Arolygiaeth Gofal Iechyd Cymru

Healthcare Inspectorate Wales

Independent Healthcare Inspection (Unannounced)

Shalom House

Hospice

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Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of Shalom House on the 21 and 22 November 2017.

Our team, for the inspection comprised of one HIW inspector and two clinical peer reviewers. The inspection was led by the HIW inspection manager.

HIW explored how the service complied with the Care Standards Act 2000, requirements of the Independent Health Care (Wales) Regulations 2011 and met the National Minimum Standards for Independent Health Care Services in Wales.

Further details about how we conduct independent service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall we could not be assured that the service provided safe and effective care at all times. It was difficult to evidence standards of care and treatment, specifically in the respite service, due to the lack of documentation to support the delivery of any such care.

We were satisfied however that the staff were committed to offering a sensitive and caring environment for patients to receive support and alternative therapies.

This is what we found the service did well:

- Staff demonstrated a very caring and courteous approach to patients and told us they had a high level of job satisfaction
- Patients were very happy with the services provided
- There was plenty of time for staff to spend with patients
- Good manual handling equipment
- Interactions between staff and patients were dignified and respectful

This is what we recommend the service could improve:

We identified the service was not compliant with a significant amount of areas of the Independent Health Care (Wales) Regulations 2011. Non-compliance notices were sent in regard to these. Further information can be found in the body of this report and Appendix B.

- There is no evidence of processes in place which can assist in improving the quality of outcomes, where this is directly relevant to particular clinical treatment
- There are no records or monitoring of clinical pathways to inform improvement
- Recording and processes for dealing with concerns and suspected abuse

- Inadequate operational systems and arrangements, for the management of medicines
- Patient records
- We are not assured that risks to service users are managed and minimised to the lowest possible level

These are serious matters and resulted in the issue of a non compliance notice to the service. At the time of publication of this report, HIW had received sufficient assurance of the actions taken to address the improvements needed.

3. What we found

Background of the service

Shalom House is registered to provide an independent hospice at 113 Nun Street, Pembrokeshire, SA62 6BP.

The service is registered to provide care for a maximum of 11 (eleven) patients (at any one time) with life limiting illnesses, specifically to aid in the management of difficulties caused by illness i.e. pain management, problems caused by chemotherapy, advance care planning. The number of patients accommodated overnight shall not exceed 5 (five). No treatment is to be provided to persons under the age of 18 (eighteen) years.

The service was first registered on 24 February 2011.

The service employees a staff team which includes three part time nurses, an occupational therapist and two part time healthcare assistants. Ancillary staff include; a business manager, administrator and catering manager (cook). The registered manager post is currently vacant although the occupational therapist is acting as interim manager.

It offers a day unit which runs Monday to Friday 9 am – 4:30 pm and respite beds which are available Monday to Friday on the first week of every month. Due to non-compliance issues identified during this inspection the Board of Trustees have agreed to voluntarily suspended the respite services while improvements are made to the service.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

All discussions held with patients were very enthusiastic and supportive of the services delivered at Shalom House. We saw that patients were being treated with dignity and respect. There were some opportunities for patients to feedback about their experience, through the utilisation of face to face discussions and although the service ustilises "I Want Great Care" survey it acknowledged that there is more work needed to capture patients views.

All staff demonstrated kindness and compassion when dealing with patients.

Shalom House provides adequate facilities for patients and their relatives. Bedrooms are in the process of being re-furbished; with some rooms including an airy, spacious lounge having beautiful views of the surrounding countryside.

During our inspection we distributed HIW questionnaires to patients and staff at Shalom House to obtain their views on the standard of care they have received at the hospice. In total, we received six completed questionnaires.

Patient questionnaire analysis

Feedback provided by patients in the questionnaires was very positive; they rated the care and treatment provided as ten out of ten and all patients agreed that staff were kind and sensitive when carrying out care and treatment and that staff provided care when it was needed. Patients provided the following comments in the questionnaires about staff:

> *"A fabulous environment to relax, recuperate within safe boundaries and the empathy and access to helpful information and services is second to none. Much needed facility and staff which sustains patients, carers and friends and family through very dark periods of life"*

“Wonderful. So kind and caring. A great team. It's a solace to have this facility on hand week by week. The staff at Shalom have the time for patients, which unfortunately the hospital staff cannot always provide”

The environment

All patients agreed in the questionnaires that the setting was both clean and tidy.

