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

5 & 6 March 2019

Registration and Inspection Unit,
Ground Floor, St George's Court,
Hill Street, Douglas, Isle of Man, IM1 1EF.

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Completing and returning your report

To complete your report form, enter text by clicking on the box, use the tab key to move to the next box.

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    a. Add details of your actions to complete the requirements/recommendations (if applicable)
    b. Confirm you have read and agree/disagree the contents of the report by clicking on the appropriate box
    c. Sign (type name when returning electronically) and date

2. Return your report to **randi@gov.im** within 4 weeks

3. Do not use any other method e.g. links to Cloud or other file sharing services

Part 1: Service information

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Part 1 - Service Information for Registered Service

Name of Service: Hospice **Tel No: (01624)** 674444

Care Service Number: ROCA/P/0187A

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

Conditions of Registration:
1. The number of persons for whom care and accommodation can be provided at any one time must not exceed 16 (sixteen) in total. This is comprised of:
   12 (twelve) adult in-patient places
   4 (four) children's in-patient places

2. The number of people for whom day care is provided must not exceed 18 (eighteen) in total. This is comprised of:
   12 (twelve) adult day care places
   4 (four) children's day care places

3. Hospice at Home (Domiciliary Care Agency)
   No conditions apply to this service

Registered company name:
Hospice Isle of Man

Email Address:
Christine.Bloomer@hospice.org.im

Name of Responsible Person:
Diane Corrin

Name of Registered Manager:
Christine Bloomer

Manager Registration number:
ROCA/M/0169

Date of latest registration certificate:
09/03/17

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

Date of previous inspection:
26 February, 2 & 6 March 2018

Number of individuals using/residing at the service at the time of the inspection:
Inpatient Unit 6 & 7
Rebecca House 4 & 3
Scholl Day Centre 6 & 3

Person in charge at the time of the inspection: Christine Bloomer

Name of Inspector(s): Mandy Quirk & Margaret McGowan

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.

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.

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.

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.

Inspections are generally themed, concentrating 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, safe and compassionate.

No	Standard	Requirements/recommendations from previous inspection	Met/not met
1	5.6	All staff must be up to date with mandatory training.	Not fully assessed
2	3.10	Efforts to develop child friendly information leaflets must be completed	Met

Feedback from relevant parties

The inspectors had the opportunity to speak to a number of service users accessing the day centre and inpatient unit (IPU).
Feedback from the day centre
Service users described a number of benefits from accessing the service including:

- reduced feelings of isolation
- access to various therapies and support services
- peer support
- staff support

They were all very positive about the service, stated how welcoming it was and looked forward going.

Feedback from IPU
The service was described by a service user and their spouse as "a centre of excellence". Both parties felt supported and stated that it felt like a "home from home". This had the knock on effect of offering comfort to other family members through knowing that their relative was being well looked after. The couple felt that the teamwork, the care and support shown by staff alongside access to additional therapies had helped turn around their negative impact of the initial diagnosis. They now feel like "this is the start and not the end".

Part 4 - Inspection Outcomes, Evidence and Requirements

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9) Standard 1 (Core Standards)
Service recipients receive clear and accurate information about the service, their treatment and its likely costs

Our Decision: Compliant

Reasons for our decision:
There was a statement of purpose in place which provided succinct information regarding all areas of the service and had recently been reviewed. Information in the document and on the website stated that the document could be provided in alternative formats if required. In addition notices were placed in the Hospice reception areas. There were also information leaflets and operational policies.

Information was provided regarding:

- the purpose of services, the referral, access and discharge processes and the roles and responsibilities of staff working in each area.
- key policies including complaints, fire, medication and safeguarding.
- staffing details including training and qualifications

A new questionnaire had been developed which sought to gain feedback from service users, including comments or suggestions about how to improve services. The document will be sent out to service users twice per year.

All information about services provided was found to be regularly reviewed and amended as required.

Evidence Source:

Observation	✓	Records	✓	Feedback		Discussion	✓

Requirements and Recommendations
None

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9) Standard 3 (Core Standards)
Systems, checks, policies, procedures and staff training ensure that people's dignity, wellbeing and safety is promoted and protected.

Our Decision: Substantially Compliant

Reasons for our decision:
All staff members had access to detailed adult and child protection procedures, to guide and inform their actions. The children's policy was currently under review and required amending to include notification to the Registration and Inspection Unit.

