Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Independent Healthcare Inspection (Unannounced)

St Josephs Hospital

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1. Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales.

HIW's primary focus is on:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW inspections of independent healthcare services seek to ensure services comply with the Care Standards Act 2000 and requirements of the Independent Health Care (Wales) Regulations 2011 and establish how services meet the National Minimum Standards (NMS) for Independent Health Care Services in Wales[1].

This report details our findings following the inspection of an independent health care service. HIW is responsible for the registration and inspection of independent healthcare services in Wales. This includes independent hospitals, independent clinics and independent medical agencies.

We publish our findings within our inspection reports under three themes:

- Quality of patient experience
- Delivery of safe and effective care
- Quality of management and leadership.

[1] The National Minimum Standards (NMS) for Independent Health Care Services in Wales were published in April 2011. The intention of the NMS is to ensure patients and people who choose private healthcare are assured of safe, quality services. http://www.hiw.org.uk/regulate-healthcare-1

2. Methodology

During the inspection we gather information from a number of sources including:

- Information held by HIW
- Interviews with staff (where appropriate) and registered manager of the service
- Conversations with patients and relatives (where appropriate)
- Examination of a sample of patient records
- Examination of policies and procedures
- Examination of equipment and the environment
- Information within the service's statement of purpose, patient's guide and website (where applicable)
- HIW patient questionnaires completed prior to inspection.

At the end of each inspection, we provide an overview of our main findings to representatives of the service to ensure that they receive appropriate feedback.

Any urgent concerns that may arise from an inspection will be notified to the registered provider of the service via a non-compliance notice[2]. Any such findings will be detailed, along with any other improvements needed, within Appendix A of the inspection report.

Inspections capture a snapshot on the day of the inspection of the extent to which services are meeting essential safety and quality standards and regulations.

[2] As part of HIW's non-compliance and enforcement process for independent healthcare, a non compliance notice will be issued where regulatory non-compliance is more serious and relates to poor outcomes and systemic failing. This is where there are poor outcomes for people (adults or children) using the service, and where failures lead to people's rights being compromised. A copy of HIW's compliance process is available upon request.

3. Context

St Josephs Hospital Ltd is registered to provide an independent hospital at St Josephs Hospital, Harding Avenue, Malpas, Newport, NP20 6ZE. The service has 26 beds. The service was first registered on 12 July 2014. Prior to this, the hospital was run by a different registered provider and initial registration as an independent hospital was 23 April 1991.

The service employs a team of approximately 200 staff which includes an Executive Chairman (Responsible Individual) and Director of Clinical Services (Registered Manager – vacant at the time of our inspection).

Within clinical services a number of staff are employed including a resident medical officer (RMO) giving 24 hour medical cover, medical staff, nursing staff, healthcare assistants, theatre staff, pharmacists, radiographers and physiotherapists. A number of clinical and non-clinical staff (including secretarial, catering and housekeeping) also work across a further eight departments including Clinical Physiotherapy, Support Services, Facilities, Human Resources, Finance, Business Development and Advanced Diagnostics.

A range of services (inpatient and outpatient) are provided which include:

- Orthopaedics
- General surgery
- Colorectal
- Gynaecology
- Breast Care
- Rheumatology
- GP service
- Ophthalmology
- Urology
- Ears, Nose and Throat (ENT)
- Cosmetic surgery
- Bone marrow harvest
- Medical investigations

- Rehabilitation, convalescence, respite and medical care
- Outpatients department
- Operating theatres
- Physiotherapy/hydrotherapy centre
- Imaging department
- Onsite pharmacy
- Urgent care centre (minor injuries unit)
- Pathology
- One stop cardiology unit.

A full list of services can be found in the registered provider's Statement of Purpose. Healthcare Inspectorate Wales (HIW) completed an unannounced inspection to the service on 25 – 26 August 2016. Our inspection team focussed on the ward, theatre, urgent care centre and physiotherapy/hydrotherapy centre. The team also visited the outpatients department.

4. Summary

Overall patient satisfaction was extremely high. Patients made positive comments about the quality of care, food, cleanliness of the environment and professionalism of staff. Overall we found that the service recognised and addressed the individual needs of patients and staff treated patients with dignity and respect. There were mechanisms in place for seeking patient feedback and to allow patients to raise concerns. In addition to some minor points, we have recommended that the service make improvements in regards to specific aspects of care planning and provision, consent and communicating effectively.

Notwithstanding the improvements highlighted within this report, we were sufficiently assured that the service provided patients with safe, effective treatment and care which was based on agreed best practice guidelines. Some areas of improvement included; ensuring staff received up to date training in important areas such as safeguarding; ensuring aspects of infection control improvements were followed through; ensuring medicines were stored securely at all times and ensuring there were specific actions and accountability for managing organisational risks.

Across all departments we found dedicated and committed staff teams. We were told the responsible individual was on site, visible and accessible. At the time of the inspection there was a vacancy for the registered manager post. As a result of our inspection the service improved the interim arrangements for covering this role. However, we found that the overall governance and accountability within the service could be improved including communication flow between the Board and operational staff. Although we saw some evidence of audits, we could not be assured that there was consistency in audit activity and practices across departments, or that there was sufficient central oversight of audit compliance and aspects of management such as staff training and appraisals.

We found that staff had not received up to date training in a number of areas. At the time of the report, HIW was liaising with the service to ensure there was a detailed training plan in place to improve staff compliance and ensuring the service had appropriate interim arrangements in place.

Given the findings from this inspection, some improvements are needed in the quality assurance and governance arrangements of this service to ensure compliance with the relevant regulations and standards. This is important to ensure the safety and effectiveness of the service provided.

Whilst this has not resulted in the issue of a non compliance notice, there is an expectation that the responsible individual and registered manager take meaningful action to address these matters, as a failure to do so could result in HIW taking action for non-compliance with the regulations.