The staff

The majority of patients confirmed in the questionnaires that they were offered the option to communicate with staff in the language of their choice. Patients were asked in the questionnaires whether they agreed or disagreed with a number of statements about the staff at Shalom House. All patients agreed that staff were always polite and listened, both to them and to their friends and family and that staff called them by their preferred name. Patient comments included in the questionnaire that praised staff included:

“I have a high regard for all of the staff, who always work so hard to fulfil our needs in every respect”

“The staff without exception here at Shalom are wonderful. Kind, caring and competent”

All patients agreed that staff have talked to them about their medical conditions and helped them to understand them, and one patient provided the following comment in the questionnaires:

“Always helpful, kind, considerate, informative and advice regarding any queries or problems forthcoming without preamble”

Your care

All patients that completed a questionnaire told us that they had time to eat their food at their own pace and that drinks were always accessible.

Those patients that needed assistance going to the toilet agreed that staff helped with their needs in a sensitive way so they didn't feel embarrassed or ashamed.

Staff questionnaires analysis

Quality of patient experience

During our inspection we distributed HIW questionnaires to staff to find out what the working conditions are like, and to understand their views on the quality of care provided to patients at Shalom House. In total, we received four completed questionnaires from staff undertaking a range of roles at the setting.

Professional development

Some staff members indicated in the questionnaires that apart from fire safety training, which each member of staff had completed in the last 12 months, the previous training or learning and development they had undertaken at Shalom House was more than 12 months ago; this was for training such as infection control, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)[1] and the privacy and dignity in the care of older persons.

Most staff that completed a questionnaire agreed that the training or learning and development they complete helps them to stay up to date with professional requirements, helps them to do their job more effectively and ensures they deliver a better experience for patients.

All staff members that answered this particular section in the questionnaire said that they have had an appraisal, annual review or development review of their work in the last 12 months, and that their manager supported them to identify and receive training, learning or development opportunities.

[1] The Mental Capacity Act 2005 includes the Deprivation of Liberty Safeguards (DoLS) – a set of checks that aims to make sure that any care that restricts a person's liberty is both appropriate and in their best interests.

Patient care

In the questionnaires, staff were given a number of statements relating to patient care and were asked to rate how often they applied in their experience. All staff that answered these questions said that at Shalom House, patients' privacy and dignity is always maintained; that patient independence is always promoted and that patients and/or their relatives are always involved in decisions about their care.

One staff member told us in the questionnaires they felt that they were never able to meet all the conflicting demands on their time at work, but most staff agreed that there are always enough staff at the organisation to do their job properly.

Staff felt that they always had access to the adequate materials, supplies and equipment to do their work. The majority of staff members that completed a questionnaire said that they were always able to make suggestions to improve the work of their team and were usually involved in deciding on changes introduced that had an affect on their work area or team.

The majority of staff felt that they were always satisfied with the quality of care they give to patients.

Your organisation

All staff members that answered these questions felt that the organisation is always supportive, and staff who deal with patients are always empowered to speak up and take action when issues arise.

Staff that completed this set of questions in the questionnaire also told us that they felt that the managers always have the right information to monitor the quality of care across all clinical interventions and take swift action when there are shortcomings. They also agreed that there is a culture of openness and learning that supports staff to identify and solve problems.

All staff members that completed a questionnaire told us that the organisation always encourages teamwork, believed that care of patients is the organisation's top priority and that the organisation acts on concerns raised by patients.

Staff that completed a questionnaire strongly agreed that if a friend or relative needed treatment they would be happy with the standard of care provided by the organisation. They also strongly agreed that they would recommend the organisation as a place to work.

Patient experience measures

All staff members that completed a questionnaire knew that patient experience feedback (e.g. patient surveys) was collected. However, only two of the four staff members that completed a questionnaire said that they received regular updates on the patient experience feedback, and agreed that patient experience feedback is used to make informed decisions.

Your immediate manager

Staff were asked questions in the questionnaire about their immediate manager, and the responses given were positive. All staff members agreed that their manager always encourages those that work for them to work as a team and that their manager could always be counted on to help them with a difficult task at work.

All staff told us in the questionnaires that their manager always gives clear feedback on their work and said that their manager always asks for their opinion before decisions were made that affect their work. Staff also agreed that their manager was always supportive in a personal crisis.

Senior managers

Staff were asked questions in the questionnaire about their senior managers. All three staff members that completed this section of the questionnaire reported that they always knew who the senior managers were in the organisation, and felt that senior managers were always committed to patient care.

Staff told us that communication was always effective between senior management and staff, and said that senior managers always involve staff in important decisions, and act on staff feedback.

Your health, well-being and safety at work

Staff were asked in the questionnaires whether they agreed or disagreed that in general, their job was good for their health; all staff members that completed a questionnaire strongly agreed with the statement. Staff also agreed that their immediate manager takes a positive interest in their health and well-being and that their organisation takes positive action on health and well-being.

Staff told us in the questionnaires that they have not seen errors, near misses or incidents in the last month that could have hurt staff or patients.

