Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

St Joseph's Hospital
Harding Avenue
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Inspection report 2009/2010

Healthcare Inspectorate Wales
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Inspection Date:	Inspection Manager and Reviewers:
17 &18 November 2009	Mrs P. Price Dr H Davies Mrs J Davies Mrs T Pope

Introduction

Independent healthcare providers in Wales must be registered with the 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. The 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 the 23 April 1991 and had an announced inspection on the 17 & 18 November 2009. 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 reception area was welcoming with adequate seating facilities for patients and visitors. The bilingual reception staff were professional and approachable in their dealings with the public. 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 member and a tour of the premises.

St Joseph's' Hospital had a detailed statement of purpose and up to date patient's guide. Information was also available about specific surgery treatments and included explanation of general and/or specific risks. Patient's undergoing 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 prospective patients, patients, relatives and staff. Audit outcomes of patient questionnaires were made available in the patient's guide annually.

Patient Centred-Care

Patient care pathways and pre-assessment patient information were viewed during inspection. Care pathways were well established and reviewed. A system for recording variance from the pathways was in place. Consent forms were also viewed.

Protocols, policies and procedures demonstrated up to date evidence based information. This was demonstrated in practice during the inspection by information examined by the lead inspector. Policies/procedures were also made 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. There were clear monitoring and auditing systems in place. A Clinical Governance Framework was maintained and links for clinical governance were established within St Joseph's Hospital. Systems were in place regarding the identification of staff and all staff had name and grade badges.

Private facilities were available for patient consultation.

Quality of Care

There were appropriate policies and procedures in place to assist staff with the provision of care. Patient privacy, dignity and individuality were considered and data protection procedures were in operation in accordance with legislation regarding confidentiality.

Policies and health procedures were in place taking into account the evaluations by the National Institute for Clinical Excellence (NICE), and clinical guidelines from the relevant medical Royal Colleges and National Health Service (NHS) National Service Frameworks. An up to date clinical procedure manual was made available for staff. 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 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 examined care pathways for a number of individual patients and observed that the processes of assessment care planning and evaluation were in place. All disciplines continued to be involved in recording information in patient's records/documentation in order to maintain effective communication regarding treatment and care. All care was documented daily.

There was 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 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.

Personnel management

The hospital manager had appropriate qualifications and experience to ensure satisfactory care for the patients. Induction training was ensured for all newly appointed staff and an orientation format 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.

Comprehensive and robust policies and procedures were available with reference to staff recruitment. Personnel files were examined and these demonstrated policies/procedures were in place.

The Criminal Records Bureau (CRB) checked all staff and there were systems 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 staff handbook was given to all staff on commencement of employment and this contained relevant information regarding disciplinary procedures. A training strategy was in place with regular staff appraisals to ensure a training needs analysis was undertake for all personnel. The clinical nurse manager ensured staff were updated on a regular basis.

Policies/procedures were in place in relation to equal opportunities.

Whistleblowing

Policies and procedures were in place in relation to whistleblowing 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. This ensures that they have an awareness 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

An occupational health service was provided by an occupational health doctor and a nurse who (as well as screening patients in the pre-assessment unit) worked with him to ensure staff were thoroughly screened before employment. A vaccination programme was in place and support for inoculation injury was provided. A database of staff immunisation was maintained and confidentiality was maintained in testing for blood borne viruses. All employees working in the clinical area were referred to the occupational health doctor/nurse for Hepatitis B vaccination and a database of staff Hepatitis B status was maintained.

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. 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.

Nursing Staff

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

Medical Practitioners/ Consultants

Policies/procedures were in place which covered all aspects of practising privileges for medical staff and included 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 and it required that a system be developed to 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.

Policies/procedures were in place regarding requirements of professional codes of practice.

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. Each medical officer had undertaken the hospitals' induction programme and was suitably qualified in resuscitation to Advanced Life Support level.

Allied Health Professionals

The physiotherapy department, including the hydrotherapy unit, provided both in-patient and outpatient services. The physiotherapy manager had a clinical role and specialised in hydrotherapy.

All the equipment in the general department and the hydrotherapy pool unit was well-maintained with services records available for inspection. Equipment manuals were also available. The department used relevant patient record forms for in-patients, outpatients and hydrotherapy patients.