Findings

Quality of patient experience

Overall patient satisfaction was extremely high. Patients made positive comments about the quality of care, food, cleanliness of the environment and professionalism of staff. Overall we found that the service recognised and addressed the individual needs of patients and staff treated patients with dignity and respect. There were mechanisms in place for seeking patient feedback and to allow patients to raise concerns. In addition to some minor points, we have recommended that the service make improvements in regards to specific aspects of care planning and provision, consent and communicating effectively.

During our inspection we spoke with a number of patients informally about the care provided and also asked patients to complete HIW questionnaires to gain formal feedback. 19 questionnaires were completed. Overall patient satisfaction was extremely high, with most patients rating the service between nine or 10 out of 10. Patients provided particularly positive feedback regarding the cleanliness and tidiness of the environment and professionalism of staff.

Some comments included:

> *'100% as perfect as possible…very impressive' (Patient – physiotherapy and hydrotherapy centre)*
>
> *'Very friendly and professional thank you. Also grounds/gardens are immaculate' (Patient - ward)*
>
> *'All staff very professional from consultant through to nursing staff, pharmacy, cleaning staff and catering/hospitality...They all have had enough time to attend to both clinical and social and emotional issues' (Patient - ward)*
>
> *'Staff are always friendly and happy to help' (Patient – outpatients department)*
>
> *'My 89 year old mum has been treated with the greatest respect' (Carer - outpatients).*

<u>Equality, Diversity and Human Rights (Standard 2)</u>

Overall we were assured that the service had equality priorities in accordance with legislation.

The physical environment as a whole was accessible to patients with limited mobility or patients who used wheelchairs. There was a designated nursing post (patient support sister) offering support and information to individuals both pre and post operatively, to discuss their individual needs and to ensure services met their needs. This supportive role was greatly appreciated by patients and was an area of best practice.

Staff told us they did not currently see a high number of patients with cognitive impairment/dementia. However, with increasing NHS waiting list activity which brings a broader client group, we suggested the service consider how to implement best practice in terms of care for people with cognitive impairment. Specifically in ensuring services, including staff training, hospital practices and the environment could fully meet the needs of patients with confusion/dementia.

Improvement needed

The service should consider any adjustments needed to ensure the service takes due regard of those patients with confusion/cognitive impairment/dementia.

Citizen Engagement and Feedback (Standard 5)

Overall we found robust mechanisms in place for seeking feedback and making changes to improve services based on feedback.

We found that the views of patients were sought through the routine distribution of questionnaires to all patients and through individual follow up with patients post-operatively by the patient support sister. There was also a suggestion box available on the ward where patients and carers could submit suggestions for improvements. We suggested that staff consider the placement of the suggestion box to ensure it was in a suitably visible place to all patients and carers. Patient feedback was considered regularly by management and we were assured that this was taken seriously and used as a mechanism to make service improvements.

We saw that the patient guide did not currently include the results of any consultation about services being provided and we have addressed this under the management and leadership section regarding the contents of the patient guide as a whole.

We saw that there was a complaints policy in place which outlined responsibilities for managing complaints, timescales and routes for escalation. We looked at the complaints log and saw that complaints were managed fairly and appropriately. The complaints log did not include the date that the complaint was acknowledged and the date it was resolved. This meant we could not assess whether complaints were being managed within the timescales outlined in the service's procedure.

Improvement needed

The service must ensure that complaints records include dates, so that they are able to demonstrate that complaints are managed in line with specified timescales.

Although the majority of patients completing HIW questionnaires knew how to make a complaint, five patients stated that they did not know how to make a complaint. The service is advised to consider whether they could make complaints information more easily visible and accessible.

Care Planning and Provision (Standard 8)

We observed staff delivering a high standard of care to patients in a timely way and found staff to be dedicated and committed to maintaining high standards.

We looked at a sample of patient records in detail, across the four areas and overall found a good standard of care planning and record keeping. We saw that care was delivered according to recognised pathways underpinned by supporting evidence and there was access to 24 hour medical care. We saw evidence of a multidisciplinary approach to care, treatment and discharge.

Patient records followed recognised assessment methods across all departments and were comprehensive. We saw that appropriate risk assessments and care plans were in place (including for example, falls, nutrition, oral hygiene) and there was a focus on patient comfort and effective pain control.

Overall we found documentation to be well organised. There was particularly good practice in the urgent care centre which used an electronic records system and there were clear, up to date notes which could not be modified, which meant a robust audit trail was in place. However, we saw some duplication of records in the physiotherapy/hydrotherapy centre where a paper notes system was in use. The department should consider reviewing the organisation of records, perhaps through implementing records audits and sharing practice from other departments.

Across the sample of records we inspected, we found that venous thromboembolism (VTE) risk assessments[3] were being carried out but there was inconsistency in how

[3] **Venous thromboembolism** is a condition where a blood clot forms in a vein and the chance of developing them increases if patients are immobile and unwell or need surgery. The National Institute for Clinical Excellence (NICE) guidelines state that all patients should be risk assessed on admission

these were being implemented and how appropriate prescribing occurred, as a result of the risk assessment. We discussed this with senior management who agreed to make a clear policy available to all staff.

Improvement needed

The service must ensure that VTE risk assessments are both carried out and actioned in a consistent way which adheres to national guidelines.

We found evidence of engagement in the World Health Organisation (WHO) surgical safety checklist[4] in every set of notes within theatre. We saw documentary evidence of staff following the 'Five Steps to Safer Surgery'[5] guidance in all areas except for recording the process of patient sign out where we found lack of completion in this area, in some cases.

Improvement needed

The service must ensure that all five steps of the 'Five Steps to Safer Surgery' are completed with documentary evidence to support this, particularly regarding the sign out stage.

Across several departments we saw some entries in patients' medical notes that were illegible and did not consistently state the doctor's grade/time/location, in line with national guidelines.

Improvement needed

All staff must ensure that written notes are legible and consistently state the doctor's grade/time location.

