Isle of Man Government
Reiltys Ellan Vannin

Department of Health and Social Care
*Rheynn Slaynt as Kiarail y Theay*

# Regulation of Care Act 2013

## Independent Hospital

Hospice

## Announced Inspection

17 November 2021

***Registration and Inspection Team,***
***1st Floor, Belgravia House,***
***34-44 Circular Road, Douglas, Isle of Man, IM1 1AE.***

## Contents

## Part 1 - Service Information for Registered Service

**Name of Service:**
Hospice

**Address:**
Hospice Isle of Man
Strang
Douglas
Isle of Man
IM4 4RP

**Telephone No:** 01624 674444

**Care Service Number:**
ROCA/P/0187A

**Conditions of Registration:**
1. The number of persons for whom care and accommodation can be provided at any one time shall not exceed 33 (thirty three).

2. The number of persons of any description mentioned below received into the Hospice shall not exceed the number specified in relation to that description:

| | |
|---|---|
| Adults Hospice In-patient Unit (IPU) | 11 (eleven) |
| Adults Scholl Centre Day Care | 12 (twelve) |
| Children Hospice In-patient in Rebecca House | 4 (four) |
| Children Hospice Day Care in Rebecca House | 6 (six) |

**Registered company name:**
Hospice Isle of Man

**Name of Responsible Person:**
Dr Ben Harris

**Name of Registered Manager:**
Vicky Wilson

**Manager Registration number:**
ROCA/M/0276

**Date of latest registration certificate:**
8/1/21

**Date of any additional regulatory action in the last inspection year (ie improvement measures or additional monitoring):**
None

**Date of previous inspection:**
5 & 6 March 2019

**Person in charge at the time of the inspection:**
Dr Ben Harris/Vicky Wilson

**Name of Inspector(s):**
Sharon Kaighin

## Part 2 - Descriptors of Performance against Standards

Inspection reports will describe how a service has performed in each of the standards inspected. Compliance statements by inspectors will follow the framework as set out below.

**Compliant**
Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken. In most situations this will result in an area of good practice being identified and comment being made.

**Substantially compliant**
Arrangements for compliance were demonstrated during the inspection yet some criteria were not yet in place. In most situations this will result in a requirement being made.

**Partially compliant**
Compliance could not be demonstrated by the date of the inspection. Appropriate systems for regular monitoring, review and revision were not yet in place. However, the service could demonstrate acknowledgement of this and a convincing plan for full compliance. In most situations this will result in requirements being made.

**Non-compliant**
Compliance could not be demonstrated by the date of the inspection. This will result in a requirement being made.

**Not assessed**
Assessment could not be carried out during the inspection due to certain factors not being available.

Recommendations based on best practice, relevant research or recognised sources may be made by the inspector. They promote current good practice and when adopted by the registered person will serve to enhance quality and service delivery.

## Part 3 - Inspection information

The purpose of this inspection is to check the service against the service specific minimum standards – Section 37 of The Regulation of Care Act 2013 and The Regulation of Care (Care Services) Regulations 2013 part 3, regulation 9.

Inspections concentrate on specific areas on a rotational basis and for most services are unannounced.

The inspector is looking to ensure that the service is well led, effective and safe.

## Summary from the last inspection

**Number of requirements from last inspection:**
Four

**Number met:**
Three

**Number not met:**
One (Not fully assessed previously)

**All requirements not met will be addressed within this inspection report**

***Please note that any requirement carried forward for three consecutive inspections will lead to the service being served an improvement notice.***

## Overview of this inspection

**Due to COVID 19 the inspection process has altered slightly. More information and evidence has been sought from providers electronically. The inspection team have desktop assessed this information and a service visit has then been undertaken to verify the evidence provided.**

Hospice Isle of Man provides palliative care, together with a variety of RELATED services to the community. The Hospice is registered for inpatient care to a maximum of twelve adult and four child places. Day care services provide twelve adult places, together with six day care in Rebecca House Children's Hospice.

The Hospice was inspected on 17 November 2021. This was the annual statutory inspection.

As part of the inspection the following were scrutinised;

- Statement of Purpose

- Paperwork relating to health and safety
- Staff pre-employment checks
- Quality assurance training systems
- Training records

Service user feedback was also gained which expressed satisfaction and appreciation for the service.

## Part 4 - Inspection Outcomes, Evidence and Requirements

### Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9) Standard 2 (Core Standards) Quality of Treatment and Care

**Our Decision:**
Compliant

**Reasons for our decision:**
Policies and procedures were in place to ensure that the care provided was appropriate to need. The Clinical Care policy directed practice, and service user feedback confirmed that treatment plans were appropriate. A chaperone was able to accompany service users to examinations as desired. Service users confirmed that they were listened to, and they themselves and their preferences were put at the heart of all care delivered.

Service users had access to their health records under the Health Data policy, which was in line with data protection legislation and professional guidelines. The Integrated Palliative Outcome Scale was in place which was utilised to measure people's experience of palliative care. Findings from this were used to evaluate care.