The majority of staff that completed a questionnaire agreed that their organisation encourages them to report errors, near misses or incidents, and agreed that when they are reported, the organisation would take action to ensure that they do not happen again.

Staff that completed a questionnaire generally agreed that the organisation treats staff who are involved in an error, near miss or incident fairly. Staff also told us that they felt the organisation treats any error, near miss or incident that is reported confidentially and that they are given feedback about changes made in response to reported errors, near misses and incidents.

Staff also said in the questionnaires that they feel that their organisation does not blame or punish people who are involved in errors, near misses or incidents.

Raising concerns about unsafe clinical practice

All staff members that completed a questionnaire said that if they were concerned about unsafe clinical practice they would know how to report it. Staff members also told us that they would feel secure raising concerns about unsafe clinical practice and that they would be confident that their organisation would address their concerns.

Staff members that completed a questionnaire also felt that their organisation acted fairly with regard to career progression or promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.

The responses given by staff in the questionnaires suggested that none of the staff have personally experienced discrimination at work either from patients, their relatives, members of the public, or from their manager or team leader or other work colleagues in the last 12 months.

Health promotion, protection and improvement

It is difficult to identify the focus of the hospice as it has changed considerably over the last few years. It no longer provides all the services described on its website or in its statement of purpose and service user guide. It does however, through a range of methods, provide support and guidance from a small team of nurses, carers, occupational therapist and visiting multi disciplinary professional.to patients with life limiting illnesses.

The hospice utilises a range of alternative therapy resources and relaxation methods to promote patients physical, mental, emotional and religious wellbeing. Examples of alternative techniques used are: massage, reflexology,

aromatherapy, Tai Chi and relaxation techniques and assisted hydrotherapy bath to name but a few. The purpose of all these therapies is to promote patients wellbeing and assist in the management of their conditions and symptoms.

We did not see a patient status at a glance board in the nurses' office which would identify which patients were in the hospice at any particular time and what their individual needs were. When we asked the nurse in charge how many patients were arriving that day, the means of checking was to count the patient files which had been put in the office.

Improvement needed

The service needs to explore future provision of care and amend the literature including the statement of purpose and service user guide to clearly outline what services are offered at Shalom House.

Dignity and respect

During the entire visit all members of the inspection team saw patients being cared for in a dignified and courteous manner. Patients told us about their positive experiences, praising the staff for the considerate and dignified care being provided to them. There were no patients receiving respite during the inspection.

We observed the lunchtime meal with patients and the experience was warm, friendly and inclusive.

All patient rooms are en-suite and provide a restful environment for patients to relax and go about their daily lives in an unobtrusive manner. During respite family and friends can spend time with patients in their rooms or in the lounge areas.

The entire layout of the building has been thoroughly thought out and designed with patients as the focus. A large lounge/dining room and smaller conservatory/lounge/activity room were available. Externally, although the gardens have been tastefully designed and provide a lovely space for people to walk and relax, they looked tired and would benefit from cultivation which we were told is undertaken each spring.

Patient information and consent

The hospice had developed a statement of purpose and service user guide which were no longer providing current information with regards to the hospice

and the services offered. This needs to be addressed so that stakeholders, patients and relatives are fully informed on service provision. This is also required as part of the registration process with HIW.

We noticed that there was limited written information available in Welsh. We advise that the hospice look at providing more written material bilingually as there is a high percentage of Welsh speaking people locally.

We did not see evidence of a consent to care documented in the patient files. This is required for any intervention between health care staff and patients.

Improvement needed

The service needs to ensure patient consent is gained and clearly recorded prior to undertaking any intervention.

Communicating effectively

During our discussions with staff and observing staff communicating with patients, we saw that all staff are aware of the need to maintain discretion at all times. Offices and designated rooms are available for staff to talk to patients and family should they need to have private discussions. Patients records are kept secured and locked away in a designated room when not in use. However, the patient files, on a day to day basis, are stored in the nurse office and the door is open all day. This means that patients' files are not kept secure at all times.

We were informed that there are Welsh speaking staff available for patients who prefer to converse in Welsh.

Improvement needed

The service should offer bilingual information leaflets in line with the Health and Care Standards (Wales) 2015.

Patients care files must be stored in a secure environment at all times.

Care planning and provision

We reviewed a sample of patient files and found that there were no care plans available for patients attending the service as a day or as a respite patient. There were incomplete assessments forms and some had handwritten notes

from patients or relatives attached. We did not see any fully completed forms. What we found was:

- referral assessments which were only a list of care needs;
- no specific assessments on admission to asses skin, sepsis, falls, nutrition, pain, communication, continence or any daily living activities.