The urgent care centre was registered to provide treatment to children over the age of 6yrs old. There were some aspects of the provision of paediatric treatment within the urgent care centre that we asked the service to review. This was in relation to

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to hospital and should be reassessed within 24 hours of admission and whenever the clinical situation changes.

[4] The **WHO Surgical Safety Checklist** is an evidence based process of checks that support informed consent and safe checking of patients for theatre.

[5] The **'How to Guide – Five Steps to Safer Surgery'** is guidance issued by the National Patient Safety Agency which supports the implementation of the WHO Surgical Safety Checklist and promotes best practice in providing safe surgical care.

both the environment and clinical expertise. In regards to the environment we found that improvements were needed to ensure it was appropriate for children. There was one designated paediatric treatment room and we found uncovered plug sockets and sharp corners in this room which could present a risk to children and did therefore not fully adhere to the service's own young person's policy. We also saw that there was no separate waiting area designated for children, which would be in line with best practice guidelines. This is an aspect we recommended the service implement at the point of registration. At present, there was no specifically trained paediatric doctor or Registered Sick Children's Nurse (RSCN) assigned to the urgent care centre. However, staff in the centre were trained in paediatric resuscitation. Although the numbers of children accessing the service were currently low and for specific treatment, we raised our concerns in this regard with the service. Staff training compliance with child protection training across the hospital was low and we have addressed this under the safeguarding section below.

Improvement needed

The service must ensure that the urgent care centre is suitable for children to access both in terms of the physical environment (separate waiting area and appropriate environment within treatment room) and in being assured that there is sufficient clinical and nursing expertise.

Patient Information and Consent (Standard 9)

There was a full and detailed Mental Capacity Assessment policy in place and staff we spoke with were aware of these guidelines.

We explored the procedure in obtaining consent for patients who were due to have surgery under local anaesthesia/minor procedures and we found that in some cases, patients were being asked for their consent in the anaesthetic room immediately prior to the operation. National guidelines recommend that consent should be obtained in advance of the procedure so as not to put undue stress on the decision making process. We discussed this with senior staff who agreed to implement these guidelines both in ensuring the policy adhered to this and that this followed through to practice.

Improvement needed

The service must ensure that national guidelines regarding consent are consistently adhered to. Specifically in ensuring that all patients are asked for their consent with sufficient time to weigh up decisions, in advance of procedures.

Dignity and Respect (Standard 10)

We observed kind and caring interactions between patients and staff and our conversations indicated that patients felt the service upheld their dignity and respect. Patients remarked that staff had time to spend with them and the overall support role undertaken by the patient support sister was also highly valued.

Overall the environment provided private areas where patients could choose to meet with staff and visitors according to their preferences for privacy. However, these spaces were limited in two areas; on the ward and in the outpatients department. In these areas we could not be assured there were sufficient private spaces on these departments for highly sensitive conversations or 'breaking bad news'. Staff told us they were aware of this and were reviewing the environment. Staff we spoke with were aware of how to maintain patients' privacy and protect confidentiality and we saw this followed through in practice.

Nutrition (Standard 14)

Although we did not assess this standard in depth we saw that patient's nutritional needs were assessed and patients made positive comments about the provision and quality of food and drink. Patients told us they liked the fact that the menu was discussed with them and they could request food at any time. Comments included;

- *'Catering staff would give you the moon if they had one in the fridge!'*

We saw that food was available 24 hours a day and patients told us they had access to a varied choice of food. We observed water being changed regularly through the day, across departments.

Communicating Effectively (Standard 18)

Our observations and patient questionnaires indicated that patients had access to sufficient information about their medical conditions. There was a range of information available to patients and we saw that the patient support sister was currently working on specific guides for each type of surgical procedure. The patient support sister also worked in their support role to ensure each patient had the information they required regarding their care and treatment both pre and post operatively. The work of the patient support sister in communicating with patients was an area of best practice.

Although a range of written information was available throughout the hospital, we found a lack of information routinely produced in other formats, including Welsh. There was a need for key information to be accessible and easily available to patients who may have varying communication needs.

Three patients who responded to HIW questionnaires stated that they could not communicate with staff in the language of their choice. The service's communication policy outlined how staff could access a local company for interpreting and translation services. However, staff we spoke with were not aware that there was a formal interpreting and translation service and told us they used differing online tools to translate and interpret information with patients on an ad hoc basis.

Improvement needed

The service must ensure that information (both written and verbal) is provided in formats that take account of patients' language and communication needs, including Welsh.

Delivery of safe and effective care

Notwithstanding the improvements highlighted within this report, we were sufficiently assured that the service provided patients with safe, effective treatment and care which was based on agreed best practice guidelines. Some areas of improvement included; ensuring staff received up to date training in important areas such as safeguarding; ensuring aspects of infection control improvements were followed through; ensuring medicines were stored securely at all times and ensuring there were specific actions and accountability for managing organisational risks.

Safe and Clinically Effective Care (Standard 7)

We found that treatment and care was based on agreed best practice guidelines and in each department we found that recognised care pathways were used to treat patients.

We had a discussion with the Chair of the Clinical Governance Advisory Board who talked us through a system of clinical governance that appeared robust. Following the inspection we also received further information around clinical governance and quality assurance arrangements. However, given our findings, we require assurance that the service has implemented a full clinical governance/clinical audit policy which details how they will meet the requirements under the regulations for registered provider visits and production of an annual report. More detail on these requirements can be found under the quality of management and leadership section.

Improvement needed

The service should ensure that there is a full clinical governance/clinical audit policy in place which demonstrates how the service will meet regulatory requirements.

We found that policies were being updated on a regular basis, although information in the statement of purpose and patient guide required review. More detail on these requirements is included under the quality of management and leadership section below. We could not be assured that there was a formalised consultation process with staff regarding policies and staff told us heads of department were responsible for disseminating information to their staff teams. The service should consider how they can involve and consult with staff in regards to policy development, where appropriate, and ensure there is consistency in the dissemination of information.

