Hospice

Minimum Standards

Registration & Inspection Unit

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Department of Social Care
Rhyenn Kiarail y Theay
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**Hospices**

**Introduction to Standards**
Section 27 (1) (a) of the Regulation of Care Act 2013 brings within the definition of ‘independent hospital’ establishments the main purpose of which is to provide palliative care. For ease of reference, such establishments are described in these standards as hospices. There are two key factors in the provision and the regulation of palliative care services. First, the need to respond to issues with a sense of urgency as time is limited for the service recipient nearing the end of their life. Second, the often complex and diverse needs of both the service recipient and their carers need to be met by access to a multi-professional specialist palliative care team with a range of skills to assist with physical, psychological, social and religious and cultural needs. The attached standards reflect this.

The standards are divided into two sections. The first section covers standards that relate both to adult and children’s hospices. These standards encompass palliative care services in a range of settings: inpatient, community (ie out-reach services provided by the establishment). The second section contains additional standards that apply to children’s hospices only.

The standards that relate specifically to children’s palliative care services are based on the principle that a dying child is a child first and foremost, and their needs as children should be accommodated as a priority. The environment therefore needs to be child friendly and as ‘home like’ as possible. Many of the conditions the children have progress slowly over a number of years, placing an enormous strain on family life. A children’s hospice aims to help families with this burden of care.

The standards also recognise the importance of the presence of the child’s family and the need to take account of the family’s wishes, and that a child’s needs for play, education and contact with peers of their own age are essential components of a holistic palliative care approach.

[See: Report of the Joint Working Party of the Association for Children with Life Threatening or Terminal Conditions and their Families, the National Council for Hospice and Specialist Palliative Care Services and the Scottish Partnership Agency for Palliative and Cancer Care *Palliative Care for Young People* (2001).]

These Hospice specific standards are to be delivered in conjunction with the core standards on Independent Hospitals.
Hospices Generally

Arrangements for Care

OUTCOME
Service recipients and prospective service recipients, their families and carers, are clear about the arrangements for palliative care.

STANDARD 1

1.1 Written information is provided about eligibility criteria for the treatment and care being provided and how to access this.

1.2 Information about eligibility criteria and access is made widely available to referring bodies.

1.3 The referral process is clearly described and response times to new referrals regularly reviewed to ensure there are no delays in gaining access.

1.4 Service recipients are discharged with all the identified support services in place.

1.5 Hospices providing a community service and care at home have a lone worker safety policy.

Palliative Care Expertise and Training for Multi-professional Teams

OUTCOME
Service recipients are cared for by people who have the relevant expertise.

STANDARD 2

2.1 Staff with specialist palliative care expertise function in multi-professional teams to ensure that the palliative care needs of service recipients and carers are met.

2.2 Multi-professional palliative care teams are recruited, developed, educated and trained for the services which the provider is registered to undertake.

2.3 The multi-professional team membership is commensurate with the service being provided.

2.4 There is a multi-professional team meeting at least weekly for service recipient management, with arrangements in place for ethical decision making and service recipient advocacy where this is indicated and required.

2.5 Formal, multi-professional team meetings are held at least annually with other related agencies or services for audit, service operation and communication review.

2.6 Members of the multi-professional team are trained in the assessment of palliative care needs across the dimensions of physical, psychological, social, religious and cultural needs.

2.7 Team members are trained in the provision of general psychological care for service recipients and carers.
2.8 Team members are able to communicate with service recipients and their carers with sensitivity, ensuring that service recipients and their carers receive all the information they want concerning their condition, treatment and care.

2.9 Team members have received training and updating in communication skills and the breaking of bad news.

2.10 There are in place systems of both professional and personal support for all those who work in the establishment.

Assessment of Service Recipients’ and Carers’ Needs

**OUTCOME**
The needs of service recipients and carers are appropriately assessed.

**STANDARD 3**

3.1 Service recipients’ and carers’ needs are assessed by a member of the multi-professional team.

3.2 The assessment covers all domains, including:
   _ physical;
   _ psychological;
   _ social;
   _ religious and spiritual;
   _ cultural.

3.3 Treatment and care choices are clearly explained to service recipients and carers with sufficient information, time and assistance to make informed decisions, and to give informed consent where appropriate.

3.4 The service recipient and carer assessment is subject to review as and when changes in care are indicated.

Delivery of Palliative Care

**OUTCOME**
Service recipients receive appropriate palliative care.

**STANDARD 4**

4.1 A member of the multi-professional team is designated as the principal contact for each service recipient and carer.

4.2 A member of the multi-professional team is identified who will provide access to agencies or services for carer support including bereavement support.

