staff de-briefs and team meetings.

Staff from community outreach services described a range of effective communication methods and highlighted a culture of peer support and continuous learning. Staff are supported through formal and informal debriefs, with the use of reflective models to promote learning, create space for reflection, and support ongoing professional development. Staff described positive and respectful working relationships, which contributes to the delivery of compassionate, well-led care. They also expressed a strong sense of pride in the service.

A review of records and discussions with human resources (HR) staff confirmed that an electronic HR portal system is in place. The system records staff mandatory training, continuing professional development (CPD) and other learning activities. This provides staff and line managers with effective oversight of training completed, enabling monitoring of compliance with mandatory training requirements.

A structured induction programme was in place, including bespoke induction arrangements for specific roles. The HR system in place provided effective oversight of supervision and appraisal processes and enabled monitoring of professional registration status. This supported assurance that appropriate governance arrangements were in place to maintain staff competence and development.

Records confirmed that a system was in place to ensure staff receive appropriate training to fulfil the duties of their role in keeping with the RQIA training guidance. The hospice further supports and promotes ongoing professional development by affording staff opportunities to undertake specialist qualification in palliative care.

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

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

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

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

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

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

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

When a new member of staff is recruited they complete an induction programme and undertake training commensurate with their roles and responsibilities.

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

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

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

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 (HSCT) should a safeguarding issue arise.

Review of records demonstrated that all staff had received safeguarding training 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' and regional policy entitled Co-operating to Safeguard Children and Young People in Northern Ireland were available for staff reference.

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

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

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

The hospice had undertaken a risk assessment to determine the emergency medication and equipment to be retained on site.

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

Review of training records and discussion with staff confirmed that training in resuscitation and the management of medical emergencies is completed prior to commencing employment and is also discussed during the induction programme. Staff received basic life support 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.

An emergency trolley for the storage of emergency equipment and medicines was provided on level one and level two of the IPU. Checklists were available and kept with the emergency medicines and equipment. Staff were designated responsibility for completing these checklists to ensure that emergency equipment and medicines are always stored in sufficient quantities and within expiry dates. The emergency equipment in place was noted to be readily available and in good working order.

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

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

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

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

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

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

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

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

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

It was noted that areas of IPC risks were being assessed and managed appropriately with robust auditing measures in place in clinical areas. Arrangements are in place to ensure the all staff adhere to IPC best practice guidance.

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

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

The provision of palliative care delivered both within the IPU and the community outreach services was reviewed. This included a review of referral process; the admission process; applicable risk assessments; discharge planning; bereavement services; care of the dying; breaking bad news and a review of a sample of care records.

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

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

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

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

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

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

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

Discussions with patients confirmed that staff are prompt in responding to patient needs. Good team work was observed when attending to patient care and responding to patient needs.

The provision of bereavement care was reviewed and this evidenced that a range of information and support services were available. The hospice offers individual counselling for patients and families, as well as referrals to external providers where appropriate. Ongoing bereavement support is available for families and children following the loss of a loved one. It was confirmed that staff who deliver bereavement care are appropriately trained and skilled in this area. Staff spoke positively about the development of initiatives and the additional training being undertaken to further strengthen the bereavement services across both the IPU and community services.

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

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

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

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

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

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

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

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

The multi-disciplinary care records reviewed contained the following:

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

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

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

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

5.2.8 Pharmacy

The management team were requested to compile a range of documents to support the inspection. These documents were reviewed by the RQIA pharmacist inspectors.

Medicines management policies and procedures were reviewed on a three yearly basis or following any policy changes or changes to legislation. Systems were in place to ensure that any updates were communicated to the nursing, pharmacist and medical staff, for example at staff meetings. Pharmacist support is available onsite from Monday to Friday.

Nurses received a comprehensive induction, which included the management of medicines and syringe drivers. Refresher training was completed on a three yearly basis or more frequently if required. Nursing staff were not permitted to administer medicines unsupervised until training and a competency assessment had been completed. Medical staff have an induction programme, which includes the relevant policies and procedures. This also includes meeting the pharmacist to discuss roles and processes regarding medicines management.