An equality and diversity policy was in place. Services aimed to meet faith needs, together with disability access and explanations given to patients at their own pace and in an individual way.

Service users confirmed that they were always treated with privacy and dignity, particularly in the provision of personal care. Signs stating "In Use" were used to ensure rooms were clearly occupied.

The issue of consent to treatment was individually assessed, including consideration of the "Gillick Competencies" in relation to consent by children. Service users confirmed that treatment was explained to them, and they were allowed choice in consent or refusal to treatment.

**Evidence Source:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Observation | | Records | ✓ | Feedback | ✓ | Discussion | ✓ |

**Requirements:**
None

**Recommendations:**
None

### Regulation of Care Act 2013 Part 2 (37) and Care Services Regulations Part 3 (9) Standard 4 (Core Standards) Equipment and Supplies

**Our Decision:**
Compliant

**Reasons for our decision:**
A risk assessment and maintenance plan for the premises was in place and seen on inspection. The health and safety officer confirmed that equipment was installed and serviced appropriately. No modifications had been carried out to equipment and would not be done without specialist advice.

The health and safety officer confirmed that there was a planned maintenance programme in place which was seen on inspection. A variety of recorded maintenance measures were in place, including legionella testing, cleaning and servicing schedules. The monthly stock rotation list was seen, together with confirmation of monthly housekeeping stock checks. The pharmacy drug fridge temperatures log was seen to be completed, together with store room temperatures monitored.

**Evidence Source:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Observation | ✓ | Records | ✓ | Feedback | ✓ | Discussion | ✓ |

**Requirements:**
None

**Recommendations:**
None

**Regulation of Care Act 2013 Part 2 (37) and Care Services Regulations Part 3 (9) Standard 6 (Core Standards) Quality and improvement**

**Our Decision:**
Compliant

**Reasons for our decision:**
The registered manager held a variety of professional qualifications and had extensive experience across the service. They were currently working towards the QCF level 5 Diploma in Leadership for Health and Social Care. Any persons deputising for the manager were qualified to least QCF level 3, and shift leaders were clearly identified on the rotas.

A comprehensive file of policies and procedures were in place and were available to all staff. Staff f confirmed that they were made aware of policies through supervisions, emails and during handovers. The Statement of Purpose contained a section entitled "Your Rights" informing service users of their right to request a copy of policy and procedure documents. Policy and procedure documents seen had been regularly reviewed and dated.

A suggestion box was available in the service, together with questionnaires on the service website. A range of tools were used in the service to measure the quality of the service provided. An audit timetable was in place. A complaints leaflet was available for service users, and the one complaint received was seen to be satisfactorily resolved. The compliments log was also viewed. An incident reporting policy was in place. The Clinical Improvement Group regularly met and considered feedback with resulting action plans from complaints implemented. An evaluations

timetable ensured timely attention. Both notifications to the Registration and Inspection Team and Datix systems were then fed into the clinical dashboard system for analysis.

An annual report including a development plan based on the outcomes of the quality assurance exercise was in place. The report was available to all. Supervisions, appraisals and observations of staff, ensured compliance with terms of employment.

Paperwork and documents seen were maintained in good order, kept in locked cabinets in an office with restricted access.

A written summary of service user rights was displayed in the service with any restricted access explained as appropriate. Confidentiality of information was seen to be maintained on inspection.

The responsible person worked at the service. A variety of audits were undertaken at the service, and action plans formulated. Audits were fed into benchmark reports.

Provision was in place for people to have their personal belongings stored safely. A policy covered this, and an inventory template was used as required which was signed by a nurse and witness.

**Evidence Source:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Observation | ✓ | Records | ✓ | Feedback | ✓ | Discussion | ✓ |

**Requirements:**
None

**Recommendations:**
None

**Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9) Standard 11 (Core Standards) Completion of Health Records**

**Our Decision:**
Compliant

**Reasons for our decision:**
A record keeping policy was in place. Entries in health records were electronically kept with date and times stated. Any alterations were clear. The responsible person confirmed that a summary of the health record would be provided to the service user's GP upon death or discharge from the service. Service users would be given a copy of their treatment record if they did not give consent for it to be provided to the GP.

**Evidence Source:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Observation | | Records | ✓ | Feedback | | Discussion | ✓ |

**Requirements:**
None

**Recommendations:**
None

**Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9) Standard 4 (Minimum Standards) Delivery of Palliative Care**

**Our Decision:**
Compliant

**Reasons for our decision:**
A palliative care clinical nurse from the relevant team was assigned to each service user. The patient list identified who would be involved with the family of the patient, seen on the weekly multi-disciplinary team weekly list. A counsellor, together with the bereavement service were also involved in line with the bereavement service operational policy.

Various literature was available at the service and also on the website regarding support for carers. Out of hours support was available via an on call rota, the inpatient unit and Hospice at Home. The palliative care team would then follow up any out of hours contact. On call arrangements were also in place in Rebecca House.