The information that was available was disorganised and unprofessional. We recommend that these areas be addressed as a matter of urgency and a non-compliance notice was sent on 24.November 2017. We received a satisfactory response on 5 December 2017. Further details can be found in Appendix B.

Citizen engagement and feedback

The hospice does not routinely obtain feedback from patients and relatives regarding their satisfaction of the service provided, though patients told us they are able to provide verbal feedback during their stay at the hospice. Additionally there was no evidence that the Responsible Individual had conducted six monthly visits as required by the Regulations. These issues were dealt with through the non-compliance notice and we received a satisfactory response on the 5 December 2017. Further details can be found in Appendix B.

Although there are systems in place for managing complaints, we did not see information available for patients, family and visitors informing them how to raise complaints / concerns.

Improvement needed

The service must introduce a system to routinely obtain feedback from patients and relatives. The Responsible Individual must visit the service at least every 6 months and produce a written report on the conduct of the establishment as per Regulation 28 of the Independent Health Care (Wales) Regulations 2011

Patients and their relatives must be given the information on how to raise a concern should the need arise.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

We could not be assured that safe and effective care is provided to patients at all times.

We found that staff support patients and their families in a holistic and inclusive manner.

Although there are numerous policies and procedures in operation to ensure that patients receive care and treatment tailored to their requirements, many of these need personalising to Shalom House rather than the name of the service which originally created the documents.

We could not evidence that patients' care needs, support and treatment has been assessed by staff and that staff review these assessments regularly in order to promote the wellbeing of patients.

We identified that all areas of patient assessments require improving and made more specific. Emergency equipment resources need to be reviewed and evaluated in order to provide specialist equipment in the event of a patient, member of staff or visitor becoming unwell with an emergency medical condition.

Managing risk and health and safety

We did not see any risk assessments for areas within the hospice and its grounds. Doors to non patient areas were not routinely kept locked and secure when not in use. Areas such as the kitchen and laundry were not locked.

However, all cleaning solutions and materials were stored in cupboards that were locked.

Oxygen masks and oxygen is available but there are no airways[2]. The hospice does not have any equipment available relating to emergency care. There is no automated defibrillator available[3]. We recommend the hospice acquires a defibrillator to assure the best possible outcomes for patients who require urgent medical treatment.

These issues were dealt with through the non-compliance notice and we received a satisfactory response on the 5 December 2017. Further details can be found in Appendix B.

Improvement needed

The service should consider purchasing a defibrillator for the purpose of providing essential emergency assistance for the benefit of patients, staff and visitors.

Infection prevention and control (IPC) and decontamination

During our visit we found the hospice to be clean, neat and tidy. Although the interior is bring refurbished, some areas remain looking tired. There were no unsavoury odours. There are no cleaning audits undertaken.

We observed that staff did not have a clear understanding of personal protective equipment such as gloves and aprons. We saw blue aprons (used for serving food) stored in a bucket in the sluice room and in the pot of a commode in the toilet. When we questioned staff we were told that these are no longer used. We therefore suggest that these are removed and destroyed. We did not see staff wearing any personal protective items during our visits.

[2] An airway is a tube which is inserted into the back of the throat to maintain an open pathway for supplying air to a person's lungs in an emergency

[3] A defibrillator is a device that gives a high energy electric shock to the heart through the chest wall to someone who is in cardiac arrest.

We saw numerous sinks for hand washing and soap was available and accessible. We also saw some staff washing their hands following patient contact. Sanitising hand gel was not available.

A cleaner works 2.5 hours on a Sunday and staff are expected to maintain the housekeeping throughout the week. High level cleaning (picture tops, wardrobes, uplighters) could be improved as we saw areas which were visibly dusty.

We asked about shared equipment and reusable medical devices such as commodes, mattresses and blood pressure cuffs (BP cuff) and were told that these were cleaned after use. We checked the BP cuff in the clinical room and saw that it was visibly dirty.

It was unclear when staff had last received training in infection control. However in discussion with staff it was evident that they had an understanding of the importance of infection prevention and control.

We viewed the sluice room and it was well presented and set out in order to promote adequate standards of infection prevention. Equipment is stored and decontaminated appropriately. Commodes are not usually provided to patients as each room has an en suite and for patients requiring more support there are two bedrooms with ceiling hoists.

Bed mattresses are decontaminated with clinical wipes regularly and staff stated that this is always undertaken when the patients leave following a respite stay.

At present, there is no infection prevention audit and therefore no infection rate data available at the hospice. We recommend that the hospice develop this area of service provision in order to identify strengths and weaknesses in their practice and highlight possible trends.

Sharps bins seen were not overfilled and were stored and maintained securely.

