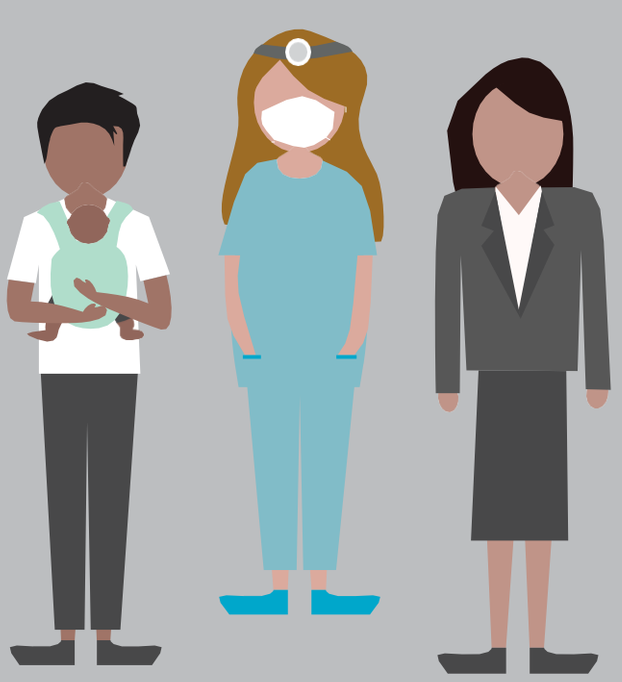
Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
St David's Hospice Care, Newport
23 March 2022

Publication date: 27 April 2022



This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

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

Digital ISBN 978-1-80364-105-8

Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of St David's Hospice Care, Newport as part of its programme of assurance work. The service provides a comprehensive range of services at the hospice and within the community. The focus of this quality check was the fifteen bed consultant-led inpatient hospice.

HIW's quality checks form part of a new tailored approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Independent Health Care (Wales) Regulations 2011. 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 are a snapshot of the standards of care within healthcare services. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to assurance and inspections can be found here.

We spoke to the registered manager, director of nursing and two ward sisters on 23 March who provided us with information and evidence about their service. We used the following key lines of enquiry:

- Is the risk of infection assessed and managed to keep patients, visitors and staff safe?
- How do you identify and effectively manage COVID-19 outbreaks / nosocomial transmission?
- Is the environment is safe for staff, patients and visitors?
- How do you meet the needs of Welsh speaking patients when accessing healthcare services in the medium of Welsh?
- Do the staff management arrangements ensure that there are sufficient numbers of appropriately trained staff to provide safe and effective care?
- How do you ensure that equality and a rights based approach are embedded across the service?
- What arrangements are in place to ensure Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) discussion and decision making is undertaken appropriately and sensitively?

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors.

The key documents we reviewed included:

- COVID-19 risk assessment
- Environmental risk assessment
- Risk management log.

We also questioned the service representatives 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:

The service had implemented a range of steps in response to the pandemic to promote a safe environment for patients, staff and visitors. At the peak of the pandemic, we were told that visiting had been restricted, with a closed door system in place to enable the service to control access. Changes were made so that only staff could use internal corridors and consideration was given to which rooms were used for staff meetings, breaks and shift handovers.

Staff told us that the existing layout and access to patient rooms had helped to further promote a safe environment, as each patient room had its own entrance and en-suite facilities. In communal areas, shared items, such as magazines, were removed and soft chairs were replaced with more appropriate furniture to enable effective cleaning. These changes were supported by use of localised risk assessments and a dedicated health and safety manager.

Staff emphasised the importance of maintaining visiting as far as possible for the wellbeing of patients and their relatives, particularly for patients in their last days of life. Staff described how this was achieved in a timely and effective manner in line with public health guidance at that time. This included initially restricting visiting numbers and COVID-19 testing for relatives before visiting.

At the time of the quality check, staff assured us that visiting arrangements had returned to allowing more than one visitor at a time, but with a retained focus on ensuring that relatives complete a COVID-19 test before they visit and use of PPE as appropriate. Communal areas and the on-site café had now fully re opened to help maintain a positive patient experience.

We confirmed that on-site accommodation facilities for relatives had resumed. We were told that 6 patient rooms contained sofa beds and a shower room to enable relatives to spend

time with their loved ones.

Staff told us that the communication needs of patients had continued to be met. Use of language line was available where it was not appropriate for relatives to translate on behalf of the patient or hospice. Staff added that some Welsh speaking staff were also available to support if required.

No areas for improvements were identified.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19, and how well it manages and controls the risk of infection to help keep patients, visitors and staff safe.

The key documents we reviewed included:

- Infection control and COVID-19 policy
- Infection control audits.

The following positive evidence was received:

The service had implemented a range of steps in response to the pandemic to promote good infection prevention and control (IPC) practises. This was supported by a COVID-19 policy and a range of risk assessments covering all areas of the service.

We were told that the service had a service level agreement in place with the Aneurin Bevan University Health Board (ABUHB) IPC department. We noted that the overarching infection prevention policy in use pre-dated COVID-19, however, the service described a range of guidance, sources of support and changes made directly in response to the latest IPC and COVID-19 guidelines at the time.

These changes included IPC and donning and doffing training for all staff. Staff were face fit tested for masks and supplied with appropriate PPE. Hand sanitiser was located throughout the building and signs were displayed to remind staff and visitors of the need to maintain IPC standards. We were told that staff ensured that they changed into their uniform in the workplace and that car sharing was paused.