St. Joseph's Hospital Physiotherapy Service Policy 'Treatment of Paediatric Patients' outlined due care and regard in treating children under 16 years as patients and the accommodation of children accompanying adults in the Physiotherapy department. Factors were taken into consideration such as choice of appointment times to lessen disruption to schooling, consent issues, clear, understandable terminology when giving information and a chaperone must be available during all children's treatment. This policy indicated good practice and a safe service for children. It would be pertinent to add that Therapists were vetted by the Criminal Records Bureau procedure and that they received appropriate Child Protection training so were aware of Child Protection procedures and how to highlight any Child Protection concerns. It was noted that it would be useful to include more toy safety details within the St. Joseph's Physiotherapy Service policy.

Osteopathy

Osteopathy was available in the hospital. The hospital had agreed 'Admission Rights' on a consultancy basis with the osteopath.

Massage Therapist

The massage therapist had Admission Rights on a consultancy basis. The massage therapist did not see in-patients but arranged his own outpatient admissions into the hospital.

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 most of the areas where children were present. However some child friendly wall posters were required in the out-patients consulting room and phlebotomy room and a distraction box should be made available.

Catering

The catering service systems and arrangements were maintained in the main building of St Joseph's Hospital. The catering department had been given a gold award for catering by environmental health. The catering manager ensured effective liaison with the nurse manager, unit manager, and with patients regarding meals and choice of meals. 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 ensured policies/procedures and systems were maintained in the hospital kitchen. The kitchen was clean and appeared well maintained. The catering manager was available to speak with patients.

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. 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. There were kitchen facilities for heating drinks but food for the patients was supplied from the main hospital kitchen. The patients completed their menu choices each afternoon, ready for the following day and the food arrived plated, ready to be served. 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 staff who undertake cooking, to enrol on the Intermediate Catering Course to obtain the Intermediate Certificate qualification.

Laundry

The laundry area was clean, tidy and with appropriate equipment. Robust operational systems were in place.

Risk Management

A comprehensive risk management strategy was in place within the organisation as a whole. Risk management meetings were held on a regular basis. The previous HIW report 2008-2009 noted that the Risk Register was to be reviewed by January 2009 to include developments to the service. The Risk Register is reviewed quarterly and was reviewed in the first quarterly meeting in 2009 and the latest update was undertaken at the Risk Committee meeting in October 2009. There was a rolling programme for each department to provide an annual Risk Report to the Risk Committee. Detailed risk assessments were in place with the subsequent action undertaken on risks identified. Hazard 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. Protective clothing/equipment was available.

Health & Safety

Health and safety policy/procedure were in place. The hospital had a nominated health and safety officer. A health and safety committee met regularly. This included staff from St Joseph's Hospital. Minutes were retained of all meetings held. Information was disseminated to all staff within the organisation.

There were nominated first aid personnel and first aid boxes and eye wash stations. Key personnel were identified in relation to the use of medical gases. Policies/procedures were in place for clinical waste classification, storage, collection, transport and disposal. A record was kept of all accidents, which included needle stick injury to staff. Policies/procedures were in place regarding TSSU.

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. Control of substances Hazardous to Health (COSHH) legislation data sheets was 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. 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. However on inspection not all the controlled drug records were completed and some unsafe practices were highlighted requiring immediate attention.

Up-to-date data sheets and reference books were available within each of the departments. The hospital did not participate in clinical trials.

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.

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 Trust 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. A system of link nurses was maintained on each ward and in each department. Clinical staff were 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. Evidence of infection control training was provided. Some storage areas required attention where packaged sterile supplies were being stored on the floor.

Decontamination

Policies/procedures were in place regarding systems for decontamination processes, health and safety and infection control.

A communication strategy was in place to ensure well-established links were maintained with the local National Health Service (NHS) Public Health Department. Policies/procedures were in place to ensure that single-use items were properly disposed of and never re-used.

Resuscitation

Resuscitation policies and procedures were evident. Staff attended basic and advanced life support, paediatric life support and anaphylaxis training. However, a protocol and algorithm for the assessment and transfer of a child with a deteriorating condition should be developed.

Records Management

Policies/procedures were in place 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. 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 up to date and all staff were aware of them and had read and adhered to 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. The inspector was informed that all staff within the operating theatre department had written job descriptions and terms and conditions. However, the inspector cannot comment on doctors, blood perfusionists or other technical staff.

Documented Procedures for Surgery – Patient Care

Pre-operative and post-operative policies were seen regarding all items identified in the standard. Robust procedures were in place to check the consent given prior to the procedure taking place.

The medical practitioner who had responsibility for the individual only discharged the patients following an assessment. Details of the admission and the procedure undertaken were sent to the patient's general practitioner 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 was available.

