Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

# St Joseph's Hospital
# Harding Avenue
# Malpas
# Newport
# Gwent
# NP20 6ZE

## Inspection 2010-2011

**Healthcare Inspectorate Wales**
Bevan House
Caerphilly Business Park
Van Road
CAERPHILLY
CF83 3ED

Tel: 029 2092 8850
Fax: 029 2092 8877

**www.hiw.org.uk**

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| Inspection Date: | Inspection Manager and Reviewers: |
|---|---|
| 18 March 2011 | P. Price<br>J Key<br>P Frowen |

## Introduction

Independent healthcare providers in Wales must be registered with Healthcare Inspectorate Wales (HIW). HIW acts as the regulator of healthcare services in Wales on behalf of the Welsh Ministers who, by virtue of the Government of Wales Act 2006, are designated as the registration authority.

To register, they need to demonstrate compliance with the Care Standards Act 2000 and associated regulations. HIW tests providers' compliance by assessing each registered establishment and agency against a set of '*National Minimum Standards,'* which were published by the Welsh Assembly Government and set out the minimum standards for different types of independent health services. Further information about the standards and regulations can be found on our website at: **www.hiw.org.uk**

Readers must be aware that this report is intended to reflect the findings of the inspection episode. Readers should not conclude that the circumstances of the service will be the same at all times.

## Background and Main findings

St Joseph's Hospital was first registered on 23 April 1991 and had an unannounced inspection on 18 March 2011. The hospital provides general medical services; general surgery; orthopaedic surgery; ultrasound services; sleep apnoea syndrome investigation; ear, nose and throat surgery; gynaecology; endoscopy; ophthalmology services and critical care. There is an x-ray department; a pathology department and pharmacy department. Additional facilities include a physiotherapy department and self-contained hydrotherapy suite.

The hospital looked clean and well maintained throughout, both internally and externally. Adequate car parking facilities were available, which provided easy access to all users, including specific disabled parking spaces. The hospital reception desk was well manned and the bilingual reception staff were professional and approachable in their dealings with the public. Patients were offered every courtesy and respect. The reception area was welcoming with adequate seating facilities for patients and visitors. An interdenominational chapel is available in St Joseph's Hospital.

Prior to the inspection visit the registered provider submitted a completed pre-inspection questionnaire. The inspection visit focused upon the analysis of a range of documentation, discussion with the registered manager and staff members and a tour of the premises. Discussion and feedback with hospital senior management team members took place throughout the and at the end of the visit.

St Joseph's Hospital had a detailed statement of purpose and patients' guide. Information was also available about specific surgery treatments, including orthopaedic, gynaecology and cosmetic surgery and included explanation of general and/or specific risks. Patients who were to undergo surgery were given a letter with information regarding their admission details and what to bring with them into hospital when attending the assessment clinic. They were also given a card with information regarding the visiting times. St Joseph's Hospital had a detailed annual report available for patients, relatives and staff. Audit outcomes of patient questionnaires were made available in the patients' guide annually and copies were also available within the reception area.

## Patient-Centred Care

Policies and health procedures were in place taking into account the guidance by The National Institute for Health and Clinical Excellence (NICE) guidance and clinical guidelines from the relevant medical Royal Colleges and National Health Service (NHS) National Service Frameworks. This information was available to guide staff on: diagnosis and treatment; verbal consent to examination; written consent to treatment; consultation and choice; access to health records; privacy, dignity, confidentiality; advanced directives and on the event of discharge against medical advice. Patient care pathways and pre-assessment patient information were viewed during inspection and a system for recording variance from the pathways was in place. A number of consent forms were also viewed, however, it was noted that one consent form did not have the required second print signature. This was brought to the attention of the clinical services manager.

There were clear monitoring and auditing systems in place. A Clinical Governance Framework was available and links for clinical governance were established within St Joseph's Hospital. Systems were in place regarding the identification of staff and all staff displayed identity badges.

Private facilities were available for patient consultation.

## Quality of Care

Patient privacy, dignity and individuality were considered and data protection procedures were in operation in accordance with legislation regarding confidentiality. An up to date clinical procedure manual was available for staff and clinical staff had access to the web site regarding obtaining up to date information.

