Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Quality Check Summary

## Nuffield Health, The Vale Hospital

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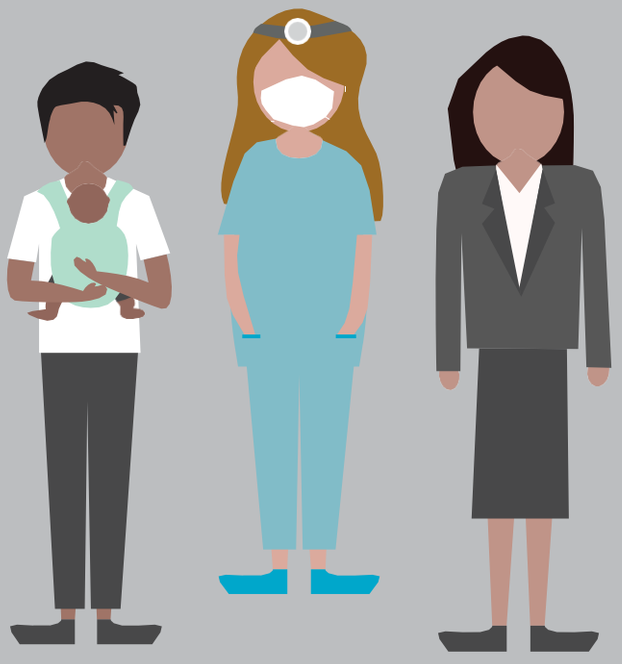

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In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

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# Findings Record

## Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of The Vale Hospital, part of Nuffield Health, as part of its programme of assurance work.

The Vale Hospital provides a range of elective surgical and diagnostic procedures. Facilities include operating theatres, consulting rooms, diagnostic services and a 25 bedded ward (set out as individual en-suite rooms), together with two beds in a designated High Treatment Unit (HTU).

The hospital has a range of X-ray facilities. Such facilities were however, not inspected during this visit, as they are considered by HIW through an alternative strand of its inspection programme associated with IR(ME)R Regulations.

The hospital employs a combined team of healthcare, administrative and ancillary staff; Consultants having defined practising privileges within the hospital. The staff team is led by a Hospital Director (who is also the registered manager) and a Responsible Individual.

Medical cover is provided by a resident medical officer (RMO), on a 24 hour, seven day week basis.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Care Standards Act 2000, Independent Health Care (Wales) Regulations 2011 and other relevant regulations. Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks capture a snapshot of the standards of care within healthcare settings. This quality check focussed on four key areas: COVID-19 arrangements; environment; infection prevention and control; and governance. More information on our approach to inspections can be found here.

We spoke to the Hospital Director (also the Registered Manager) and the Matron on 27 January 2021 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How do you ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care?
- How do you ensure that the risk of infection is assessed and managed to keep patients,

visitors and staff safe?

- How do you ensure that the ward environment is safe and protects patients from harm, and how do you ensure that patient dignity is maintained?

## Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments, incident reviews and any pressure or tissue damage which has occurred. We also questioned the setting on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

**The following positive evidence was received:**

Throughout COVID-19, the service has been designated as a green site[1]. All patients had been subject to enhanced pre-assessment procedures to ensure their suitability for treatment, including obtaining a negative COVID-19 test result prior to any procedure. As a result, the service had been able to carefully manage the flow of patients, which had enabled them to continue to provide a range of elective procedures[2].

We confirmed that a risk assessment and action plan had been completed to ensure suitability of the patient environment, which had been regularly reviewed by the Hospital Director and Matron.

We saw evidence that a range of committees regularly take place in order to monitor and promote patient safety within the environment, such as health and safety, resuscitation and a medical devices committee.

The service has a range of audits scheduled throughout the year to further support patient safety. These included audits on medicines management and patient handling and tissue damage. We found clear governance processes in which these audit results were reviewed and discussed to ensure any learning is applied.

All patients receive care in single en-suite rooms in order to maintain their privacy and dignity. We were told that dressing gowns are provided for patients and that traffic light signs are positioned on patient room doors to indicate when patients are receiving direct care or are being examined.

**No areas for improvement were identified**

[1] A designated COVID-19 free site
[2] Surgical procedures that are scheduled in advance

## Infection prevention and control

During the quality check, we considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments.

**The following positive evidence was received:**

We found there to be clear oversight of IPC arrangements through a quarterly infection prevention and control (IPC) committee meeting, chaired by the Matron who was also the IPC lead for the service. These arrangements were supported by comprehensive and recently reviewed policies and procedures for infection prevention and control (IPC), which had been created at a corporate level and adapted to meet the local requirements of the service.

