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6 June 2014

Dear Sister Bernadette

Re: Healthcare Inspectorate Wales unannounced visit to St Joseph's Hospital, on the 12 March and a further unannounced visit on the 20 March 2014.

As you are aware Healthcare Inspectorate Wales' (HIW) visit to St Joseph's Hospital, Newport undertaken on 12 March 2014 highlighted a number of issues that required urgent action which were discussed with the registered manager and other members of the hospital senior management team at the end of our visit on 12 March 2014.

A letter was sent to the registered manager and the responsible individual on the 12 March 2014 with a summary of Healthcare Inspectorate Wales concerns. The registered manager submitted an action plan which included timescales to action and complete requirements.

OVERALL VIEW OF THE HEALTHCARE SETTING

St Joseph's 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 manned with bilingual reception staff who were professional and

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approachable in their dealings with the public. The reception area was welcoming with adequate seating facilities for patients and visitors. The environment in most areas of the hospital is clean, bright and spacious, welcoming and reasonably comfortable. An interdenominational chapel is available in St Joseph's Hospital.

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. St Joseph's Hospital provided an annual report 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.

Quality of Care

Patient care pathways and pre-assessment patient information were viewed during inspection and a system for recording variance from the pathways was in place. Clear, patient-centred care pathways were developed for each patient and the care and treatment provided was evidence based, or reflecting best practice, using national standards and guidelines for example National Service Frameworks (NSF's) National Institute for Health and Care Excellence (NICE) and the Royal Marsden Guidelines.
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.

The reviewers 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. However, it was noted that though care and treatment plans were multidisciplinary, there appeared to be limited input from other disciplines, other than nurses and a number of records did not incorporate medical notes.

The catering service systems and arrangements were maintained in the main building of St Joseph's Hospital. 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.

Any special dietary requirements were catered for via the catering service and/or the dietician at the Royal Gwent Hospital. Meal satisfaction surveys had been undertaken and these indicated a high level of satisfaction with the service provision.

Privacy and Dignity

Patient Views
Patients spoken with felt the standards of care and treatment they had received were high and that all staff were professional, courteous and more than helpful.

Patients spoken with were very happy with the food choices, quality and presentation. Menus had recently been revised to incorporate current nutritional standards. There is a Nutritional Steering Group and the Malnutrition Universal Screening Tool (MUST) has recently been adopted.

Throughout the Inspection patients were observed to be treated with dignity and respect and this appeared to be integral to the general ethos of the hospital.

Information leaflets were available for patients and patients spoken to said that they had excellent information, both written and verbal, provided both pre and post operatively.

A recently revised patients' survey indicated that the majority of patients had had a very positive experience. Any issues that had arisen were dealt with and followed through and there was no evidence of any themes or concerns emerging.

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 Clinical Nurse Manager, the Head of Clinical Services. The Head of Clinical Services leads a multidisciplinary team of Clinical Managers and there was evidence of strong clinical leadership and effective multidisciplinary team working. The All Wales Leadership and Empowerment Programme had been adopted for all Ward Sisters and Charge Nurses.
Staff meetings were held regularly and patient hand overs and informal discussions reflecting care and practice were a daily occurrence.

Ward staff spoken to were caring and professional in their approach to patients and their families. Despite being informed of major and imminent organisational changes on the day of the Inspection, staff seemed remarkably positive and optimistic about the future and remained focussed on the provision of high standards of care to their patient group.

Communications between staff were noted to be professional, yet with a good sense of team spirit, warmth and humour.

All clinical staff undertook relevant mandatory training and there were opportunities for staff to undertake vocational training based on competency assessment, professional development and patient need.

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 (MDT) 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 with regard to hospital information.

Comprehensive 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) (DBS) checks were undertaken and that there was a system in place to ensure that all staff were up-to-date with their professional qualifications. Confirmation of staff induction and training programmes was verified on examination of staff training folders.

The hospital had systems in place for verifying Nursing and Midwifery Council registration. Clinical supervision and support for staff was available. There were clear lines of professional accountability for the majority of staff, some staff appraisals were in place and some staff were receiving clinical supervision or mentorship, but a more robust and strategic approach to these important areas of professional support and clinical accountability lines for all levels of staff is required.

The reviewers were informed that appraisals were on-going and that clinical supervision was being reviewed.

Point 8: Staffing is reviewed on a daily basis to ensure that patient safety is not compromised this, at times, can mean that meetings are cancelled and study days cannot be attended if on a particular day this occurs but the focus is always upon providing appropriate and adequate staff in line with the patient need.