Patients were assessed by registered nurses who had the appropriate training, skills and apparent expertise to undertake assessments and were involved with audit and change management. Registered nurses worked within the multi-professional team and actively participated in case conferences and inter-disciplinary team meetings.

## Records of Care

The inspector viewed documentation with regard to a number of individual patients and observed that the processes of assessment, care planning and evaluation appeared in place. Treatment and care episodes were documented following these interventions. All disciplines appeared to be involved in recording information in patients' records/documentation in order to maintain effective communication regarding treatment and care.

## Personnel Management

There appeared to be a clear organisational and management structure. The registered manager (also the Chief executive officer/managing director) was supported by the deputy chief executive director and the clinical nurse manager. There were clear lines of accountability and oversight between the senior management, clinical and nursing staff and other staff employed within the hospital.

Induction training was provided for all newly appointed staff and an orientation format was available for agency and/or bank staff. The hospital had a multidisciplinary working approach to providing patient care. The registered manager of the hospital did not grant any practitioner admission rights without evidence of registration and ongoing registration with the appropriate professional registration body. A staff handbook was given to all staff on commencement of employment and this contained relevant information regarding disciplinary procedures.

Comprehensive and robust policies and procedures were available with reference to staff recruitment. A number of personnel files were examined and these demonstrated that Criminal Records Bureau (CRB) checks were undertaken and that there was a system in place to ensure that all staff were up-to-date with their professional qualifications. Staff annual appraisal and personal development systems were in place. A training strategy was in place with regular staff appraisals which provided information on the training needs analysis that was undertaken for all personnel. The clinical nurse manager was responsible for keeping staff updated on a regular basis.

## Whistle Blowing

Policies and procedures were in place in relation to whistle blowing in order for staff to be comfortable with reporting concerns on poor care practices to senior staff. Information on raising concerns was contained within the staff handbook. Education and training takes place on induction and on a continuous basis for all members of staff, so that they are aware of their duty to express concerns. Human resources policies/procedures were available regarding conduct and disciplinary action and arrangements were in place for addressing supervision and removal of practising privileges.

## Staff Occupational Health

A pre-employment screening and occupational health service was provided by an occupational health doctor and nurse. A vaccination programme was in place and support for inoculation injury was provided. A database of staff immunisation, which included Hepatitis B vaccination, was available and confidentiality was maintained in testing for blood borne viruses.

## Adult and Child Protection

A policy and procedure regarding adult and child protection was available in the hospital. The Local Authority policy and procedure for the Protection of Vulnerable Adults (POVA) was available. Training was delivered annually in conjunction with other health and safety courses and records demonstrated that adult and child protection training had been provided. A designated lead nurse was available with regard to children's issues. Links were maintained with the Area Child Protection Committee in Newport, South Wales. However, please see comments under allied health professionals.

## Nursing Staff

The hospital had systems in place for verifying Nursing and Midwifery Council registration. Clinical supervision and support for staff was available.

## Medical Practitioners/Consultants

Policies/procedures were in place which covered all aspects of practising privileges for medical staff and included requirements of professional codes of practice and terms and conditions of employment. The qualifications and the experience of each medical practitioner were validated and each appointment was subject to consideration by the Medical Advisory Committee at the hospital. This was currently undertaken once a year. An electronic system was available to flag-up and ensure that General Medical Council registration and indemnity insurance was monitored according to expiry dates. Consultants received a handbook, which contained the statement of purpose and structure of the organisation.

Consultants signed the policy and procedure and agreement regarding the granting and review of practising privileges. Medical staff were required to complete documentation that they had undertaken regular appraisals and Continuing Professional Development (CPD). Clinicians were then required to sign and date documentation to evidence that this had been undertaken.

Contracts of employment, job descriptions, staff handbooks and practising privileges agreements all indicated that any breach of codes was a disciplinary offence. A resident medical officer was on duty or on call at all times. A facility was available within easy reach of the ward for the on-call doctor. The medical officer had undertaken the hospital's induction programme and was suitably qualified in resuscitation to Advanced Life Support level.