These issues were dealt with through the non-compliance notice and we received a satisfactory response on the 5 December 2017. Further details can be found in Appendix B.

Nutrition

The inspection team observed patients during the lunchtime meal and spoke with the cook in the kitchen regarding meal planning and cleaning schedules. Everyone thought the food was appetising and nutritious. Meal times are valued by all patients and it's viewed as a sociable time. The quantity of food portions

is good. Patients are offered alternatives at mealtimes if the food is not to their preference. Discussion with the cook revealed that most of the food is vegetarian, although chicken is available once a week for patients on respite. This limits the choice for patients who required a high protein diet or do not like vegetarian food.

There is no food hygiene rating and we observed some practices in the kitchen which are not compatible with preventing contamination. We therefore spoke with the Environmental Health Department to ask why there was no food hygiene rating and were told that they had not inspected the service because they did not realise there were vulnerable patients attending. An unannounced inspection is to be undertaken in the near future. This was discussed with staff and the Chair of the Trustees during the feedback session of our inspection.

Improvement needed

The service must provide a varied choice of nutritious meals which meet the needs of the patients.

Medicines management

Medication is prescribed by the patients' own GP and brought in to the hospice with the patient. The hospice is not utilising the all Wales Drug Charts, but have their own documentation for the safe and effective management of medication administration. Generally the medication charts that we looked at demonstrated that records are completed consistently and evidence clearly what medication has been administered by staff. However there were no signatures of staff receiving the medication in from the patient or secondary signatures from a staff member checking when medication was transcribed on to the medication charts. Additionally for identification purposes and safe administration there is only a name and date of birth recorded on the charts; there should also be a full address. At present no staff administer intravenous medication. If this is required, the hospice has assistance from Hywel Dda University Health Board staff. Oxygen is stored in a cupboard with a sign on the door however, inside the oxygen cylinders are not chained to a wall. This needs to be addressed for safe storage of oxygen (as recommended by Health and Safety at Work Act 1974).

Although there are locked cupboards in the bedroom for patients to store their medication if they wanted to self medicate, we did not see any assessments or policies to support this choice. All other medication is stored in an unlocked room, on a shelf, in plastic containers. We identified that, at present, the

hospice does not monitor the temperature of the room where medication is stored. We recommend that this be addressed because certain medications can begin to perish and become less effective if the temperature rises above 25 degree centigrade.

There is a fridge specifically to store medication but there was no medication being stored at the time. Again the temperature of the fridge is not being record to ensure optimum storage temperature.

During our visit we did not view any medication being left unattended although we did see medication pots being used and left unattended with an oil like substance inside. This could have been ingested in error.

Discussion with the acting manager and staff indicated that there are no medication audits undertaken internally or externally.

These issues were dealt with through the non-compliance notice and we received a satisfactory response on the 5 December 2017. Further details can be found in Appendix B.

Safeguarding children and safeguarding vulnerable adults

Patients are able to access all patient facilities without obstruction. Staff areas are secured sufficiently to ensure the safety of patients in the hospice.

During our evaluation of patients records we identified that Deprivation of Liberty Safeguards (DoLS) were not being considered fully as an integral component of ensuring patients had the designated capacity to consent to receiving care and treatment. Staff have not received training in identifying and managing Safeguarding issues for some time. We looked at the policy and this does not include local emergency contact numbers. These issues were dealt with through the non-compliance notice and we received a satisfactory response on the 5 December 2017. Further details can be found in Appendix B.

Medical devices, equipment and diagnostic systems

The hospice has sufficient numbers of hoists, monitoring equipment, commodes and pressure relieving mattresses available to meet the needs of all patients. All equipment viewed are maintained to good standards and serviced regularly under contract. Portable appliance testing (PAT) is also rigorously monitored at regular intervals. All beds in operation at the hospice are electronic which allow patients to alter its height and position according to their preference. All beds are supplied with high risk mattresses to assist with the prevention of pressure area damage arising.

There is a range of manual handling equipment including aids to assist moving in bed and for transferring a patient safely.

Safe and clinically effective care

We could not be assured that treatment outcomes were within acceptable ranges because there are no records or monitoring of clinical pathways to inform improvement in;

- Tissue viability; specifically pressure damage[4]
- Percutaneous endoscopic gastrostomy (PEG)[5] feeding regimes
- Pain relief

Additionally, staff are not aware of safety bulletins and alerts and therefore do not act on these within required time scales.

Although policies, procedures and protocols were reviewed in 2015, a number of the documents are not specific to Shalom House and continue to have the name of the service which originally created the documents.

These issues were dealt with through the non-compliance notice and we received a satisfactory response on the 5 December 2017. Further details can be found in Appendix B.