Evidence suggests that nurse staffing levels were often inadequate, particularly when there were significant periods of staff sickness, or as in recent months because of retirements and resignations. This impacted on meetings and training, which often had to be cancelled to cover service needs. We were informed that staffing is reviewed on a daily basis to ensure that patient safety is not compromised this, at times, can mean that meetings are cancelled and study days cannot be attended if on a particular day this occurs but the focus is always upon providing appropriate and adequate staff in line with the patient need. In-house training was provided; however funding was seemingly unavailable for some identified key areas of external training and skills development, to ensure continuing professional development for all clinical staff and to meet the identified needs of their patient group. We were informed that all study had been reviewed and since January 2013 a more suitable

timetable has been produced with in-house training and compliance with mandatory training. The reviewers were informed that the clinical services manager had reviewed some aspects of training. For example, not all staff needed to attend ALS. The clinical services manager had discussed this with The Resuscitation Council representative (Cwm Taf) and had a training plan to introduce ILS/alert training to a core of staff. There were arrangements in place to employ additional staff on a '*bank shift*' basis should the need arise.
This was discussed with the management team during feedback.

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.

Clinical Governance

Clinical policies reviewed were up to date and reflecting national guidelines and current best practice wherever possible.
Regular and robust Clinical Audits were undertaken and monitored by the Clinical Governance Development Group; actions were taken and followed up where relevant.

Recent audits indicated infection rates were low and there was 95% compliance with their hand washing procedure.

There were regular general risk assessments and daily clinical risk assessment for all patients, in areas such as prevention of falls.

There was a robust complaints procedure in place. All complaints were taken seriously, followed up verbally and in writing with patients and were reviewed by the Clinical Governance Development Group.

The Clinical Governance Development Group were operational, meet regularly and focus on and reviewed key areas of clinical care and professional practice, including promoting evidence based practice, audit and research, clinical improvement projects, risk management, training, clinical leadership, medicine management, appraisal and clinical supervision, effective use of resources and developments in standards of care and Welsh Assembly Government Initiatives such as, Fundamentals of Care and Dignity, Nutritional, Cleaning and Infection Control Standards and 1,000 Lives.

The Clinical Governance Development Group provided a monthly report to the Hospital Board incorporating a "Quality Dashboard " which was a graphic chart immediately identifying improvements, or trends and themes of concerns, over a twelve month period.

The Head of Clinical Services undertakes regular "Walkabouts "with another member of staff, for example the house keeper, or a member of the MDT , meeting patients

and staff, observing the environment, issues of patients privacy and dignity, interactions between patients, their families and standards of care and practice.

Recommendations from the “Francis Report “had been reviewed and actions taken where appropriate as a high priority.

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.

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. 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.
There were link nurses taking a lead role in key areas of care, for example Infection Control, Nutrition, Manual Handling.

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.

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.

There was an infection control file with appropriate policies in place available. 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. There was a policy for housekeeping and cleaning in-patient areas and evidence of infection control training was provided.

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.

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 Caldecott principles.

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.

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.

Premises, Environment and Facilities

During the course of the two inspections, documentation in relation to estates maintenance was examined.

The hospital is accessed via a foyer and the reception is located in this area to ensure that people entering the building could be observed and welcomed. Each bedroom has an individual nurse call system. Bathroom and toilet facilities are accessible from the bedrooms and provided specialist baths/showers. Moving and handling equipment was available to assist in patient care. However, some areas of the hospital look tired and required upgrading and refurbishment. Some patients' bedrooms were carpeted, making it difficult to maintain high standards of cleanliness, hygiene and infection control. A child-friendly environment had been developed in the areas where children were present.

A Fire Risk Assessment had been made on 7 January 2014, and most of the action points had been completed. A few minor ones were still outstanding in relation to door signage, and were awaiting a further evaluation by the assessor.

There was an in-house training programme for staff on fire safety, and fire drills were held on at least two occasions a year. These were also supplemented by actual fire alarm calls.

Until now, records of service testing information had all been in a hand written format, but these were gradually being transferred to a computerised system.

The fire alarm installation records were satisfactory, with adequate records to substantiate regular weekly testing and servicing of the installation.

Regular discharge tests of the emergency lighting installation were undertaken, and concerns were expressed that it had taken almost eight weeks to complete the last discharge test. Further reference is made to this within the 'concerns' section below. On the second inspection, the extent of the failures was further discussed. Some 100 fittings required repair or replacement, and management had responded positively to a repair programme, commencing initially with the high risk areas

The Electrical Periodic Re-Inspection certificates for the complex were inspected, and errors were noted regarding the main building, as set out in 'Concerns' below. This omission has been since dealt with, and was mainly due to an administrative error by the issuing company, which has since been rectified.