There was a whistleblowing policy in place which had recently been reviewed.

Copies of the Isle of Man Adult Safeguarding Policy and Adult Protection Procedures 2018-2020 were available for staff members to refer on staff computers or in paper format.

All new staff had undertaken safeguarding training within their first six months of employment. In addition to this periodic refresher training was conducted. As part of the induction process the manager stated that safeguarding was discussed but this was not evidenced on the paperwork. During the inspection the induction programme was amended to address this issue.

The complaints policy and procedure were in place and recently updated. The policy covered all required areas. There was specific encouragement for service users and or their relatives/friends to raise any issues for the benefit of the service. Any issues raised were appropriately recorded, investigated and where relevant, actions implemented; within identified timescales.

All required fire safety measures were in place and had been regularly conducted, with appropriate records maintained. A fire risk assessment had been completed with no further actions identified. Staff members were up to date with training and refreshers.

Policies and procedures were in place to ensure the Hospice complies with relevant legislation that supports Safety, health and hygiene and the Health and Safety at Work Act 1974.

Records showed that all equipment, including therapeutic equipment and vehicles are checked regularly and any faults/repairs are dealt with promptly.

Staff received training in Infection Control and there were robust policies to support good practice. Housekeeping staff have good records as evidence that daily, weekly, monthly and deep cleaning is being carried out.

Written records, observations and feedback confirmed that food hygiene regulations were complied with. There were a number of relevant policies to support and guide staff practice in addition to annual training.

Each working area had a COSHH folder containing up to date advice and guidance in relation to the use of controlled or hazardous substances.

Reporting Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) were referred to in the health and safety policy. Incidents were correctly recorded and relevant parties informed.

A valid electrical installations certificate was in place.

There were systems in place to control the risk of exposure to Legionella micro organisms and the risk from hot water temperatures.

Central heating and boiler maintenance was up to date

There was a written procedure for staff to follow in the event of an interruption of a medical gas line.

A valid public liability certificate was on display in the reception area of the inpatient unit.

There was a waste management policy in place which was observed to be followed by staff working in Hospice. All waste was suitably separated, labelled, as required, and stored externally in locked containers.

Staff members working in Hospice follow the Department of Health and Social Care (DHSC) policy on blood borne viruses. There was also other supplementary policy and procedures to advise and support practice.

There were no Hospice employees with practising privileges.

Staff members were aware of the procedures to follow in the event of infection and of their responsibilities to inform relevant parties.

A new system in respect of staff vaccinations had been set up and all records were in the process of being completed.

Single use medical devices were found to be disposed of as intended whilst multi use devices were decontaminated in line with approved guidelines.

Evidence Source:

Observation	✓	Records	✓	Feedback		Discussion	✓

Requirements and Recommendations
Two

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9) Standard 9 (Core Standards)
Service recipients, staff and anyone visiting the registered premises are assured that all risks connected with the establishment, treatment and services are identified, assessed and managed appropriately.

Our Decision: Compliant

Reasons for our decision:
A current register of all risks within the establishment, which have been identified and assessed, was available for the inspection.

The methods used to manage those risks were listed and included good housekeeping, staff training and use of personal protective equipment.

Staff were also observed taking the appropriate precautions while delivering care, for example, disposing of clinical waste and used personal protective equipment in the prescribed manner.

The practice development lead and the nurse consultant had responsibility for dealing with alert letters, hazard notices and information from the Medical Devices Agency and the Medicines Control Agency.

There were two policies in place which dealt with issues regarding suspension of duties or restricted practise.

There was a call bell system in operation.

Evidence Source:

Observation	✓	Records	✓	Feedback		Discussion	✓

Requirements and Recommendations
None

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9) Standard 10 (Core Standards)
Measures are in place to ensure the safe management and secure handling of medicines. Medicines, dressings and medical gases are handled in a safe and secure manner. Controlled drugs are stored, administered and destroyed appropriately.

Our Decision: Compliant

Reasons for our decision:
Observation of staff members dealing with medication showed that they were in compliance with legislation and guidelines.

Hospice had a detailed safe handling of medicines policy which covered all required topics and the in patient, day service and community services.

There was an emergency medicines bag available, the contents of which was checked weekly and recorded. This was stored in the locked medication room.

Medication was only administered to service users following a written prescription. Medication administration charts were then put in place which staff members signed only after ensuring that the administration process was complete and if not, stating the reason for this.