The hospice does not utilise patient status at a glance boards (PAGB)[6]. Due to the small size of the hospice. Staff stated they were very aware of patients' conditions, needs and requirements. However as stated earlier the nurse in

[4] Tissue viability primarily considers all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and all forms of leg ulceration.

[5] Percutaneous endoscopic gastrostomy (PEG) is a procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.

[6] PSAG is a visual patient management system which shows important patient information that can be updated regularly. The aim is to make patient information clear and easily understandable for staff.

charge could not tell us on our arrival how many patients were expected at the day unit that morning, their level of need or diagnosis.

As previously identified the hospice must ensure that DoLS is considered for all patients especially those with dementia or demonstrating signs of confusion.

Pain management is not undertaken in a consistent and effective manner. Medication is administered as prescribed, however there is no pain management tool in use and no record of whether the medication has been effective or not. However, the hospice also promoted the use of alternative therapies to manage pain in order to provide a comprehensive and holistic pain management plan for patients. Therapies such as massage and aromatherapy are used to promote patients wellbeing and help alleviate the symptoms of pain and fatigue.

These issues were dealt with through the non-compliance notice and we received a satisfactory response on the 5 December 2017. Further details can be found in Appendix B.

Records management

We found patient records are being stored securely when not in use to prevent access by unauthorised persons. However, when in use they were stored in the nurses office which is unlocked.

We could not be assured that patients' records demonstrate consistency and continuity of inputs because those reviewed were incomplete and didn't give a full account of patients' respite stay at the hospice.

These issues were dealt with through the non-compliance notice and we received a satisfactory response on the 5 December 2017. Further details can be found in Appendix B.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Independent Health Care Regulations and National Minimum Standards.

Because there is currently no responsible individual (the person representing the charity) and no registered manager, we found that management structures, lines of delegation and accountability are not clearly visible at the hospice. We concluded that, at present, the services provided at Shalom House are not managed satisfactorily and there is no clear vision for the service.

A significant amount of improvements have been identified and a non-compliance letter has been issued on the 24 November 2017 which provides the service with direction and incentive to improve in identified areas.

We received a full and satisfactory response to the non-compliance notice in a timely manner on the 5 December 2017.

Governance and accountability framework

During our first day at the service, we were initially introduced to the nurse who was in charge for the day. The acting manager returned to the hospice after attending a multi disciplinary meeting at the local district general hospital. Both have many years experience of working at Shalom House and are knowledgeable in caring and supporting patients with life limiting conditions. We were also introduced to the new business manager who had commenced work two weeks previously.

It became evident during our visit that the hospice no longer delivers (for various reasons) all the services which it was initially registered to offer. Currently there is no business plan, although we were told this was being developed. This means there is no clear direction for what or how the service is intending to develop or change.

Dealing with concerns and managing incidents

There were no robust policies procedures and monitoring systems in place in order to monitor concerns, complaints and incidents. We discussed with the acting manager how concerns are dealt with and were told that there has not been any significant issues for many years and all issues brought to attention have been dealt with immediately. There were no written records for us to check systems and procedures.

An accident book is available which staff stated recorded information on accidents and near misses.

The complaint policy was looked at and contained the correct information including HIW's contact details.

Improvement needed

The service must have robust systems in place to record all concerns so that patterns and trends can be highlighted and monitored.

Workforce planning, training and organisational development

Documentation relating to training and appraisals are kept in individual staff files. However there is no overall record of staff training and appraisals which could assist in monitoring compliance rates of staff and highlight when training was due to expire. We recommend that the service develops an overall record to assist in monitoring staff training and appraisals.

We were informed by staff that there has not been a great deal of training in recent months. However they indicated that they are able to request specific training pertinent to their roles. We identified that most staff either, require updating or specific training in order to meet mandatory training requirements.

We saw records which identified that staff appraisals are not being undertaken annually; although staff stated in the questionnaires that they have received appraisals. We recommend that all staff be provided with an annual appraisal in a timely and consistent manner.

Improvement needed

The service must ensure that staff receive all mandatory training in a timely manner

The service must ensure that staff receive annual appraisals.

Workforce recruitment and employment practices

There are comprehensive recruitment practices in operation. We viewed a sample of staff files and identified that all staff have received a Disclosure and Barring Service check. References and job applications are also stored on file. Contracts of employment were available and have been signed by the employee. Qualified nurses working at the hospice also have documentation in place evidencing their registration status with the Nursing and Midwifery Council[7].

The service has been attempting to recruit to the registered manager post for some time but has been finding it difficult. This is not a problem specific to the service but at present is an all Wales issue. Discussion with the Chair of the Board of Trustees and the business manager indicated that they were considering re-advertising the post with an amended job description.