## Allied Health Professionals

It was possible on this visit to meet with a number of Health Professions Council (HPC) registered staff, these were:

- Physiotherapist
- Medical Laboratory Scientific Officer
- Radiographer
- Operating Department Practitioner

All appeared aware of the factors required to ensure the best possible patient experience was provided and that the patients were treated with dignity and respect from the outset. Staff believed that the ethos of the hospital was one in which the patient was put first without emphasis on financial gain. It appeared that all had knowledge of policies and protocols pertinent to their patient contact and reference was consistently made to the *'Red File'* in which they were to be found.

There was evidence that awareness training in respect of the policies associated with the protection of vulnerable adults and children was provided however, much reliance was placed upon the nurse manager for further advice and guidance when required. The senior management team may wish to review the current system of support and advice with regard to possible issues of child protection to ensure that secondary support and/or further training is available if required. This was discussed with the senior management team at post-inspection feedback briefing. There was evidence that opportunities for staff development were in place and all maintained appropriate Certificate in Personal and Professional Development (CPPD) and it was indicated that in addition to events arranged in-house opportunities some conference attendance was supported in respect of time though not always in respect of funding. There did appear to be a little discrepancy in respect of time that was protected for continuous professional development (CPD) and self reflection between different areas – such time seemed established within physiotherapy but less well defined in the other areas. This again was discussed with the senior management team during the post inspection feedback period.

## Physiotherapy

The physiotherapy area was well equipped; the unit is modern and comfortable having been refurbished in recent years. The facilities include: individual treatment rooms, a gymnasium and a hydrotherapy pool. All were well maintained and fully utilised.

## Radiography

Whilst all HPC staff were employed by St Joseph's Hospital and their employment records were compliant with the regulations expected by Healthcare Inspectorate Wales (HIW), computed tomography (CT) and magnetic resonance imaging (MRI) radiographers were provided by Alliance Medical, who are external contractors operating within mobile units. As a consequence it was not apparent how St Joseph's Hospital's Human Resources maintained a record of the professional status, staff development, CPD and Criminal Records scrutiny of the staff who were utilised by this organisation. This again was discussed with the senior management team during the post inspection feedback period.

Radiography equipment complied with Ionising Radiation (Medical Exposure) Regulations 2000 (amended 2006) (IR(ME)R) and was regularly inspected and tested by their radiological protection adviser (RPA).

## Operating Department Practitioners

Staff members considered that there was a good teamwork ethic within the department. This enabled flexibility when required and reflected the commitment that all had to the department. Staff development needs were considered by the training committee and where appropriate encouraged.

The equipment utilised by operating department practitioners (ODPs) was effective appropriate and well maintained.

All physiotherapy, radiography, pathology and ODP staff were confident that they were able to work within the regulatory frameworks that were set by their statutory and professional bodies and that all equipment complied with the regulations that were laid down. They were confident that a clear management structure was in place and they were able to influence change where appropriate, they indicated that the management structure was open and approachable and that they were able to bring matters of concern to their attention.

## Facilities

The hospital was accessed via a foyer and the reception was located in this area to ensure that people entering the building could be observed and welcomed. Each bedroom had an individual nurse call system. Bathroom and toilet facilities were accessible from the bedrooms and provided specialist baths/showers. Moving and handling equipment was available to assist in patient care.

A child-friendly environment had been developed in the areas where children were present.

## Catering

The catering service systems and arrangements were maintained in the main building of St Joseph's Hospital. The catering department had been awarded five stars by environmental health. The catering manager ensured effective liaison with the management team and with patients regarding meals and choice of meals. The catering manager was available to speak with patients. Each patient was offered three full meals a day and/or given a menu choice of at least one cooked meal option per day. The catering manager was responsible for maintaining policies/procedures and the systems used in the hospital kitchen. The kitchen was clean and appeared well maintained.

A choice of menu was available for patients and any special dietary requirements were catered for via the catering service and/or the district general hospital's dietician. The patients completed their menu choices each afternoon, ready for the following day and the food arrived plated, ready to be served. Religious and cultural needs were catered for and a member of the catering staff had attended a course on special diets. Meal satisfaction surveys had been undertaken and these indicated a high level of satisfaction with the service provision.