The implementation and authorisation of patient group directives policy covered situations where medicines can be administered without a written directive. The competence of nurse practitioners, who carry out this task, was assessed annually by the consultant.

Medication doses were observed to be prepared immediately prior to administration.

Medicines were only used for the service user to whom they were prescribed. Any excess stock was returned to Nobles pharmacy or community pharmacy.

Nurses verbally inform service users about the use, benefits and potential harm of any medications used. In addition to this, information sheets are given with each medication prescribed on discharge.

There were up to date copies of the British National Formulary (BNF) available for reference.

Administration of medicines was in line with prescriptions and patient group directions.

Patient group directions comply with the DHSC and the Medicines Control Agency Guidance.

There was an audit trail available in relation to the ordering, receipt, supply, administration and disposal of all medicines dressings and medical gases.

The clinical room was locked and access restricted. Inside the room all drugs were contained in suitable lockable storage. In addition to which there was sterile non lockable storage.

Medical gases were stored externally except for when not appropriate due to the negative impact of low temperatures.

The nurse in charge on any given shift was the person responsible for the control of all keys.

Medicines requiring cold storage were kept in a lockable fridge, utilised solely for medication. Fridge temperatures were checked and recorded daily.

Controlled drugs were stored in a specified cabinet with records maintained in line with the Misuse of Drugs Act and its regulations.

Controlled drugs were not destroyed on site but returned to Nobles Pharmacy. In a locked, tamper proof bag.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements and Recommendations
None

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9) Standard 1 (Minimum Standards)
Service recipients and prospective service recipients, their families and carers, are clear about the arrangements for palliative care.

Our Decision: Complaint

Reasons for our decision:
Information about the eligibility criteria, referral and discharge processes for the range of services provided by Hospice was found in the statement of purpose, information leaflets and standard operating policies for each service area.

The referral and discharge policy was available on the Hospice website. Referral forms were found to be shared with General Practitioners (GPs), Noble's and Ramsey Hospitals.

Data was collated with regard to referral response times and reviewed regularly to ensure that access to services was prompt. In most cases this was within twenty four hours.

There was a multi-disciplinary approach to discharge planning.

A lone working policy was in place for those staff working in the Hospice at Home service.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements and Recommendations
None

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9) Standard 8 (Minimum Standards)
Responsibility for obtaining, prescribing, storing, use, handling, recording and disposal of medicines is clear.

Our Decision: Compliant

Reasons for our decision:
The consultant was the nominated person responsible for safe medicines systems within Hospice.

There was no in house pharmacy. All medicines were provided by Noble's hospital pharmacy.

Evidence Source:

Observation	✓	Records	✓	Feedback		Discussion	✓

Requirements and Recommendations
None

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9) Other areas identified during this inspection / Or previous requirements which have not been met.

Standard 5.6
The inspectors only reviewed training in relation to areas mentioned previously in the report. Not all mandatory training records were checked therefore this requirement will be carried forward to the next inspection.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements and Recommendations
One

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 identify any inaccuracies, please do not hesitate to contact the Registration and Inspection Unit.

Inspector: Mandy Quirk & Margaret McGowan **Date:** 20/03/19

Part 5 - Provider's action plan and response.

The provider must complete this page in respect of all the requirements made within the report.

Requirements and Recommendations

Standard 3.2
The children's safeguarding policy must include reference to notifying the Registration and Inspection Unit
Timescale: Met post inspection

Standard 3.4
The induction paperwork must be amended to evidence that safeguarding has been discussed during the first week of employment
Timescale: Met during the inspection

Standard 5.6
All staff must be up to date with mandatory training
Timescale: Carried forward as not assessed during this inspection

Provider's Action Plan

To: The Registration and Inspection Unit, Ground Floor, St George's Court, Hill Street, Douglas, Isle of Man, IM1 1EF

From: Hospice

I / we have read the inspection report for the unannounced inspection carried out on **5 & 6 March 2019** at the establishment known as **Hospice**, and 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). ☒

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) ☐

Please return the whole report which includes the completed action sections to the Registration and Inspection Unit within 4 weeks from receiving the report. Failure to do so will result in your report going on line without your comments.

Signed
Responsible Person Diane Corrin
Date 09/04/19

Signed Christine M Bloomer
Registered Manager
Date 09/04/19

Action plan/provider's response noted and approved by Inspector:
Date: 10/04/19 **Signature/initials:** MQ