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

[7] The Nursing and Midwifery Council is the professional regulatory body for nurses and midwives in the UK. Their role is to protect patients and the public through efficient and effective regulation.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes details of the matters of non-compliance identified during our inspection and the action the registered provider has/will be taking to make improvements
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a non-compliance notice. The issuing of a non compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect independent services

Our inspections of independent services may be announced or unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection. In some circumstances, we will decide to undertake an announced inspection, meaning that the service will be given up to 12 weeks' notice of the inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of independent healthcare services will look at how services:

- Comply with the Care Standards Act 2000
- Comply with the Independent Health Care (Wales) Regulations 2011
- Meet the National Minimum Standards for Independent Health Care Services in Wales.

We also consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within independent services.

Further detail about how HIW inspects independent services can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns identified in this inspection			

Appendix B – Matters of Non-Compliance

The table below provides details of the matters of non-compliance identified during our inspection and the action the registered provider has/will be taking to make improvements

Description of Non-Compliance / Action to be taken	Timescale for completion	Regulation number	Registered provider actions
There is no evidence of processes in place which can assist in improving the quality of outcomes, whether this is directly relevant to particular clinical treatment, such as clinical audit, or wider care provision and activities, for example, internal audit, risk assessment or patient satisfaction surveys	7 working days	9, 19, 28, 31	Ref detail 1.1.1 to 1.1.4. Hospice UK audit tools accessed and under review. Risk assessment docs reviewed & with printer. Home visit to every patient planned. New admission pack and named nurse
We could not be assured that treatment outcomes were within acceptable ranges because there are no records or monitoring of clinical pathways to inform improvement in; • Tissue viability; specifically pressure damage • Percutaneous endoscopic gastrostomy (PEG) feeding regimes • Pain relief Additionally, staff are not aware of safety bulletins	7 working days	15	Ref detail 2.1.1 to 2.1.4.By end Jan 2017, all regular patients files will be reviewed and put into new format & staff training completed on usage. New system for safety alerts introduced.

and alerts and therefore do not act on these within required time scales. Although policies, procedures and protocols have been reviewed in 2015, a number of the documents are not specific to Shalom House and continue to have the original sources identified.			Ref detail 3.1 All existing PPPs under review and system put in place for disseminating to current, bank and new staff. As a minimum list of policies & where to find it provided to all staff in interim
We are not assured that through operational policies, those who work in the service are supported and confident to raise concerns about abuse or potential abuse because; • Systems and procedures do not mirror best practice guidance for the protection of children and vulnerable adults (safeguarding) • There are no designated lead roles for child and adult protection at senior level • There are no links to the local multi-agency co-ordinators for child and adult protection Through discussing scenarios we are not assured that all persons who work in the service will; • know what abuse is and how to recognise the signs of abuse • have received training in safeguarding which is	7 working days General comment: We accept the comments relating to children and vulnerable adults in relation to visiting children & vulnerable adults. It should be noted we do not take any patients under 18 years of age, nor do we cater for adults with dementia or significant learning disabilities. Currently we require	16	Detail refs 4.1.1. to 4.2.4.. All contact details will be incorporated into staff handbook and policy included in initial patient information pack. Mandatory training, including POVA, to be completed for all clinical contracted staff on 11/12

appropriate to their role • know how to respond appropriately to suspected or actual abuse Referral processes and information sharing protocols are not in line with multi-agency procedures and did not include contact details (address, telephone and fax) for coordinators to whom referral should be made. We did not see information for service users explaining how they can raise concerns about abuse	patients, whilst recognising the severity of their life-limiting diagnosis, to be in a stable condition and not in the final stages of their palliative care.		
We are not assured that the health, safety and wellbeing of people who receive medicines whilst on respite, is not adversely affected by inadequate operational systems and arrangements, for the management of medicines. This is because; • Procedures for the self administration of medicines by patients does not include a documented assessment of the risks and arrangements for regular checking that the medicines are being taken as prescribed • There is no robust system for reporting medicines incidents and investigating the causes	7 working days	9, 15	Detail refs 5.1.1 to 5.5.2. Documentation modified. New procedures put in place.