There were kitchen facilities for heating drinks but food for the patients was supplied from the main hospital kitchen. A training strategy was in place in relation to catering staff and other members of hospital staff involved in food handling. The manager encouraged all catering staff to enrol on the Intermediate Catering Course to obtain the Intermediate Certificate qualification.

## Risk Management

A comprehensive risk management strategy was in place within the organisation and risk management meetings were held on a regular basis. The Risk Register was reviewed quarterly and the latest update was undertaken at the Risk Committee meeting in March 2011. There was a rolling programme for each department to provide an annual Risk Report to the Risk Committee and detailed risk assessments were in place with the subsequent action undertaken on risks identified. Alert notices were forwarded to the chief executive officer and then disseminated by formal process to all staff.

Clinically there were systems in place to reduce risks to both staff and patients, such as moving and handling policies and education and training in the use of medical devices.

## Health & Safety

The hospital had a nominated health and safety officer. A health and safety committee met regularly and minutes were retained of meetings held. Information was disseminated to all staff within the organisation.

Health and safety policies and procedures were in place with regard to the following:

- Clinical waste classification
- Storage, collection
- Transport and disposal
- Theatre sterile supplies unit (TSSU)

There were nominated first aid personnel and first aid boxes, eye wash stations and protective clothing/equipment were available.

Key personnel were identified in relation to the use of medical gases. A record was kept of all accidents, which included needle stick injury to staff.

A record of patient/visitors/staff accidents was maintained and yearly statistics analysis completed. Requirements in relation to the Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) were undertaken and Control of substances Hazardous to Health (COSHH) legislation data sheets were maintained.

A communication policy was in place regarding responsibilities for informing Healthcare Inspectorate Wales (HIW) of Regulation 27 requirements.

## Staff Fire Training

There was a current fire risk assessment in place. There was a nominated person responsible for fire safety of the premises and there was on-going fire drill/updating for all personnel.

## Medicines Management

Pharmaceutical services were provided from a pharmacist based in the hospital. A comprehensive policy and procedure was available for recording the administration and supply of medicines to patients, including errors. There were policies and procedures for the handling and management of medicines which included ordering, receipts, supply, administration and disposal. Patients did not self-medicate.

Up-to-date data sheets and reference books were available within each of the departments. However, it was noted that the out-patients department's medicines system required clarity with regard to auditing of the system. The hospital did not participate in clinical trials.

Policies/procedures were in place to guide staff in the event of interruption to the medical gas supply.

## Infection Control

There was a comprehensive infection control file with appropriate policies in place. There were clear structures in place to support infection prevention. There were good links to the local NHS health board with clear lines of accountability and a functioning infection control committee supported by an infection control doctor. Minutes of meetings were documented and arrangements for microbiological advice and support were clear. A control team was maintained in the hospital with a consultant and designated infection control nurse and a system of link nurses was maintained on each ward and in each department. Clinical staff appeared knowledgeable about basic infection control procedures. The National Patient Safety Agency (PSAG) *'clean your hands campaign'* had been implemented. There was a policy for housekeeping and cleaning in-patient areas and evidence of infection control training was provided. However, it was noted in the outpatient department that written information regarding longevity and usage of disposable screen curtains in out-patient room was unavailable. The date information regarding use of curtain also needs to be completed when disposable curtains are used. The cleaning protocol requires amending to include appropriate, were applicable, information on the cleaning of the disposable curtains.

## Decontamination

Policies/procedures were in place regarding systems for decontamination processes, infection control and that single-use items were properly disposed of and never re-used.

A communication strategy was in place to ensure well-established links were maintained with the local National Health Service (NHS) Public Health Department.

## Resuscitation

Resuscitation policies and procedures were evident. Staff attended basic and advanced life support, paediatric life support and anaphylaxis training.

## Records Management

Policies/procedures were available regarding the creation, management, handling, storage and destruction of records in line with the Data Protection Act 1998 and the Private and Voluntary Healthcare Regulations (2002, Amended - 2007).