Safeguarding Children and Safeguarding Vulnerable Adults (Standard 11)

The service had up to date safeguarding policies and procedures in place in relation to the protection of vulnerable adults, deprivation of liberty safeguards and young persons' services (including child protection procedures) which were clear and detailed.

Our discussions with staff indicated that they were aware of their responsibilities and actions for identifying and reporting abuse. However, we identified that training compliance in these areas was particularly low with only three staff being in date with child protection training and five staff being in date with Protection of Vulnerable Adults (POVA) level one and two training. This meant that we could not be assured that all staff were sufficiently up to date with the training required to manage safeguarding concerns.

Improvement needed

All staff must receive up to date training in safeguarding (both POVA and child protection) on an ongoing basis.

Infection Prevention and Control (IPC) and Decontamination (Standard 13)

There were suitable infection prevention control policies and staff followed agreed protocols to minimise the risk of healthcare associated infections. We saw that infection rates were low.

We found the environment to be visibly clean and tidy however, some modifications to the environment were needed to ensure best practice guidelines in infection control were fully followed. For example, on the ward we found carpeted floors in some cubicles and corridor. We also saw that the material of patient chairs was not wipeable. Some PPE equipment was not available in the physiotherapy department.

There was a designated and very knowledgeable infection control nurse in place and although senior staff told us that there was designated time for this role, in practice we heard that there was some difficulty in ensuring this happened. The infection control nurse liaised with national groups to ensure they were up to date on developments and delivered training to both clinical and non clinical staff. Training records we saw were not clear in relation to current staff compliance. Staff training as a whole is addressed further, under the management and leadership section below.

Heads of department were responsible for carrying out hand hygiene audits and we were not able to fully assess whether these were routinely carried out due to a lack of centrally stored audit information. The infection control nurse reported to the infection control committee. Minutes from these meetings indicated that appropriate infection control matters were discussed at a senior management level.

Improvement needed

The service should address the following points in relation to infection control:

- ***The issues as outlined in regards to several aspects of the physical environment (carpets, chairs, PPE equipment in physiotherapy department) should be reviewed and addressed where needed.***

- ***The service must be assured that infection control audits are consistently carried out and that sufficient oversight exists to monitor this activity.***

- ***Ensure that there is demonstrable evidence that the Infection Control nurse is given adequate time to fulfil the function of the specialised role.***

Medicines Management (Standard 15)

There was a clear medicines management policy in place. The medicines administration records we saw had been accurately completed. We saw that allergies were clearly documented. Onsite pharmacy services provided support to all departments. We found that patients were provided with appropriate medicines advice and information.

We saw that the lock on the medicines trolley on the ward was broken. This meant that when the medication trolley was used on rounds, there was a risk that, if the registered nurse was called away, the trolley could be left unlocked in the corridor. We also witnessed one instance where the medication bedside locker of one patient was unlocked and open, with the patient having gone to theatre and medication being present and unsecured. This meant that the service needed to review these aspects to ensure medicines were stored securely to prevent unauthorised access. We raised these concerns at the time of the inspection and they were dealt with immediately.

Improvement needed

The service must ensure that medications are stored securely at all times.

We found good organisation and monitoring of resuscitation trolleys to ensure all appropriate equipment was in place in the event of medical emergencies. We found that one first aid kit (wall mounted in the main corridor of the physiotherapy/hydrotherapy department) had not been checked to ensure all contents were in date.

Improvement needed

The first aid kit in the physiotherapy/hydrotherapy department must be checked. The service must be assured that all first aid kits across the hospital are checked and the contents within date.

Managing Risk and Health and Safety (Standard 22)

There was a comprehensive risk management policy in place which explained how risks to patients were managed and minimised within the service.

Appropriate health and safety policies and risk assessments were available, for example, fire safety and dealing with verbal and physical abuse. There was one occasion where we saw that a cleaning reagent had been left out in a patient area which could pose a health and safety risk. We raised this with staff at the time who immediately rectified it.

Improvement needed

All Control of Substances Hazardous to Health (COSHH) items should be securely stored at all times.

Staff told us and we observed, that the temperature on the ward could become high and uncomfortable on warm days. We saw that this had been raised with management and the service should consider how to resolve this, to ensure the temperature is comfortable for patients and staff.

An organisational risk register was in place. There was a lack of detail within the risk register regarding specific actions to be taken to minimise risks and a lack of specified timescales for action.

Improvement needed

The service must be able to demonstrate that there is a robust system in place for identifying, assessing, managing, recording and reviewing risks on an ongoing basis where responsibilities, specific actions and timescales are clearly outlined.

We found there was a system in place to ensure safety bulletins and alerts were acted on and heads of department took responsibility for this. In practice we found one area where alerts were not always filtered down to operational staff for information, if the alert was not applicable, whereas in other departments all alerts were disseminated. All alerts should be shared with staff to promote staff learning and awareness. The service must ensure that procedures are consistently followed in regard to sharing patient safety information with staff.

Improvement needed

The service must ensure that all patient safety bulletins and alerts are shared with operational staff consistently and across all areas.

Dealing with Concerns and Managing Incidents (Standard 23)

We found that incidents and concerns were managed appropriately. There was a process in place to manage regulation 31 incidents (incidents which require the service to notify HIW). However, this role was undertaken by the registered manager prior to them leaving and the person taking accountability for this in the interim had not been formalised. We addressed this outside of the inspection process and this was subsequently formalised.

There was a process in place for reporting and managing clinical incidents and incidents were monitored by the chair of the clinical governance board and through the clinical governance structure.

Quality of management and leadership

Across all departments we found dedicated and committed staff teams. We were told the responsible individual was on site, visible and accessible. At the time of the inspection there was a vacancy for the registered manager post. As a result of our inspection the service improved the interim arrangements for covering this role. However, we found that the overall governance and accountability within the service could be improved including communication flow between the Board and operational staff. Although we saw some evidence of audits, we could not be assured that there was consistency in audit activity and practices across departments, or that there was sufficient central oversight of audit compliance and aspects of management such as staff training and appraisals.