4.3 Information about carer support services and how they may be accessed is easily accessible in a variety of formats and places.

4.4 There are procedures for service recipients and carers, and for those who work in the establishment, for accessing out-of-hours specialist advice and support.
4.5 Care pathways are in place which delineate the care to be provided to service recipients and their carers and which are used as a part of clinical audit and outcomes analysis.

4.6 The multi-professional team employ evidence-based clinical guidelines.

4.7 Arrangements are in place for regularly and systematically obtaining service recipient and carer views about their experience of using palliative care services from the provider.

4.8 The environment in which care is given affords service recipients and carers the privacy they require and enables them to be treated with dignity at all times.

4.9 Care and services are delivered in such a manner as to be service recipient- and carer-centred, taking into account service recipient and carer preferences and requests.

4.10 The care of the service recipient after death takes into account all religious and cultural requirements, and the requests of both the service recipient and family.

Records of Care

OUTCOME
Service recipient care is based upon accurate records.

STANDARD 5

5.1 Members of the multi-professional team have continuous access to up-to-date records and other information about service recipients and their carers.

5.2 Team members keep service recipient records up to date following each service recipient/carers contact.

5.3 There is access to an information system capable of supporting service review.

5.4 Communications between team members and services are concise and in a language which is readily comprehensible between professionals.

Infection Control

OUTCOME
The risk of service recipients, staff and visitors acquiring a health care-associated infection is minimised.

STANDARD 6

6.1 There are formal links and membership of an infection control team; this may be within another organisation.

6.2 There is a registered nurse with designated responsibilities for infection control that are included in a documented job description and there is a defined time commitment for infection control activities.

6.3 The infection control link nurse has training in infection control and provides evidence of continuing professional development (CPD) in relation to the role in infection control.
6.4 Prevention and control of infection are considered as part of all proposed service developments.

6.5 Written policies, procedures and guidance for the prevention and control of infection are implemented and reflect relevant legislation and published professional guidance, including:

- major outbreaks of communicable infections;
- isolation of service recipients;
- antimicrobial prescribing;
- control of MRSA, VRE and other antimicrobial resistant micro-organisms;
- control of tuberculosis, including multi-drug resistant tuberculosis;
- collection, packaging, handling and delivery of laboratory specimens;
- handling of medical devices in procedures carried out on known/suspect CJD service recipients and on service recipients in risk categories for CJD as defined in the ACDP/SEAC guidance (including disposal/quarantining procedures).

6.6 Each department or service has a current copy of the approved policies, procedures and guidelines pertinent to its activities.

Resuscitation

**OUTCOME**

Service recipients’ rights are observed around the issue of resuscitation.

**STANDARD 7**

7.1 Information about the hospice’s resuscitation policy is available for service recipients.

7.2 The registered person must ensure that service recipients’ rights are central to decision-making on resuscitation.

7.3 The policy includes appropriate supervision arrangements to review resuscitation decisions.

7.4 Health care professionals with a thorough understanding of the resuscitation policy and its application are on duty at all times and are available to make resuscitation decisions.

Responsibility for Pharmaceutical Services

**OUTCOME**

Responsibility for obtaining, prescribing, storing, use, handling, recording and disposal of medicines is clear.

**STANDARD 8**

8.1 The medical director or senior registered nurse is responsible for safe medicines systems, unless there is a pharmacy department supplying medicines within the same body corporate as the hospice, when the senior pharmacist will be responsible.
8.2 The hospice has a ward/clinical pharmacy service and pharmacist medicines information service.

Ordering, Storage, Use and Disposal of Medicines

**OUTCOME**
Medicines, dressings and gases are handled in a safe and secure manner.

**STANDARD 9**

9.1 All medicines, medical gases and interactive wound dressings are obtained by, and stored under the control of, the senior registered nurse, or medical director under the control of the senior nurse, or the pharmacist.

9.2 The pharmacist or, where there is no pharmacist employed, the senior registered nurse or medical director, authorises any orders to obtain prescription-only medicines from wholesale suppliers.

9.3 Stocks of medicines in current use on the unit or ward are the responsibility of the senior registered nurses designated for the purpose by the registered nurse manager.

9.4 A medication record is kept for each service recipient, the entries signed by the prescriber, showing:
   - the name and date of birth of the service recipient;
   - registration number and ward where appropriate;
   - the name of the medicine;
   - the dose;
   - the route of administration;
   - the frequency and time for administering each dose;
   - the date of prescribing;
   - any known medicines hypersensitivity or allergies;
   - any special requirements.