Designated personnel were responsible for the medical records department. Patients' records were clear, extensive and up to date and all members of the multidisciplinary team used the same record system. Patients and their families were involved in making decisions about their care. Records observed were legible, dated and signed, except in the one instance as noted previously. Additional records pertaining to the care of individual patients were maintained on a clipboard with their prescription chart, pressure risk scores, nutritional assessments, wound assessments, pain control assessments and manual handling and risk assessments.

## Information Systems

An information strategy was in place with a designated responsible individual for information systems.

Policies/procedures were in place in relation to the following:

- Data Protection Act 1998
- Caldicott principles
- Professional bodies

Confirmation of staff induction and training programmes was verified on examination of staff training folders. Policies/procedures were in place regarding access to healthcare records.

St Joseph's Hospital had a confidentiality policy in place. This complied with medical confidentiality guidelines and data protection legislation. The staff induction programme included training on data protection and confidentiality.

## Surgery

Working practices policies were in place and staff appeared aware of them. Pre-operative assessments and checklists were in place. There were arrangements in place to employ additional staff on a '*bank shift*' basis should the need arise.

## Documented Procedures for Surgery – Patient Care

Pre-operative and post-operative policies were available and the medical practitioner, who had responsibility for the individual, only discharged the patient following an assessment. Details of the admission and the procedure undertaken were sent to the patients' general practitioners within the identified time-scales.

## Anaesthesia and Recovery

The anaesthetic area had sufficient equipment to facilitate endotracheal intubation. If intubation was required within the Post Anaesthesia Care Unit (PACU) emergency equipment was readily available. Appropriate anaesthetic, PACU and surgical suction were available and artificial ventilation equipment when used had the appropriate disconnection alarms as did the anaesthetic machines. A portable anaesthetic ventilator was available if required within the anaesthetic area.

Sufficient equipment was available to monitor and record the condition of each patient in the theatre department and close monitoring was undertaken on a one-to-one basis by staff that appeared to have the required skills and expertise.

## Facilities for Carrying out Surgery
## (including general anaesthesia for dental treatment)

Risk assessments and COSHH assessments were available, however, one storage facility required review in order to comply with infection control standards. It was noted that some boxed items had been placed on the floor of the theatre unit storage room. This was brought to the attention of the theatre unit manager and the items had been removed prior to the end of the visit. A new theatre storage facility is currently being outfitted, which will have an increased storage capacity.

## Pathology

It was reported that equipment utilised was appropriate and well maintained. Where required new items were provided to maintain the best service possible and recently a new haematology analyser was acquired. The entire unit had been redeveloped three years ago to make better use of space and improve the working environment. The member of staff believed that management processes were good, open and informative and enabled change to be implemented when necessary.

The department had haematology, transfusion, chemistry and histology sections and is in the process of undertaking Clinical Pathology Accreditation (CPA) accreditation. It received approximately 11,000 patient requests per annum but only a small proportion of these were performed in-house. There was no in-house microbiology technical service; this was provided by the Royal Gwent Hospital, Newport under contract. Similarly there was histopathology but the technical processing of the selected blocks was performed under contract by the Spire Hospital, Cardiff. A range of chemical pathology and haematology investigations not undertaken in-house were sent to the pathology departments of the Royal Gwent Hospital. Consultant pathologists' advice and expertise was provided in each of the major disciplines. There was close liaison with the infection control nurse.

The local consultant pathologists provided an advisory service for their individual speciality.

The inspection team wishes to acknowledge and thank the management team, staff and patients for their assistance, time and co-operation during the inspection process.

## Achievements and Compliance

No regulatory requirements were outstanding from 2009-2010 inspection cycle.