We found that staff had not received up to date training in a number of areas. At the time of the report, HIW was liaising with the service to ensure there was a detailed training plan in place to improve staff compliance and ensuring the service had appropriate interim arrangements in place.

Improvements are needed in the quality assurance and governance arrangements of this service to ensure compliance with the relevant regulations and standards. This is important to ensure that safe and effectiveness service are provided to patients at all times.

Governance and accountability framework (Standard 1)

At the time of our inspection there was a vacancy for the registered manager. Staff told us the responsible individual was regularly on site and accessible. We found that the overall lines of governance and accountability within the service could be improved. This was because:

- The registered manager had recently left and the interim arrangements, which staff told us could potentially be up to five months long, involved current staff taking on additional responsibilities to cover the role, in addition to their ongoing duties. We could therefore not be assured that the arrangements were robust or formal enough to provide appropriate cover for the registered manager role and responsibilities. We addressed this outside of the inspection process and the service subsequently appointed a current member of staff to provide full time interim cover for the registered manager role.

- On the days of our inspection we found that a number of key senior individuals across the hospital were on annual leave. This included senior management staff in addition to key management staff within several clinical departments. Due to there also being a vacancy for the registered manager at this time, we could not be assured that annual leave had been coordinated

across departments to ensure clear lines of accountability were in place during this period of annual leave. Should an incident have occurred, which required a senior manager to be present with a clinical knowledge base, the service was not well placed to provide onsite resolution.

- We could not be assured that there were effective communication channels between frontline services and the Board. This is because we found some significant gaps in staff training compliance which the Board had not been made aware of by the relevant departments. Staff on the ground told us they felt dissemination of information from the Board and senior management to them, could be improved.

19 staff completed HIW staff questionnaires which asked a range of questions about the working environment, employment practices, training and support. Over the course of the inspection we also spoke with staff informally and staff were also able to give their feedback to HIW through other available routes.

Overall, staff were positive about the quality of training they received and the quality of care they gave to patients. However, there was some variability in staff responses to feeling that there were enough staff to enable them to do their jobs properly and in how supportive they found the organisation. Staff also raised some individual concerns with us around the culture of the organisation. We addressed these concerns with the service outside of the inspection process and at the time of the report we had not yet received confirmation on how the service planned to address this.

In one area (theatre) we found particularly good management and leadership with staff who felt well supported and noticeable improvements being made to services. Across all departments we found a committed and dedicated staff team.

Staff indicated that they felt communication flow between senior management and operational staff could be improved. We saw that an engagement event had recently taken place to reflect on the last two years and we heard about planned improvements to enable staff to give feedback on services. Our findings suggest that staff would welcome improvements in these areas.

There was a lack of availability of space on the ward for staff to be able to change and take breaks. We also found that staff on the ward did not have access to a computer to enable them, for example, to easily access policies and best practice guidelines.

Improvement needed

The service should consider how to improve engagement and communication flow with staff. The service should consider the detailed feedback provided by HIW around staff concerns and identify how they will make improvements.

The service should consider making improvements to staff facilities on the ward regarding the aspects outlined above.

We had a discussion with the Chair of the Clinical Governance Advisory Board who talked us through a clinical governance structure consisting of Clinical Heads of Department meetings, a Clinical Advisory Governance Board and the Board to provide oversight. Staff gave us some examples of improvements that had been made to services as a result of clinical needs being demonstrated through this structure, which was good practice. We found there was a quality dashboard in place to monitor aspects of services and this had been extended to include incidents. The quality dashboard however, had a particular surgical focus and we saw that nursing data, for example, was not included and patient outcome data such as complaints and feedback was considered elsewhere. We suggested that the dashboard could be extended to include all quality improvement data for improved ease of oversight.

We found a lack of consistency across departments in terms of audit activity. Within the departments we visited it was difficult to find evidence of audits and we could not be assured that there was a system in place for monitoring relevant nursing data. We also advised the service to review the key performance indicators within the physiotherapy/hydrotherapy centre to ensure they were sufficiently clinically driven with a focus on patient outcomes. This meant that we could not be assured that there was consistency across departments in terms of quality improvement and audit activity and whether the current structures provided sufficient oversight to all departments in this regard.

Improvement needed

The service should ensure that there are consistent and agreed quality improvement activities across departments and must ensure that systems are in place to allow sufficient oversight of these activities.

There was a statement of purpose in place but we found that this had not been updated and there was some information missing. For example, there was reference to NMC guidance from 2004 (now out of date), some allocation of responsibilities required updating due to the registered manager vacancy and parts nine and 11 of the regulation needed to be added to make the statement of purpose compliant.

Improvement needed

The Statement of Purpose must be updated and must include all information as listed under Schedule 1 of the Independent Healthcare (Wales) Regulations.

There were inpatient and outpatient guides available which staff used as their patient guide. These documents did not include all information required for a patient's guide under regulation 7.

Improvement needed

The Patient's Guide must include all information as listed under Regulation 7.

We found that formal, 6 monthly registered provider visits were not taking place as specified under regulation 28 of the Independent Healthcare (Wales) Regulations. We also found that staff did not produce a written annual assessment of the service as specified in regulation 19 (3) and at the time of the report we had not received further detail around ongoing quality assurance processes.

Improvement needed

The service must carry out and document 6 monthly registered provider visits.

The service must produce an annual assessment including information as specified under Regulation 19 (3).

Records Management (Standard 20)

Overall we found the service's records to be designed, reviewed and accessible to meet the required needs.

There was one area where we found the storage/security of patient records required review to ensure they were safely and securely stored. This was in the physiotherapy/hydrotherapy centre where we found some historical patient records with identifiable information, stored in an unlocked cupboard.

Improvement needed

The service must ensure that all patient records are stored safely and securely.

Workforce Recruitment and Employment Practices (Standard 24)

We looked at a small sample of staff files and found that the service undertook appropriate recruitment and employment checks to ensure staff were suitable to work in the service before starting employment. There were systems in place to ensure ongoing registration compliance with relevant professional bodies and other checks. The HR department was currently making improvements to some of the electronic systems to ensure all information could be easily accessed and located.