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 whilst in the theatre department. Close monitoring was undertaken on a one-to-one basis by staff who had the necessary skill and expertise.

Facilities for Carrying Out Surgery (including general anaesthesia for dental treatment)

Working practice policies were in place and up to date and all staff were aware of them and had read them. These policies were diligently adhered to. All risk assessments, COSHH assessments had been diligently attended to and updated were required. However some storage facilities required review in order to comply with infection control standards.

Operating Theatres

All theatre policies had been reviewed and were up to date. No children were treated under the age of sixteen (16) years. All electrical equipment had been tested within the year. There was a strict selection of patients to ensure suitability for St Joseph's. The theatre booking system was carried out by the booking clerk and individual surgeons. This required monitoring and audit to ensure that appropriate bookings/operating schedules were maintained.

Support services were provided if not within the hospital but sourced from other areas if required. A senior person was on duty every shift. This was normally a senior nurse. The operating theatre could accommodate all relevant personnel.

Pathology
Standard not fully inspected

The laboratory was an integral part of the hospital and was recently refurbished this year. It had haematology, transfusion, chemistry and histology sections and will be seeking 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.

There was a laboratory manager who was accountable to the clinical governance lead/quality manager for the hospital. The laboratory manager was a fully accredited member of the Institute of Biomedical Scientists.

The department only performed a small range of tests. Within chemistry the machine provided results for urea and electrolytes, a bone profile and liver function tests. It also conducted pregnancy tests. In haematology there was a machine providing a full blood count but there were no in house clotting studies. Blood was grouped and saved and when necessary x-matched by the Royal Gwent Hospital before storage in the blood bank fridge by theatres.

The inspection team, wish 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 outstanding from 2008-2009 inspection cycle.

Registration Types

This registration is granted according 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. 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

The 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. The 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, the 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	Patient 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

Number	Standard Topic	Assessment
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 almost met
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 almost 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 almost met
C27	The risk of patients, staff and visitors acquiring a hospital acquired infection is minimised	Standard 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 almost 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 almost met
A21	Documented procedures for surgery - general	Standard 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 met

Number	Acute Hospital Standards	Assessment
A30	Level 2 or Level 3 Critical Care within the Hospital	Standard met
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 Standard met
A36	Ordering, storage, use and disposal of medicines	Standard met
A37	Administration of medicines	Standard almost met
A38	Self administration of medicines	Standard almost 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. The 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
C19 A 16.3	Regulation 35(b)	**Findings:** Out-patients phlebotomy and consulting rooms were not child friendly. **Action Required** The registered person is required to place child friendly posters on the walls and distraction boxes to be made available.	3 months from receipt of report. Discussed on day of visit Completed December 2010
A20. 1,2	Regulation 35(b)	**Findings:** No clear written guidance for transfer of sick children. **Action Required** The registered person is required to develop an algorithm for the transfer of children from the hospital to others health care areas.	1 month from receipt of report. Discussed on day of visit. To be completed by March 2010
C25. 1,4 C26.1 A 36. 8 A37.5	Regulation 14 (5)	**Findings:** Controlled drug records not fully maintained. Several patients receiving drugs from ampoules designed for single use **Action Required** The registered person is required to stop the practice of bracketing signatures across several patients is to be stopped and ensure that all spaces in the controlled drugs record book are to be individually signed. Additionally the practice of shared administration of one vial or ampoule of controlled drug between several patients is to be stopped and each patient to receive individual drug doses.	48 hours Discussed on day of visit (Completed November 2009)

Standard	Regulation	Requirement	Time scale
C11.2 A3 .1, 2, 3	Regulation 18(2)(b)(d)	**Findings:** No flag up system for ensuring GMC registration and indemnity insurance is current **Action Required** The registered person is required to develop a system for ensuring that Consultants with practicing privileges have up to date GMC and Indemnity insurance should be developed and that these are checked as expiry approaches.	8 weeks on Receipt of report. Discussed on day of visit. Ongoing
C27	Regulation 14 (6)	**Findings:** Storage areas required attention where packaged sterile supplies are being stored on the floor. **Action Required** The registered person is required to ensure that supplies are not placed directly on a floor surface.	Immediate as discussed on day of visit

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
C27	Some theatre storage facilities required review in order to comply with infection control standards. Completed November 2010.
A16	It was noted that it would be useful to include more toy safety details within the St. Joseph's Physiotherapy Service Policy