## Registration Types

This registration is granted according to the type of service provided. This report is for the following type of service

| Description |
|---|
| **Independent Hospital providing listed service:** |
| • **Medical treatment under general anaesthesia or intravenous sedation.** |

## Conditions of Registration

This registration is subject to the following conditions. Each condition is inspected for compliance. The judgement is described as Compliant, Not Compliant or Insufficient Assurance.

| Condition Number | Condition of Registration | Judgement |
|---|---|---|
| 1. | The number of persons accommodated shall not exceed 51 Beds.<br><br>Medical/Surgical through all age groups. | Compliant |
| 2. | The staffing notice for St Joseph's Hospital is through an agreed workload analysis undertaken by each individual ward/department manager. | Compliant |

## Assessments

Healthcare Inspectorate Wales carries out on site inspections to make assessments of standards. If we identify areas where the provider is not meeting the minimum standards or complying with regulations or we do not have sufficient evidence that the required level of performance is being achieved, the registered person is advised of this through this inspection report. There may also be occasions when more serious or urgent failures are identified and the registered person may additionally have been informed by letter of the findings and action to be taken but those issues will also be reflected in this inspection report. Healthcare Inspectorate Wales makes a judgment about the frequency and need to inspect the establishment based on information received from and about the provider, since the last inspection was carried out. Before undertaking an inspection, Healthcare Inspectorate Wales will consider the information it has about a registered person. This might include: a self-assessment against the standards, the previous inspection report findings and any action plan submitted, provider visits reports, the Statement of Purpose for the establishment or agency and any complaints or concerning information about the registered person and services.

In assessing each standard we use four outcome statements:

| | |
|---|---|
| Standard met | No shortfalls: achieving the required levels of performance. |
| Standard almost met | Minor shortfalls: no major deficiencies and required levels of performance seem achievable without extensive extra activity. |
| Standard not met | Major shortfalls: significant action is needed to achieve the required levels of performance. |
| Standard not inspected | This is either because the standard was not applicable, or because, following an assessment of the information received from and about the establishment or agency, no risks were identified and therefore it was decided that there was no need for the standard to be further checked at this inspection. |

## Assessments and Requirements

The assessments are grouped under the following headings and each standard shows its reference number:

- Core Standards
- Service Specific Standards

Standards Abbreviations:

C = Core standards
A = Acute standards
MH = Mental health standards
H = Hospice standards
MC = Maternity standards
TP = Termination of pregnancy standards
P = Prescribed techniques and technology standards
PD = Private doctors' standards

If the registered person has not fully met any of the standards below, at the end of the report, we have set out our findings and what action the registered person must undertake to comply with the specific regulation. Failure to comply with a regulation may be an offence. Readers must be aware that the report is intended to reflect the findings of the inspector at the particular inspection episode. Readers should not conclude that the circumstances of the service will be the same at all times; sometimes services improve and conversely sometimes they deteriorate.

## Core Standards

| Number | Standard Topic | Assessment |
|---|---|---|
| C1 | Patients receive clear and accurate information about their treatment. | Standard met |
| C2 | The treatment and care provided are patient – centred. | Standard met |
| C3 | Treatment provided to patients is in line with relevant clinical guidelines. | Standard met |
| C4 | Patients are assured that monitoring of the quality of treatment and care takes place. | Standard met |
| C5 | The terminal care and death of patients is handled appropriately and sensitively. | Standard met |
| C6 | Patients' views are obtained by the establishment and used to inform the provision of treatment and care and prospective patients. | Standard met |
| C7 | Appropriate policies and procedures are in place to help ensure the quality of treatment and services. | Standard met |
| C8 | Patients are assured that the establishment or agency is run by a fit person/organisation and that there is a clears line of accountability for the delivery of services. | Standard met |
| C9 | Patients receive care from appropriately recruited, trained and qualified staff. | Standard met |
| C10 | Patients receive care from appropriately registered nurses who have the relevant skills knowledge and expertise to deliver patient care safely and effectively. | Standard met |
| C11 | Patients receive treatment from appropriately recruited, trained and qualified practitioners. | Standard met |
| C12 | Patients are treated by healthcare professionals who comply with their professional codes of practice. | Standard met |
| C13 | Patients and personnel are not infected with blood borne viruses. | Standard met |
| C14 | Children receiving treatment are protected effectively from abuse. | Standard met |
| C15 | Adults receiving care are protected effectively from abuse | Standard met |
| C16 | Patients have access to an effective complaints process. | Standard met |
| C17 | Patients receive appropriate information about how to make a complaint. | Standard met |
| C18 | Staff and personnel have a duty to express concerns about questionable or poor practice. | Standard met |
| C19 | Patients receive treatment in premises that are safe and appropriate for that treatment. Where children are admitted or attend for treatment, it is to a child friendly environment. | Standard met |