There was a process in place to ensure that checks were carried out to ensure all persons granted practising privileges were competent to undertake the clinical care they wish to provide.

Workforce Planning, Training and Organisational Development (Standard 25)

Overall we found staff were able to spend time with patients in order to meet their needs. However, on the ward we observed particularly busy times (for example when patients returned from surgery), when nursing staff were particularly busy. On the first day, the workload at certain points meant that nursing staff had not been able to take their breaks. We raised this with the staff member in charge who ensured staff were then able to take their breaks. The periods of high patient flow should be accounted and planned for, to ensure there are sufficient numbers of staff to cover these times.

Improvement needed

The service should review staffing on the ward accounting and planning for the particularly busy times and those times where there may be a higher level of patient flow, to ensure there are sufficient numbers of staff available.

Staff told us there was an appraisal system in place and we saw template forms that could be used. However, responsibility for appraisals and supervision rested with the heads of department and compliance was not centrally and consistently monitored. We were therefore not able to easily access any data relating to appraisal compliance.

Improvement needed

The service must ensure there are systems in place to provide sufficient oversight of staff support systems including appraisals and supervision so that there can be assurance that staff are appropriately supported.

The service's website states that nursing staff are 'highly trained and continually refreshing their knowledge of the latest developments in nursing'. However, we found a lack of oversight in regards to staff training as a whole. We found that staff had not received up to date training in a number of areas including mandatory topics such as child protection (three staff in date, 74 staff out of date), manual handling (five staff in date, 66 staff out of date) and basic life support (59 staff in date, 18 staff out of date). We found that training records were held both at department level and by the HR department, however, it was unclear whether the central training register was up to date during our inspection. We followed this up outside of the inspection and senior management staff told us they had not been aware of the low training compliance across areas. At the time of the report, HIW was liaising with the service to ensure there was a detailed training plan in place to improve staff compliance and ensuring the service had appropriate interim arrangements in place.

HR staff advised that each department was responsible for overseeing the induction of new staff. We saw that the corporate and departmental inductions were signed and returned to HR when complete. Staff told us they planned to formalise this process.

Improvement needed

The service must urgently act in supporting staff to develop, maintain and ensure they have the right knowledge and skills to provide safe treatment and care. The service should ensure that:

- ***Staff training records are kept up to date on an ongoing basis***
- ***There are clear responsibilities in regards to training***
- ***There is sufficient oversight to monitor training compliance and action is taken where needed.***

Given the areas for improvement identified during this inspection, consideration should be given to ensuring that there are more effective and proactive arrangements in place at the service to monitor compliance with relevant regulations and standards. Whilst no specific recommendation has been made in this regard, the expectation is that there will be evidence of a commitment to address the issues identified in this report and a notable improvement in this respect at the time of the next inspection.

5. Next Steps

This inspection has resulted in the need for the service to complete an improvement plan in respect of St Josephs Hospital. The details of this can be seen within Appendix A of this report.

The improvement plan should clearly state how the improvements identified St Josephs Hospital will be addressed, including timescales.

The improvement plan, once agreed, will be published on HIW's website and will be evaluated as part of the ongoing inspection process.

Appendix A

Improvement Plan

Service: **St Joseph's Hospital**

Date of Inspection: **25 – 26 August**

Page Number	Improvement Needed	Regulation / Standard	Service Action	Responsible Officer	Timescale
Quality of Patient Experience					
8	The service should consider any adjustments needed to ensure the service takes due regard of those patients with confusion/cognitive impairment/dementia.	Regulation 17, 18 Standard 2	Policies are amended as necessary. Associated procedures regarding Informed Consent are in the process of being updated subsequent to professional advice having been taken from social services. Pre-admission process is timely and robust, detailed and thorough in seeking to identify patients with impairment. Individual needs are planned for accordingly. Dementia "Champion" in post with plans to train another. The hospital recognises the importance of making adjustments necessary to deal with patients with dementia and cognitive impairment. Our figures suggest that the load of dementia patients in the hospital is currently very low, but we will monitor the numbers	Director of Clinical Services	2 months

			closely going forward. We do have some patients who will be cognitively impaired in the immediate post-operative period. Our policy with regards to care planning of patients with dementia and cognitive impairment is to create individual plans to fit all their needs. All patients with such impairment are in a spectrum and we believe that our individual plans are more specific and address each patient's individual needs. We also recognise and applaud the All Wales Dementia Strategy. Our aim is to work towards a gold standard dementia policy with all necessary adjustments as and when the load on the hospital demands it.		
9	The service must ensure that complaints records include dates, so that they are able to demonstrate that complaints are managed in line with specified timescales.	Regulation 19, 28, 24 Standard 5	Actioned.	Executive Chairman's PA	Complete
10	The service must ensure that VTE risk assessments are both carried out and actioned in a consistent way which adheres to national guidelines.	Regulation 9, 15, 47 Standard 8	Action taken to ensure nursing staff complete VTE assessment as directed. All admissions to the hospital are risk assessed using a NICE/1000 lives approved VTE risk assessment form. The patient is then provided with all the relevant information for them to make a decision about the preventative measures that are being offered.	Director of Clinical Services	Complete

			As there are a wide range of surgical procedures and different risks the final decision for the method of preventative measures is left to the patient and his/her surgeon. All decisions are documented and regular audits are conducted to ensure that we have 100% compliance with the risk assessments. With regards to the issue with chemical prophylaxis it is the responsibility of the surgeon to choose the type of anti-coagulant in conjunction with the patient. We will implement the All Wales Prescription sheet shortly (with some minor modifications) in which there is a new section recording VTE directions and which is to be completed by the named consultant.		
10	The service must ensure that all five steps of the 'Five Steps to Safer Surgery' are completed with documentary evidence to support this, particularly regarding the sign out stage.	Regulation 9, 15, 47 Standard 8	Re-state requirement to all theatre users, Consultants to be reminded that 100% compliance is required. Audit instigated to ensure compliance.	Theatre Manager and Executive Chairman	Complete
10	All staff must ensure that written notes are legible and consistently state the doctor's grade/time location.	Regulation 9, 15, 47, 23 Standard 8	Consultants to be informed that this is a mandatory requirement. A reminder has been sent to all consultants that it is mandatory that they state their grade and time etc. on every note entry	Executive Chairman	Complete