9.6 Records are kept for eight years from the date of discharge or death of the service recipient.

9.7 Medicines brought into the hospice by individual service recipients, and which are not used, are kept separate from other medicines on the ward and held in a safe place until discharge of the service recipient when they are returned to the service recipient or his/her representative. A written policy should exist for the use of service recipients’ own medicines including criteria to assess the suitability of medicines for reuse.

9.8 The disposal of waste is carried out by an authorised contractor who is used to complying with the arrangements for pharmaceutical waste, including cytotoxic waste where appropriate.

9.9 When a service recipient dies in the hospice the service recipient’s medicines are kept for at least one week in case there is a need for a coroner’s inquest.
Administration of Medicines

OUTCOME
Appropriately trained and qualified health care professionals administer all medicines and drugs to service recipients.

STANDARD 10

10.1 Medicines are administered by a registered medical practitioner or a registered nurse in accordance with the UKCC’s Guidelines for the administration of medicines or by another registered professional assessed as competent to administer those medicines.

10.2 There is a secure method for transporting medicines from the medicines cupboard to the service recipient.

10.3 When medicines are no longer required by the named service recipient they are returned to the pharmacy or pharmacist for disposal.

Self-administration of Medicines

OUTCOME
Service recipients are assessed, consulted and advised before they are enabled to self-administer medicines.

STANDARD 11

11.1 There is a written policy and procedure for self-medication, which conforms to the duty of care inherent in the relationship of the hospice to the service recipient.

11.2 Where the risks have been assessed and it is deemed appropriate, service recipients are enabled to self-administer their medicines.

11.3 Arrangements are made only with the agreement of the senior registered nurse, the service recipient and the medical practitioner responsible for the service recipient’s care.

11.4 Medicines dispensed for service recipients to self-administer have full directions and BNF cautionary warning where appropriate.

11.5 Regular checks are made on the quantity of medicine given to the service recipient to ensure the service recipient is not taking higher doses of medicine than prescribed.

11.6 The medicine is stored in a personal lockable cupboard or drawer, the keys being held by the service recipient.

11.7 There is a spare key to which health care staff have access.
Storage and Supply of Medical Gases

OUTCOME
Medical gases are stored and supplied appropriately.

STANDARD 12

12.1 Where piped medical gases are used there is a named Authorised Person MGPS (medical gas pipeline systems) responsible for the storage, identification, quality and purity of all gases at the terminal units, and for maintaining gas pipelines, and compliance with HTM 2022; this may be an appropriately qualified employee or through a contract with a medical gas company.

12.2 Where the Authorised Person is not employed on site at the hospital there is a named member of staff delegated to be his representative on the site as the Quality Controller of the medical gas pipeline system; this person must have training and familiarity with medical gas systems.

12.3 Prior to use of a new system, or resumption of use of a repaired system, the named quality controller is required to indicate that he or she is satisfied with the operation of the pipelines system and the identity and purity of the gases at terminal units alongside the signature of the Authorised Person who accepts responsibility of the correct operation of the pipeline systems.

12.4 Any engineers (competent persons) delegated to work on the medical gas pipelines systems have training and are authorised to do so by the Authorised Person.

12.5 All work on medical gas pipeline systems is controlled by a permit to work procedure, which includes ensuring that all paperwork with respect to work carried out on the medical gas pipeline system is copied to the Authorised Person.

12.6 Policies and procedures are produced for recording the delivery, handling and storage of full and empty medical gas cylinders, with an indication of who is in charge of this procedure at each site.

Additional Standards for Children’s Hospices

Assessment and Care of Children

OUTCOME
The special needs of children are addressed.

STANDARD 13

13.1 The child and family’s needs are assessed (prior to admission if possible) and a care plan is developed, which is updated when required.

13.2 The assessment process includes the child’s developmental and educational needs.

13.3 The child and parents are included in any discussions and decisions about treatment and care, and choices are explained with sufficient information, time and assistance to make informed decisions, and to give informed consent where appropriate.
13.4 Care staff recognise the unique wishes of each child and their family and accommodate these and the child’s daily routine in an individualised care plan which is agreed with the family and, where possible, with the child.

13.5 The child’s care plan is reviewed on each visit to the hospice or during each episode of care in the community, but also updated as and when changes in care are indicated.

13.6 Where children are cared for, the services provided are child and family-centred and promote a child orientated routine.

13.7 The treatment and care provided encourages parental involvement in their child’s care.

13.8 The treatment and care promotes a child centred routine with regard to sleeping and feeding requirements, and there is sufficient flexibility to accommodate individual children’s usual pattern of daily care.

13.9 The child and parents are kept informed about the child’s condition.

13.10 In partnership with parents, information is provided to the child and siblings about treatment and care which is appropriate to their age, understanding and the specific circumstances.