| Number | Standard Topic | Assessment |
|---|---|---|
| C20 | Patients receive treatment using equipment and supplies that are safe and in good condition. | Standard met |
| C21 | Patients receive appropriate catering services. | Standard met |
| C22 | Patients, 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. | Standard met |
| C23 | The appropriate health and safety measures are in place. | Standard met |
| C24 | Measures are in place to ensure the safe management and secure handling of medicines. | Standard met |
| C25 | Medicines, dressings and medical gases are handled in a safe and secure manner. | Standard almost met |
| C26 | Controlled drugs are stored, administered and destroyed appropriately. | Standard met |
| C27 | The risk of patients, staff and visitors acquiring a hospital acquired infection is minimised. | Standard almost met |
| C28 | Patients are not treated with contaminated medical devices. | Standard met |
| C29 | Patients are resuscitated appropriately and effectively. | Standard met |
| C30 | Contracts ensure that patients receive goods and services of the appropriate quality. | Standard met |
| C31 | Records are created, maintained and stored to standards which meet legal and regulatory compliance and professional practice recommendations. | Standard met |
| C32 | Patients are assured of appropriately competed health records. | Standard met |
| C33 | Patients are assured that all information is managed within the regulated body to ensure patient confidentiality. | Standard met |
| C34 | Any research conducted in the establishment/agency is carried out with appropriate consent and authorisation from any patients involved, in line with published guidance on the conduct of research projects. | Standard not inspected |

## Service Specific Standards- these are specific to the type of establishment inspected

| Number | Acute Hospital Standards | Assessment |
|---|---|---|
| A1 | Patients receive clear information about their treatment. | Standard met |
| A2 | Patients are not mislead by adverts about the hospital and the treatments it provides. | Standard met |
| A3 | Patients receive treatment from appropriately trained, qualified and insured medical practitioners. | Standard met |
| A4 | Medical practitioners who work independently in private practice are competent in the procedures they undertake and the treatment and services they provide. | Standard met |
| A5 | Patients receive treatment from medical consultants who have the appropriate expertise. | Standard met |
| A6 | Patients have an appropriately skilled and trained doctor available to them at all times within the hospital. | Standard met |
| A7 | Patients receive treatment from appropriately skilled and qualified members of the allied health professionals. | Standard met |
| A8 | Patients receive treatment from appropriately qualified and trained staff. | Standard met |
| A9 | Health and safety. | Standard met |
| A10 | Infection control. | Standard met |
| A11 | Decontamination. | Standard met |
| A12 | Resuscitation. | Standard met |
| A13 | Resuscitation equipment. | Standard met |
| A14 | Meeting the psychological and social needs of children. | Standard met |
| A15 | Staff qualifications, training and availability to meet the needs of children. | Standard met |
| A16 | Facilities and equipment to meet the needs of children. | Standard met |
| A17 | Valid consent of children. | Standard met |
| A18 | Meeting children's needs during surgery. | Standard not applicable |
| A19 | Pain management for children. | Standard met |
| A20 | Transfer of children. | Standard met |
| A21 | Documented procedures for surgery – general. | Standard almost met |
| A22 | Anaesthesia and Recovery. | Standard met |
| A23 | Operating Theatres. | Standard met |
| A24 | Procedures and Facilities Specific to Dental Treatment under General Anaesthesia Facilities. | Standard not inspected |
| A25 | Cardiac Surgery. | Standard met |
| A26 | Cosmetic Surgery. | Standard met |
| A27 | Day Surgery. | Standard met |
| A28 | Transplantation. | Standard not inspected |
| A29 | Arrangements for Immediate Critical Care. | Standard not inspected |