			Having recognised the issues with illegibility of hand written note keeping, we are moving towards a fully typed system. All discharge summaries are now typed as are all operation notes.		
11	The service must ensure that the urgent care centre is suitable for children to access both in terms of the physical environment (separate waiting area and appropriate environment within treatment room) and in being assured that there is sufficient clinical and nursing expertise.	Regulation 9, 15, 39, 47 Standard 8	We accept and are willing to improve the physical environment in Urgent Care. We believe that our clinical staff in the Urgent Care Unit are highly qualified in child protection expertise and we have asked you to reconsider that issue. We strongly support best practice in the treatment of all children in the hospital and understand the unique demands of providing such care. In urgent care we have a separate examination room for children and we have ensured that the environment in this room is physically safe. In an ideal world we would like to provide a separate waiting area for children. In reality due to the small numbers that we see our policy is to never make children wait. If there is a short wait then the children and their parents are transferred into the children's examination area upon arrival. If the demand for the service increases we would support the development of a separate waiting area. Our Urgent Care nursing and medical staff are suitably trained in the treatment of children. For example they have all completed the	Executive Chairman	6 months Ongoing

			Paediatric life support, safeguarding children courses etc. They all have extensive experience in treating children in the NHS It is our intention to look in the future to having a RSCN in the department when the demand increases. We would strongly support modular training to our current staff. Until such time we have a policy in place where in situations of need we can contact our paediatric consultants.		
11	The service must ensure that national guidelines regarding consent are consistently adhered to. Specifically in ensuring that all patients are asked for their consent with sufficient time to weigh up decisions, in advance of procedures.	Regulation 40 Standard 9	We strongly support national guidelines for the consenting process and informed consent. Following the very rare event of one consultant not obtaining consent correctly we reminded all Consultants that the correct protocol regarding consent must be adhered to which will be closely audited in the future.	Executive Chairman	Complete
13	The service must ensure that information (both written and verbal) is provided in formats that take account of patients' language and communication needs, including Welsh.	Regulation 18 (1) Standard 18	We have very little demand for information to be provided in different languages but if requested or if identified at initial consultation or pre-admission, we will provide translations of patient information documents. The hospital also has other language speakers generally available. Verbal translation services will also be arranged as and when is requested/required.	Executive Chairman	Complete

Delivery of Safe and Effective Care					
14	The service should ensure that there is a full clinical governance/clinical audit policy in place which demonstrates how the service will meet regulatory requirements.	Regulation 15, 9 (1) (o) Standard 7	A comprehensive Quality Assurance and Clinical Governance process is in place and fully functioning. The hospital has a robust Clinical Governance and Advisory Board in place. This Board has representation from all sub specialities and is attended by all clinical and non-clinical key stakeholders. The Board looks at a number of quality standards and key indicators and trends. We have recently commenced auditing the data that is submitted. Different quality sub groups report into this Board which meets every two months. These include • Infection control sub group • Theatre user group • New procedures group • Training and audit report • Complaints Every aspect of quality and governance is discussed at these meetings. Clinical critical incidents and near misses are also discussed in a no blame fashion and information and lessons learned are cascaded to all members of staff. The Chair of the Governance Board has regular meetings with the GMC to ensure compliance with good medical practice. He also has regular communication with the RO	Executive Chairman	Complete

			of the Gwent to share relevant information especially if there is concern		
15	All staff must receive up to date training in safeguarding (both POVA and child protection) on an ongoing basis.	Regulation 16, 39, 47 Standard 11	The training database is now held by the HR department and all records have been updated. It has been identified that a number of staff require training in POVA and POCA. These staff will complete this training by the end of November. A process has been implemented to ensure that refresher requirements are flagged electronically so that arrangements for training can be made.	Director of Clinical Services and HR Manager	31st December 2016
16	The service should address the following points in relation to infection control: • The issues as outlined in regards to several aspects of the physical environment (carpets, chairs, PPE equipment in physiotherapy department) should be reviewed and addressed where needed. • The service must be assured that infection control audits are consistently carried out and that sufficient oversight exists to monitor this activity. • Ensure that there is demonstrable evidence that the Infection Control nurse is given adequate time to fulfil the function of the specialised role.	Regulation 9, 15 (8) Standard 13	The physical environment of the hospital is rigorously cleaned at all times. We are undertaking a programme of refurbishment throughout the hospital. Infection Control audits are consistently carried out and oversight exists. Our Infection Control nurse is a full-time senior nurse who, in addition to her normal duties within the Outpatient Department, is assigned time (regularly and more as and when is necessary) away from the usual work area to manage infection control. This involves policy and procedure review, implementation of best practice, assimilation of current or new information, audit and assessment, and advice to new services or new staff. The IC nurse has the direct support of IC Link-staff who are representatives of the	Facilities Director Director of Clinical Services	Ongoing Complete