We were told that all patients receive an individual risk assessment as part of their pre-admission screening. This included a COVID-19 test prior to their admission and at regular intervals thereafter. Staff continue to complete regular COVID-19 testing.

We found that a health and safety meeting was held monthly and we were told that any IPC issues were reviewed and monitored by this group. Good links with the IPC team within the

local health board were described, as well as with Public Health Wales.

We found that there had been one COVID-19 outbreak involving a small number of staff since the pandemic started. We confirmed that this was reported to Public Health Wales and HIW and that appropriate advice and support was provided. We were told that COVID-19 guidelines were re-enforced to all staff at the time.

The following areas for improvement were identified:

There were a breadth of IPC audits completed on a monthly basis. We reviewed a sample of these audits and found them to be positively scored overall. However, we found that compliance with the PVC[1] and CAUTI[2] bundle audits had scored poorly for several months. This service must monitor compliance with these audits to ensure that compliance is increased and sustained.

Governance / Staffing

As part of this standard, HIW questioned the service representatives about how, in the light of the impact of COVID-19, they have adapted their service. We explored whether management arrangements ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care.

The key documents we reviewed included:

- Responsible Individual report
- Incident reports
- Training data
- Patient voice data
- Staff vacancy and sickness data
- Patient treatment and escalation procedures.

The following positive evidence was received:

We found that there was an appropriate governance structure, which included clinical, governance and health and safety committees. There were clear lines of accountability between these committees, senior management and the clinical teams.

We were provided with the average occupancy rate and found that the service had an appropriate staffing structure in place to meet patient need. The staffing team during the day includes registered nurses, healthcare support workers, minimum of one specialist doctor and consultant sessions 3 times per week. We were told that there is a senior nurse on call 24

[1] Peripheral Venous Cannula (PVC) audit
[2] Catheter-Associated Urinary Tract Infection audit

hours a day and there was an established process in place to contact the GP out of hours service or on-call consultant if required.

Staff told us that the multidisciplinary team has worked well throughout the pandemic and that they have responded flexibly to ensure that patient needs are met, for example through the use of remote prescribing and advice.

We found that sickness had increased in recent months, but we were told that this was due to the increased COVID-19 transmission within the community. However staff told us that there was a good pool of bank staff to cover shifts when required and that agency staff are not used.

Completion rates for annual staff appraisals were highly scored and we found that a range of supplementary clinical training had been provided for staff to help to maintain their clinical skills and competencies.

The service had an appropriate policy and procedure in place to follow in the event of any safeguarding concerns relating to potentially vulnerable adults or children. There was a designated safeguarding lead for the hospital and we confirmed that training had been completed to an appropriate level.

We reviewed a sample of incidents and found that a number of patient falls had been reported. However staff told us that a recently appointed falls co-ordinator reviews every incident to understand if patient care needs to be reviewed or if there is learning for service. The service is advised to continue to carefully monitor patient falls through its governance processes to ensure that any improvements are sustained.

We reviewed how sensitive care discussions are held with patients and their relatives, including end of life care and use of the cardiopulmonary resuscitation (CPR). The service described clear and thoughtful ways in which this is achieved, including if patients wish to change their mind. This included the use of formal documentation, such as advance care plans and an All Wales tool[3].

We found that patient feedback was encouraged and that there was steps in place to collect this from all patients on a regular basis. Patient feedback was positively scored in all areas. We noted that there had been one recent complaint which had been responded and resolved in a timely manner.

We were told that these incidents are scrutinised by the health and safety and clinical governance committees. Other steps included use of chair and room sensors in ten bedrooms for those patients identified as at risk of falls on admission.

The following areas for improvement were identified:

[3] All Wales Guidance: Care Decisions for the Last Days of Life

We found that mandatory training levels to be low in a number of areas. The service told us that the impact of the pandemic had affected training levels, but that they had a management plan in place to achieve 100% within two months of the quality check. We recommend that training is prioritised accordingly, with a particular focus on ensuring that falls training is completed as soon as practically possible.

What next?

Where we have identified areas for improvements during our quality check and require the service to tell us about the actions taken to address these, an improvement plan providing details will be provided at the end of this quality check summary.

Where an improvement plan is required, it should:

- 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 areas for improvements 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 the areas for improvements 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.

If no areas for improvement were identified during this quality check, an improvement plan will not be required, and only the quality check summary report will be published on HIW's website.

Improvement plan

Setting: St David's Hospice Care, Newport

Date of activity: 23 March 2022

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

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	This service must monitor compliance with the PVC and CAUTI audits to ensure that compliance is increased and sustained.	Regulation 15 / 19	Karen Hughes will meet with the two ward sisters (R Buttweiler and K Pritchard) and review the monthly audit statistics to ensure compliance is increased and maintained K Hughes will instruct the two ward sisters to ensure the PVC and CAUTI audits are discussed at the regular staff meetings to highlight the importance of compliance K Hughes will monitor the audits on a monthly basis going forward	K Hughes	Within two months and then ongoing

2	The service must ensure that mandatory training is prioritised and completed accordingly. We recommend that a particular focus in placed on ensuring that falls training is completed as soon as practically possible.	Regulation 21	A management plan will be put in place to achieve 90-100% compliance over the next 2 months (we may not be able to meet 100% due to staff sickness but this will be our aim)	K Hughes	Two months

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.

Name: K Hughes

Date: 19/04/2022