13.11 Symptom control is used to promote comfort and enhance quality of life of the child. (Symptom control means the management of any/all symptoms a child may experience in order to promote comfort and enhance the quality of life. Symptom control is much more than simply pain relief, although this is an important feature of symptom control.)

13.12 Symptom control is evaluated, at least daily, by a member of the multi-professional team.

13.13 The evaluation of symptom control involves the family, and where necessary other agencies contributing to the care of the child and family.

13.14 The symptom control and evaluation takes account of the particular vulnerabilities of children with sensory impairment and those who are unable to communicate.

13.15 The care of the child both before and after death respects the wishes of both the child and family and takes into account religious and cultural requirements.

13.16 When death occurs within the children’s hospice, there is a room with suitable facilities for the child’s body to remain until the time of the funeral if that is the parents’ wish.

13.17 The family are offered accommodation at the hospice during this period and a designated team member should be made available to give sensitive emotional support and information about, or practical help with, organising the funeral and any other aspects relating to the death.

13.18 Bereavement care is offered in accordance with the wishes of the family which includes bereavement support for siblings.

13.19 Staff communicate regularly and work in close co-operation with all other statutory or voluntary health care workers involved in the care of the child and family.
Qualifications and Training for Staff Caring for Children

OUTCOME
Children are cared for by appropriately qualified and trained staff.

STANDARD 14

14.1 The multi-professional team at a children’s hospice is led by a qualified children’s nurse with a further qualification in paediatric palliative care and/or experience in the palliative care of children and young people.

14.2 There are arrangements in place for on-call medical cover at all times. (Preferably by a medical practitioner with training and expertise in paediatrics and palliative care, but, if not, access to this expertise must be available at all times.)

14.3 There is a communication policy agreed/service level agreement with the Department of Health, to include frequency of multi-professional meetings with staff inside and outside the hospice.

14.4 Staff have training to recognise the vulnerability of ill children, including in the following areas:
   _ child protection;
   _ assessing pain and discomfort;
   _ how the child asserts his/her own best interests.

14.5 Staff are trained to understand the communication needs of children according to their age and ability, and any disability they may have.

14.6 There is a minimum of one children’s nurse on duty at all times.

14.7 There are sufficient numbers of children’s nurses employed to allow two children’s nurses to be available for each shift in 24-hours if necessary.

14.8 There is flexibility in how children’s nurses are deployed, allowing them to be rostered according to the needs of children.

14.9 Staff are trained in the calculation and administration of medicines to children, and those staff are the only ones allowed to check drugs for children.

14.10 Care staff are trained in the assessment of the child across the dimensions of physical, psychological, social, developmental, educational, spiritual and cultural needs.

14.11 Staff are trained in supporting families when there are decisions about treatment and end of life care to be made.

14.12 Staff are aware of sources of advice and guidance regarding ethical dilemmas.
Environment for Care of Children

OUTCOME
Children’s special needs are addressed by the facilities provided.

STANDARD 15
15.1 The establishment is furnished and equipped to meet the needs of children and young people, with particular efforts made to minimise the clinical and institutional environment and to promote a homely and welcoming setting.

15.2 Accommodation is provided for the child’s family, including siblings, and unrestricted parental involvement in the child’s care is promoted.

15.3 Children are cared for alongside other children and their play and educational needs are met.

15.4 Arrangements are made to ensure that:
   _ qualified play staff are employed;
   _ indoor and outdoor play areas are accessible to all (including children in wheelchairs);
   _ there is a wide variety of play equipment to meet the needs of infants and children of different ages, developmental stages and differing intellectual abilities and to help them express their feelings and prepare for experiences ahead.

15.5 There is access to teaching staff and educational facilities, and equipment for all children aged between five and 16 years, including provision for those with special educational needs.

15.6 Where practicable children and young people should be cared for alongside children in similar peer groups and not in a facility unsuitable for their age.

15.7 Provision is made to meet the needs of children with disabilities.

15.8 Meals are a family occasion, centred on a communal dining area with a varied menu. Choice of where to take meals is also available.

15.9 A children’s menu is available which meets current nutritional advice and can be adapted for children of different age groups in terms of size, content and timing of meals.

15.10 The children’s menu should cater for the tastes and preferences of children and accommodate special diets for cultural and medical purposes.

15.11 Cutlery and utensils are available which suit the needs of children of different ages and abilities.

15.12 Planning of the environment for children includes preventing access by a child to hot surfaces, hot water, storage of cleaning materials, and access to power points.

15.13 All staff are made aware of their responsibility to protect children.

15.14 Staff are alert to the presence of strangers and establish their identity immediately.

15.15 The children’s hospice is secured at night.
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