The Merseyside and Cheshire pathways were followed in the service. Rebecca House followed the "Together for Short Lives" policy. A variety of audits were undertaken, together with benchmarking, and patient and staff evaluations all contributed to analysis.

Evidence based clinical guidelines including National Standards, NICE Care of the Dying and Noble's Hospital Formulary were all incorporated into practice. Collaborative working with the North West helped to ensure sharing of best practice.

Surveys were available for service user and carers to complete.

The service environment had recently undergone refurbishment. All service users had single bedrooms which were en suite. Service user feedback confirmed that they were treated with compassion and dignity in each aspect of their care at hospice. They also confirmed that they themselves felt right at the heart of the care provided.

Staff had undergone training in "Opening the Spiritual Gate," a course to cater for spiritual requirements and provide compassionate care for all.

**Evidence Source:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Observation | ✓ | Records | ✓ | Feedback | ✓ | Discussion | ✓ |

**Requirements:**
None

**Recommendations:**
None

**Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9) Standard 11 (Minimum Standards) Self ADMINISTRATION OF MEDICINES**

**Our Decision:**
Compliant

**Reasons for our decision:**
A written medication policy was in place. A self-medication risk assessment was in place and carried out for each service user. Arrangements in place included agreement of the service user, senior registered nurse and designated medical practitioner. Medications dispensed by the pharmacy were confirmed to have full directions in place. A registered nurse was also available to give information and supervise when the service user was self-medicating. Each bedroom had its own lockable cupboard, with a spare key being held in a locked box in the pharmacy room.

**Evidence Source:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Observation | ✓ | Records | ✓ | Feedback | ✓ | Discussion | ✓ |

**Requirements:**
None

**Recommendations:**
None

**Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9) Standard 12 (minimum standards) Storage and supply of gases**

**Our Decision:**
Compliant

**Reasons for our decision:**
Specific individuals were identified to be responsible for all matters relating to medical gases. They were responsible for all liaison with contractors. The hospice pharmacist was responsible for the piped oxygen policy. The qualified medical gas pipeline quality controller was always on site when contractors were present, with evidence seen of competency seen on inspection. Confirmation was given that engineers would be appropriately trained, and permit to work would be in place as appropriate.

The policy and procedure was seen to be in place and included recording delivery, handling and storage. The quality controller certificate was seen on inspection.

**Evidence Source:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Observation | | Records | ✓ | Feedback | ✓ | Discussion | ✓ |

**Requirements:**
None

**Recommendations:**
None

**Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9) Standard 14 (Minimum Standards) Qualifications and training for staff caring for children**

**Our Decision:**
Compliant

**Reasons for our decision:**
The team at Rebecca House was led by a qualified children's nurse, who held a further qualification in palliative care, together with extensive experience. On call medical cover by a general practitioner was in place at all times. A standard operational procedure was in place and agreed with the Department of Health and Social Care. Staff training included safeguarding, symptom management and listening to children.

Staff had received training in interactions with children, together with some staff trained in sign language. There was always a minimum of one children's nurse on shift. If necessary, two registered children's nurses were available.

A resource allocation framework was in place. An assessment was carried out with the parent of the child and Rebecca House, together with regular reviews to ensure needs were being met. Registered nurses undertook a drug administration assessment. Nursery nurses and senior health care assistants undertook a full competency package before second checking drugs. A hospice competency framework had recently been implemented regarding assessment in the needs of children. Nursing staff completed advanced communication training on breaking bad news and also "Through the Spiritual Gate" training. The "Together for Short Lives" policy provided guidance for staff. Staff feedback confirmed that senior staff were always available for advice and guidance on ethical matters, with the nurse consultant holding a master's degree in ethics and carrying out training for staff.

**Evidence Source:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Observation | | Records | ✓ | Feedback | ✓ | Discussion | ✓ |

**Requirements:**
None

**Recommendations:**
None

**Other areas identified during this inspection /or previous requirements which have not been met.**

Standard 9.7
Identified issues with the call bell system must be satisfactorily addressed.

Standard 5.6
Some training was overdue and had not been refreshed appropriately.

**The inspector would like to thank the management, staff and service users for their co-operation with this inspection.**

**If you would like to discuss any of the issues mentioned in this report or have identified any inaccuracies, please do not hesitate to contact the Registration and Inspection Unit.**

**Inspector:** Sharon Kaighin **Date:** 16 December 2021

## Provider's Response

**From:** Hospice

I / we have read the inspection report for the inspection carried out on 17 November 2021 at the establishment known as Hospice, and confirm that there are no factual inaccuracies in this report. ☒

I/we agree to comply with the requirements/recommendations within the timescales as stated in this report. ☒

**Or**

I/we am/are unable to confirm that the contents of this report are a fair and accurate representation of the facts relating to the inspection conducted on the above date(s) ☐

**Signed**
**Responsible Person** Dr Ben Harris
**Date** 05/01/2022

**Signed** Vicky Wilson
**Registered Manager**
**Date** 05/01/2022