so that action is taken to prevent recurrence • Medicines for respite patients are not stored safely and securely because they are stored on shelves in plastic boxes and the main door is unlocked • Accurate records of the medicines administered to patients are not maintained such as; PEG feeds and Oxygen therapy. Additionally information about allergies or sensitivities are not recorded on the medication charts • Systems are not in place to audit the effectiveness of procedures and compliance with the legislation such as; PEG feed regimes, pain relief			New lock fitted Intake/output charts adapted and put into use. Routine and in place. Hospice UK audit tools being assessed.
We are not assured that checks to ensure that any records about service users are completed contemporaneously and are accurate. This is because all of the four selected patient records we inspected were not fully completed, were disorganised and unprofessional in layout. We are not assured that health care professionals and persons involved in patient assessment,	7 working days	23 and Schedule 3	Details ref 6.1.1. to 6.3.3. New risk assessment package including pre admission visit will generate required documentation in care plans to ensure outcomes

provision of treatment and care or discharge, record all treatment and nursing care given and any recommendations, in the patient's health record. This is because there are no records of PEG feeds being administered, no record of initial assessment or continued risk assessment for pressure relieving intervention, such as tissue viability on admission, regular turning or pressure relieving aids. There is no evidence of any audit of healthcare records against best practice benchmarks. Records are not created with a unique identifier only patient names. Staff may not understand their personal responsibilities and accountability, in relation to service user records because they have not received training.			Training being organised. Addressographs will be attached to all documentation Training being organised
We are not assured that risks to service users are managed and minimised to the lowest possible level because: • We did not see evidence of risk assessment in patient records so that risks are identified, assessed, managed, recorded and reviewed	7 working days	9,19,26	Detail refs. 7.1.1. to 7.2.3 Mandatory training 11/12

• We did not see risk assessments or planning for moving and handling of patients with equipment. • We are not assured that staff have received appropriate up to date manual handling training specific to the equipment that they use.			New documentation and systems identified Mandatory training 11/12. Further training under discussion

Appendix C – Improvement plan

Service: Shalom House

Date of inspection: 21 and 22 November 2017

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The service needs to explore future provision of care and amend the literature including the statement of purpose and service user guide to clearly outline what services are offered at Shalom House.	3. Health promotion, protection and improvement	Future provision to be evaluated in new Business Plan in light of LHB funding provision, not yet known. Statement of Purpose and User Guide redrafted	J. Thomas J. Thomas	June 2018 Completed
The service needs to ensure patient consent is gained and clearly recorded prior to undertaking any intervention.	9. Patient information and consent	New forms now introduced. Policy will be disseminated again at team meeting on 8 Jan and senior staff will monitor	RGNs	8 Jan 18 & ongoing
The service should offer bilingual information leaflets in line with the Health and Care Standards (Wales) 2015.	18. Communicating effectively	We are exploring grant funding and local translation opportunities. As new leaflets are finalised, we will obtain bilingual versions	J Thomas	July 2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Patients care files must be stored in a secure environment at all times.		Patient's files of those who have not visited recently will be stored in dedicated file room. Keypad lock will be fitted on downstairs access door to admin area. Patient files in nurses' office are stored in lockable cabinet.	RGNs J Thomas	Jan 18 Feb 18
The service must introduce a system to routinely obtain feedback from patients and relatives. The Responsible Individual must visit the service at least every 6 months and produce a written report on the conduct of the establishment as per Regulation 28 of the Independent Health Care (Wales) Regulations 2011 Patients and their relatives must be given the information on how to raise a concern should the need arise.	5. Citizen engagement and feedback	Monthly team meetings organised to review questionnaires/comments obtained monthly/quarterly Eleanor Thomas, Chair-Trustees to complete report Contained in new user guide and statement of purpose	J Thomas E Thomas J Thomas	Completed Ongoing Completed /ongoing
Delivery of safe and effective care				
The service should consider purchasing a	22. Managing risk and health	RGN on duty at all times for emergency		31 Jan 18

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
defibrillator for the purpose of providing essential emergency assistance for the benefit of patients, staff and visitors.	and safety Arrangements	care & to commence CPR. Policy is to call first responders who are located some 200 metres away and who have a defibrillator. We are not convinced that our own defibrillator will improve outcomes. Purchase of defibrillator will be offered as a fund-raising opportunity and/or via Wales Ambulance community grant scheme.		Monthly wef 6 Feb 18
The service must provide a varied choice of nutritious meals which meet the needs of the patients.	14. Nutrition	See factual accuracy disputed comments. We are not happy to accept this as an improvement measure but do undertake to continuously monitor food quality, patient feedback and preferences and to meet patient needs in line with dietician recommendations, all of which are being done already.		
Quality of management and leadership				
The service must have robust systems in place to record all concerns so that patterns and trends can be highlighted and monitored.	23 Dealing with concerns and managing	To be raised, minuted, dealt with and revisited at monthly team meetings now scheduled for 2018		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	incidents			
The service must ensure that staff receive all mandatory training in a timely manner The service must ensure that staff receive annual appraisals.	25. Workforce planning, training and organisational development	Mandatory training completed for clinical staff. Training schedule being drawn up for future needs monitoring Rolling programme of appraisals to be introduced on monthly admin days		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Judith Thomas

Job role: Business Manager

Date: 10 January 2018