We found that a high proportion of staff had completed mandatory IPC training, which included online and practical exercises, such as Aseptic Non Touch Technique[3] and hand hygiene.

In response to COVID-19, we found that access to personal protective equipment (PPE) had remained stable and was monitored to ensure sufficient stocks were maintained. Face fit testing[4] had been provided by a lead face fit tester and additional staff training in donning and doffing had also been provided to help staff apply and remove PPE correctly.

We found evidence that steps had been taken to protect patients, visitors and staff against COVID-19, which included completion of a recently reviewed risk assessment and action plan. These actions included COVID-19 screening and twice weekly testing for staff, and a period of shielding and the requirement of a negative COVID-19 test for all patients prior to their procedure. This included the re-testing of patients who had been admitted for longer than three days and testing of chaperones, where required.

The service had a no visiting policy in place. However, the service confirmed that should a patient require a chaperone to stay with them, then exceptions can be made to enable this to be done in a safe manner.

A range of recent highly scored IPC audits had also been undertaken, these included audits on theatre scrub, hand hygiene and social distancing.

The service also told us that management undertake regular quality spot checks to ensure compliance with IPC requirements in a proactive and supportive manner. Visual reminders had also been placed throughout the hospital in order to remind staff, patients and visitors of the need to wear masks and maintain good hand hygiene.

[3] Aseptic Non Touch Technique is a tool used to prevent infections in healthcare settings.
[4] This enables trained staff to ensure that respiratory protective equipment fits other staff correctly and that they are adequately trained in its use.

We saw evidence that enhanced cleaning regimes had been implemented in all patient and clinical areas, such as regular cleaning of touch-points[5]. Housekeeping staff had also completed appropriate training in order for them to safely and effectively carry out their role.

We found that ventilation requirements had been taken into account in the risk assessment and that staff were aware of fallow times[6] in clinical areas. Staff told us that a prudent approach to procedures had been adopted to ensure that only essential treatments are provided during the pandemic, which included initially suspending or limiting aerosol generating procedures.

**No areas for improvement were identified**

## Governance

As part of this standard, HIW explored whether management arrangements ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care. We reviewed staffing and patient levels, staff training and absences, management structures, ward functions and capacity, incidents and a variety of policies (such as escalation).

**The following positive evidence was received:**

We were told that the setting has been able to support the local NHS Health Board with a number of time sensitive and diagnostic procedures. We found evidence of effective working relationships, including Health Board nursing staff working on site to support the pre-admission of NHS patients and integrated standard operating procedures (SOPs) to ensure consistency.

In order to be satisfied of a clinician's suitability to practice from service, the service demonstrated a comprehensive procedure for granting practising privileges. This included confirmation of identity, contractual status and professional registration.

The service told us that they had experienced no notable staffing issues during the course of the pandemic. This was due to the service undertaking a number of elective procedures, which enabled them to plan ahead effectively. Access to a healthy number of bank[7] staff had also further supported this.

[5] Process of cleaning key areas or items that are touched frequently throughout the day, e.g. doorknobs, light switches etc
[6] A fallow period is designed to allow droplets to settle and be removed from the air
[7] Bank staff is the collective name used for a pool of people an employer can call on from within the organisation as and when required to work.

We were told that there had been several incidences of staff testing positive for COVID-19. However, it was reassuring to hear that the service had determined these to be single, isolated cases with no known workplace cause. All staff had undergone a workplace risk assessment.

We saw good examples of support that is available for staff, including regular opportunities for staff to provide feedback, with an emphasis placed on the emotional wellbeing needs of staff.

We saw evidence to confirm that completion of mandatory training was high in all areas and we were told that this was carefully monitored by on-site management and at a corporate level.

Under the regulations, the Responsible Individual (RI) is responsible for supervising the management of registered settings. This included visits to the service and the production of a report every six months. We were pleased to note that, following the latest visit, a detailed report had been produced. This demonstrated a good awareness of the setting and its management by the RI.

We explored a sample of incidents and discussed these with the setting to understand how incidents were reported, managed and responded to. The service described a clear process for reporting incidents, including how these were reviewed by clinical management and how learning was shared.

**No areas for improvement were identified**

# What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan below.

Where an improvement plan is required, it should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the Quality Check.

As a result of the findings from this quality check, 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.