| Number | Acute Hospital Standards | Assessment |
|---|---|---|
| A30 | Level 2 or Level 3 Critical Care within the Hospital. | Standard not inspected. |
| A31 | Published Guidance for the Conduct of Radiology. | Standard met |
| A32 | Training and Qualifications of Staff Providing Radiology Services. | Standard met |
| A33 | Published guidance for the conduct of radiology. | Standard met |
| A34 | Training and qualifications of staff providing radiology services. | Standard met |
| A35 | Responsibility for pharmaceutical services. | Standard met |
| A36 | Ordering, storage, use and disposal of medicines. | Standard almost met |
| A37 | Administration of medicines. | Standard met |
| A38 | Self administration of medicines. | Standard met |
| A39 | Medicines management. | Standard met |
| A40 | Management of Pathology Services. | Standard met |
| A41 | Pathology Services Process. | Standard not inspected |
| A42 | Quality Control of Pathology services. | Standard not inspected |
| A43 | Facilities and Equipment for Pathology Services. | Standard not inspected |
| A44 | Chemotherapy. | Standard not inspected |
| A45 | Radiotherapy. | Standard not inspected |

## Schedules of Information

The schedules of information set out the details of what information the registered person must provided, retain or record, in relation to specific records.

| Schedule | Detail | Assessment |
|---|---|---|
| 1 | Information to be included in the Statement of Purpose. | Standard met |
| 2 | Information required in respect of persons seeking to carry on, manage or work at an establishment. | Standard met |
| 3 (Part I) | Period for which medical records must be retained. | Standard met |
| 3 (Part II) | Record to be maintained for inspection. | Standard met |
| 4 (Part I) | Details to be recorded in respect of patients receiving obstetric services. | Standard not inspected |
| 4 (Part II) | Details to be recorded in respect of a child born at an independent hospital. | Standard not inspected |

## Requirements

The requirements below address any non-compliance with The Private and Voluntary Health Care (Wales) Regulations 2002 that were found as a result of assessing the standards shown in the left column and other information which we have received from and about the provider. Requirements are the responsibility of the *'registered person'* who, as set out in the legislation, may be either the registered provider or registered manager for the establishment or agency. Healthcare Inspectorate Wales will request the registered person to provide an *'action plan'* confirming how they intend to put right the required actions and will, if necessary, take enforcement action to ensure compliance with the regulation shown.

| Standard | Regulation | Requirement | Time scale |
|---|---|---|---|
| **C25**<br>**A 35** | Regulation 14(5) | **Findings:**<br><br>It was noted that the out-patients department medicines system required clarity with regard to auditing of the system.<br><br>**Action Required:**<br><br>Review current system of audit, including ordering, disposal and checking of stock.<br>This should include the signature of the person undertaking the audit. | Two weeks. (Advised on day of visit). |
| **A21** | Regulation 8(2) | **Findings:**<br><br>Procedure for completing consent forms must be adhered too.<br><br>**Action Required:**<br><br>The registered person is required to ensure that policy and procedure is adhered to with regard to second signature requirement on a consent form. | Immediate (Advised on day of visit). |
| **C27** | Regulation 14 (6) | **Findings:**<br><br>Boxes of sterile supplies are being stored on the theatre floor. | Immediate (Completed on day of visit). |

| Standard | Regulation | Requirement | Time scale |
|---|---|---|---|
| | | **Action Required**<br><br>The registered person is required to ensure that supplies are not placed directly on a floor surface. | |

## Recommendations

Recommendations may relate to aspects of the standards or to national guidance. They are for registered persons to consider but they are not generally enforced. It was noted that it would be useful to include more toy safety details within the policy.

| Standard | Recommendation |
|---|---|
| **C14** | Review current system of support and advice with regard to possible issues of child protection to ensure that secondary support is available if required. |
| **C18** | It is advised that senior management review procedure to clarify that all appropriate information regarding external contractors is available. |
| **C27** | Written information regarding longevity and usage of disposable screen curtains in out-patient room needs to be made available. Cleaning protocol requires amending to include the cleaning of the disposable curtains. The date information panel regarding use of curtain also needs to be completed when disposable curtains are used. |