			various departments within the Hospital. These individuals are responsible for assisting the IC nurse to ensure best practice is maintained across the site. They are also responsible for ensuring departmental audits are performed e.g. handwashing audits. St. Joseph's Hospital also has the services of a Consultant Microbiologist who is available for advice and generally oversees our Infection Control strategy. Meetings are regular.		
16	The service must ensure that medications are stored securely at all times.	Regulation 9, 15 (5) Standard 15	Fully compliant. The broken lock was repaired on day of inspection. Medicines safety audit performed regularly.	Facilities Director Head of Pharmacy	Complete Complete
17	The first aid kit in the physiotherapy/hydrotherapy department must be checked. The service must be assured that all first aid kits across the hospital are checked and the contents within date.	Regulation 15, 26 Standard 15, 4	All First Aid kits have been checked and contents replaced if necessary. Audit programme in place.	Facilities Director	Complete
17	All Control of Substances Hazardous to Health (COSHH) items should be securely stored at all times.	Regulation 19, 26, 40 Standard 22	Cleaning cupboards and trolleys audited. Staff instructed to ensure no cleaning bottles are left unattended.	Facilities Director	Complete
17	The service must be able to demonstrate that there is a robust system in place for identifying, assessing, managing, recording and reviewing risks on an	Regulation 19, 26 Standard 22	The Hospital maintains an extensive risk register in accordance with the Risk Management Policy.	Executive Chairman	Complete

	ongoing basis where responsibilities, specific actions and timescales are clearly outlined.		The risk register is regularly reviewed and up-dated by the Senior Management team, which identifies actions to continually review and act to minimise the risk profile.		
18	The service must ensure that all patient safety bulletins and alerts are shared with operational staff consistently and across all areas.	Regulation 19, 20, 26 Standard 22	All safety bulletins and alerts will be issued to all staff in future.	Director of Clinical Services	Complete
Quality of Management and Leadership					
20	The service should consider how to improve engagement and communication flow with staff. The service should consider the detailed feedback provided by HIW around staff concerns and identify how they will make improvements.	Regulation 20, 18 (2) Standard 1	An annual communications plan will be developed to further enhance the current communications mechanisms that are in place for staff. This plan will be formulated by end of December 2016 for implementation from 1st Jan 2017. The plan will provide for regular Staff newsletters, a bi-annual opportunity to participate in a briefing by the Executive Chairman and regular team up-dates by all Heads of Departments. A communication will be sent to all staff reminding them of the grievance and whistle blowing policies and procedures that already exist within the Hospital.	Executive Chairman and HR Manager	31st December 2016
20	The service should consider making	Standard 1	We believe that staff facilities are good but we	Director of	Complete

	improvements to staff facilities on the ward regarding the aspects outlined above.	Regulation 26 (3)	will review and improvements will be put in place if practicable. A staff restaurant is available and food can be purchased throughout the day by staff at subsidised prices. Some staff prefer to stay on the ward particularly so if they just want a drink (which is readily available from the ward kitchen).	Clinical Services	
21	The service should ensure that there are consistent and agreed quality improvement activities across departments and must ensure that systems are in place to allow sufficient oversight of these activities.	Regulation 15, 19 Standard 1	Many clinical and non-clinical audits are performed and action plans and reports subsequently written (for example Health and Safety, Control of Infection and subsequent meetings with Consultant Microbiologist, Clinical HoD's)	Director of Clinical Services	Complete
21	The Statement of Purpose must be updated and must include all information as listed under Schedule 1 of the Independent Healthcare (Wales) Regulations.	Regulation 6, Schedule 1 Standard 1	Amended and forwarded to HIW on 23 Sept 2016	Executive Chairman	Complete
22	The Patient's Guide must include all information as listed under Regulation 7.	Regulation 7 Standard 1	Amended and forwarded to HIW on 23 Sept 2016	Executive Chairman's PA	Complete
22	The service must carry out and document 6 monthly registered provider visits.	Regulation 19, 28 Standard 1	The management and the Registered Provider are based on site, however, a 6 monthly review will be documented.	Executive Chairman	Ongoing
22	The service must produce an annual assessment including information as	Regulation 19 (3)	Accepted and this will be done on an annual basis.	Executive Chairman	Ongoing

	specified under Regulation 19 (3).	Standard 1			
22	The service must ensure that all patient records are stored safely and securely.	Regulation 23 Standard 20	Compliant	Director of Clinical Services	Complete
23	The service should review staffing on the ward, accounting and planning for the particularly busy times and those times where there may be a higher level of patient flow, to ensure there are sufficient numbers of staff available.	Regulation 20 Standard 25	We have reviewed staffing and we have always been above the national and professional guidelines. However we accept that during certain times of patient activity, more staff available at that particular time can be beneficial and we now take steps to supplement the nursing staff during those times by calling on support from other departments who have capacity. We can also control admission and discharge timings to relieve pinch points. Our patients are always safe and will never be put at risk. They are looked after to the highest standards and this is reflected in our patient feedback.	Director of Clinical Services	Complete
23	The service must ensure there are systems in place to provide sufficient oversight of staff support systems including appraisals and supervision so that there can be assurance that staff are appropriately supported.	Regulation 20 Standard 25	We are going to introduce a new system of appraisal during the first 6 months of 2017. This system will include objective setting, interim review meetings (6 months) and appraisal meetings (12 months). The system will ensure that objectives and development plans are in place for staff and that staff performance is measured against these, along with ongoing support to achieve the objectives	HR Manager	Ongoing

			set.		
24	The service must urgently act in supporting staff to develop, maintain and ensure they have the right knowledge and skills to provide safe treatment and care. The service should ensure that: • Staff training records are kept up to date on an ongoing basis • There are clear responsibilities in regards to training • There is sufficient oversight to monitor training compliance and action is taken where needed.	Regulation 25 Standard 20	All staff training records have been merged and there now exists one Hospital Training Record. This records name, department, nature of training, and date training completed. It is also being used to schedule forthcoming training. This record is now held centrally by our HR Department. Roles and responsibilities with regards to training have been clearly defined. On-line training has been purchased and is being used for: manual handling (theory), POVA, Safeguarding, Child Protection, Control of Infection, Privacy and Dignity, Equality, Communication, Medical Gases, Health & Safety etc. Two additional Manual Handling trainers have been trained. Monthly status reports will be issued to SMT members for planning and review purposes.	Executive Chairman, Director of Clinical Services and HR Manager	End December 2016

Service Representative:

Name (print): **Brian L Staples**

Title: **Executive Chairman/Responsible Individual**

Date: **30th November 2016**