A current Legionella Risk Assessment, version 4, dated June 2013 was in place, and due for review in 2016. Water sample tests were taken weekly at pre-set tap outlets around the Hospital, the bowls of the Endoscopy cabinet and the hydro-therapy pool. Test results were filed on receipt, and the majority of these were of a satisfactory nature. When an isolated report showed a slight bacteriological count, the details were referred to the retained Control of Infection Officer for her opinion. These reports were also presented to the regular Control of Infection meetings.

There were three cold water storage tanks serving the site, and these were used singly on a rotational basis, in order to ensure a good flow through the tanks, and prevent the potential build up of bacteria. All three tanks were chlorinated on an annual cycle.

Servicing and insurance inspection reports for the four lifts and patient hoists and assisted baths were retained on file, and all appeared to be satisfactory.

All of the central heating boilers, serving physiotherapy, outpatients, bungalow and the main building had been serviced on 16 January 2014, and appropriate gas safety inspections on 10 June 2013.

Information in respect of the Uninterruptible Power System (UPS) for the Endoscopy theatre and the standby emergency generator, were examined. Several PPM record sheets highlighted a deficiency in the batteries of the UPS System for some time,, and a later inspection of the equipment revealed that the UPS units had been by-passed at some time in the past, and were not operating.

Servicing information for the main stand-by generator was viewed, and the last two six-monthly reports had an exclusion of testing for the switchgear, auxiliary contacts and mechanical interlocks. These tests were carried out under a separate contract and information retained on file showed this to be an annual check. The last service report was dated 27 December 2012, but no report was available for December 2013, as it was advised that the inspection had been cancelled by the Hospital. It was hoped that the inspection could be made over the Easter period, but no specific arrangements were yet in place.

These two serious issues were specifically drawn to the attention of the Chief Executive Officer at the end of the inspection, as potentially, the emergency back-up systems could be at risk.

Discussion and feedback with hospital senior management team members took place throughout the and at the end of each visit.

New requirements from this inspection discussed at the time of inspection:

Action Required	Timescale for	Regulation Number

	completion	
1.Electrical wiring installation Main Building	Regulation 26(2)(a) Completed	13.3.2014
2. MDU	Regulation 21(2)(d) Completed	17.3.2014
3.Emergency Lighting	Regulation 26(4)(a)(b) Completed	23.3.2014
4. The recent 1 hour discharge testing regime for the emergency lighting installation had taken about 8 weeks to complete, and due to the protracted time scale, it was not possible to fully assess the outcomes of the test. It was advised that there had been failures, and it could be that a phased programme of battery replacements may be considered. It is of concern to note the lengthy time period to ensure that the system is fully operational, and a notice is to be issued requiring an assessment report of the situation to date, and a programme of improvements to ensure a fully operational system. This is required within 48 hours of the inspection	Regulation 26(4)(a)(b)	48 hours Completed
5. The Periodic Re-Inspection Report for the electrical wiring installation of the main building (St. Andrews, St Patricks', Main Kitchen, Plant Room, Endoscopy etc..) was viewed. It was undertaken by PHS Ltd on 29 September 2011, and unlike the test certificates for other areas of the complex, it showed a re-test period of only 12 months. No subsequent inspection report could be produced, and therefore a notice was issued that re-testing of the Installation should commence within a timescale of 48 hours, to ensure safety of the building. In the meantime, Management are to	Regulation 26(2)(a)	48 hours Completed

ensure that adequate risk assessments are in place to ensure the safety of patients and staff within affected areas.		
6.Replace the batteries/UPS units serving the Endoscopy theatre	Regulation 26(3)(d)	2 weeks
7. Carry out service/inspection of the efficient operation of the stand-by generator switchgear, in the event of a mains supply failure.	Regulation 26(3)(d)	5 weeks maximum, or sooner
8. Appropriate staffing levels need to be available to meet patient need.	Regulation 20(1)(a)	Immediate and ongoing Confirmed, response provided 12.6.2014
9. All staff must undertake appropriate and required training.	Regulation 20(2)(a)(b)	Immediate and ongoing Confirmed, response provided 12.6.2014
10. All staff should receive supervision and appraisal.	Regulation 20(2)(a)	Immediate and ongoing Confirmed, response provided 12.6.2014

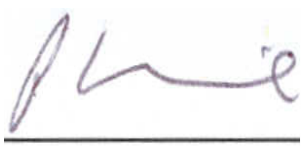
Please would you forward an action plan to hiw@wales.gsi.gov.uk by Friday 13 June 2014

Healthcare Inspectorate Wales (HIW) would like to thank all members of staff for their time and co-operation during the visit.

A copy of this letter is being sent to:
Mr Nigel Morris, Registered Manager St Joseph's Hospital

Please do not hesitate to contact me should you wish to discuss the content of this letter.

Yours sincerely



Phil Price
Inspection Manager