Robust arrangements were in place to ensure the safe management of medicines when a patient was admitted to the hospice. Medicines were reconciled by the pharmacist or admitting doctor using the Northern Ireland Electronic Care Record (NIECR), information provided by the patient or their family and the patient's supply of medicines. Medicine kardexes were written by a doctor and checked by the pharmacist to ensure accuracy. The medicine kardexes were reviewed by the medical staff and by the pharmacist each day.

Satisfactory records for the ordering and receipt of stock medicines were in place. Medicine related records were well maintained. A medicine kardex was in place for each patient; this is a record that details the medicines prescribed for each patient. Medicine administration records were accurately completed and medicines were available for administration when patients required them. Two nurses were involved in the administration of medicines administered intravenously or via syringe driver. There was evidence that syringe driver pumps were checked regularly during administration.

Medicines were stored safely and securely. Controlled drug cabinets and a medicine refrigerator were available for use as needed. Temperatures of the medicine refrigerators were monitored and recorded daily. Two opened liquid medicines with limited shelf life once opened were identified in the stock cupboard, no date of opening had been recorded to facilitate disposal at expiry. These liquids were not in use at the time of the inspection and this was highlighted to the manager for ongoing monitoring.

Standard Operating Procedures were in place for the management of controlled drugs and satisfactory arrangements for their management were observed. The Accountable Officer is responsible for the safe management of controlled drugs and related governance issues; the Accountable Officer for Southern Area Hospice Services is the registered manager.

Robust systems were in place to ensure that patients were given advice about their medicines and were provided with a continuous supply of their medicines at discharge. Relevant information was shared with other health care professionals as necessary. The disposal of medicines was managed appropriately. Records of medicine disposal were signed by the two members of staff involved.

A range of audits was completed to ensure the safe and effective management of medicines, including medication administration record audits, kardex audits, clinical audits and controlled drugs audits. The audit process is currently under review by the pharmacist and a gap has been identified regarding antibiotic prescribing auditing. The implementation of a regional antibiotic prescribing audit is planned to address this.

An effective incident reporting system was in place to identify, record, report and share learning from any medicine related incidents. Medication incidents were reviewed at weekly incident meetings and at monthly medicines management meetings. Relevant incidents are reported to RQIA and any that involve controlled drugs are reported to the Local Intelligence Network.

Systems were in place for the management of drug and medical device alerts. A record of all alerts received and the actions taken in response was maintained.

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

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

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

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

The Board meets approximately seven times a year and will arrange an extraordinary meeting if required. Terms of reference for the operation of the Board were in place. Mrs Cuddy is the company secretary for the Board. Each subcommittee is chaired by a member of the Board and prior to meetings, Board members are furnished with all minutes of sub-committee meetings and other relevant papers. There is a set agenda for Board meetings and at every Board meeting, the CEO report and the reports for all subcommittees are reviewed and discussed. A review of the Board meeting minutes confirmed that they detail the reports reviewed by Board members and action taken, where necessary.

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

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

It was confirmed that policies and procedures are saved on a shared folder that can be accessed from any hospice computer. Access can be restricted to identifiable individuals if necessary, depending on roles and responsibilities.

Each of the directors is responsible for the review of identified policies and arrangements were in place to ensure the policies due for review would be prioritised. Where a policy/protocol is amended an email is sent to all staff members to notify them of any changes or updates made to the respective document and staff members must confirm by email that they have read and understood the relevant documents.

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

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

It was confirmed that medical staff are either directly employed by the hospice or the Southern Health and Social Care Trust (SHSCT) and that any medical staff not directly employed by hospice are subject to a practising privileges agreement. Advice and guidance was provided in respect of evidencing the two yearly renewal of practising privileges agreements. Following the inspection RQIA received a copy of the hospice's 'Practising Privileges 2 yearly Review Form'. A review of this form demonstrated that completion of this form will provide evidence of a robust practising privileges renewal procedure.

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

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

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

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

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

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

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

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

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

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

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

The hospice has a complaints policy and procedure in place in accordance with the relevant legislation and Department of Health (DoH) guidance on complaints handling. It was confirmed that the complaints policy had been updated in accordance with Northern Ireland Public Services Ombudsman (NIPSO) Model Complaints Handling Procedure (MCHP). A copy of the complaints procedure is made available for patients and/or their representatives.

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

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

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

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

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

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

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

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	0

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



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