Independent Healthcare Inspection (Unannounced)

St David's Hospice Satellite Unit

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

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 an independent hospice located within a health board community hospital in the Betsi Cadwaladr University Health Board area on the 22 and 23 March 2022.

Our team, for the inspection comprised of two HIW inspectors, one clinical peer reviewers and one patient experience reviewer. A HIW inspection manager led the inspection.

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

We found evidence that the service provided safe and effective care.

Patients who participated in the inspection expressed satisfaction with the care and treatment received. Patients' care needs had been assessed by staff, and staff monitored patients to promote their well-being and safety.

We found good management and leadership in the hospital with staff commenting positively on the support that they received form the management team.

This is what we found the service did well:

- Good staff and patient engagement
- Welcoming and well maintained environment both inside and out
- Provision of food and drinks
- Comprehensive policies and procedures
- Multidisciplinary approach to provision of care
- Infection prevention and control
- Management overview, auditing and reporting
- Family engagement and involvement.

This is what we recommend the service could improve:

- Some aspects of the care planning and assessment documentation
- Aspects of medication management
- Management of sepsis
- Fridge temperature checks.

We identified regulatory breaches during this inspection regarding some aspects of care planning and assessment and medication management. Further details can be found in Appendix B. Whilst this has not resulted in the issue of a non-

compliance notice, there is an expectation that the registered provider takes meaningful action to address these matters, as a failure to do so could result in non-compliance with regulations.

3. What we found

Background of the service

The independent hospice was registered to provide specialist palliative care to patients aged 18 (eighteen) years and over at the setting within the Betsi Cadwaladr University Health Board area.

The service could accommodate up to four patients overnight and was first registered on 19 January 2021.

The service employs a staff team which includes clinical, nurses, health care support workers and domestic staff.

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.

Patients told us that staff were kind and caring. We observed good interactions between staff and patients, with staff supporting patients in a calm, dignified and respectful manner.

We found that the environment, both inside and outside, was of a high standard. The interior of the hospice was well furnished and decorated to a high standard.

We spoke to two patients and their families during the inspection. Family and patient comments included the following:

> *"The balance is right between professional competency and humanity, compassion and kindness"*
>
> *"Staff will do anything for you"*
>
> *"If that was you in the bed, you'd want them {the staff} looking after you".*

HIW also issued an online survey to obtain staff views on the hospice. In total, we received eight responses from staff at the department. Not all respondents answered all of the questions. We also spoke with several members of staff of a variety of roles and grades.

Health promotion, protection and improvement

There were leaflets available outside the ward that included reference to advocacy, healthy living and norovirus. Transfer of care information given to patients included activities of daily living, support required for the patient and assessments would go with them. There was no information on display on the

ward, except the patients' guide[1] and the statement of purpose[2], which could be taken away. The statement of purpose and patients' guide complied with the requirements of the Independent Health Care (Wales) Regulations 2011.[3] The service complied with the conditions of registration, which was also displayed on the ward.

We saw there were signs in various areas of the hospice that prompted everyone to wear a facemask, where appropriate, and wash their hands. Hand sanitiser dispensers were available for staff and visitors to use in order to help reduce the risk of cross-infection.

Dignity and respect

Patients and carers we spoke to told us they were treated with respect and staff were kind to them. They were full of praise for the staff and stated that nothing was too much trouble. One example given was where a patient said that staff would charge their electronic device and download books for them

We saw staff treating patients kindly and with respect. Staff were discrete and sensitive when speaking to patients and they ensured patient's privacy when giving personal care. Staff appeared to be sensitive when speaking to patients and appeared to be professional and kind in their approach. The patients looked well cared for and clean, wearing clean gowns.

Regarding patient care, all staff agreed that patients' privacy and dignity was maintained, that they were involved in decisions about their care and were provided with sufficient information.

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[1] The patient information leaflet is supplied to patients and includes the information required by Schedule 2 to the above regulations. The information included a summary of the statement of purpose, arrangements seeking patients' views, access to the premises and keeping appointments.

[2] The statement of purpose is a written statement compiled in accordance with regulation 6 and schedule 1 of the Independent Healthcare Regulations (Wales) 2011. This includes the aims and objectives of the organisation and the names and qualifications of the of the registered provider and any registered manager. Additionally, it should list the kinds of treatment, facilities and all other services provided in or for the purposes of the organisation, including details of the range of needs which those services are intended to meet.

[3] The Independent Health Care (Wales) Regulations 2011 (legislation.gov.uk)

There was a relatives' room near the entrance to the ward that contained comfortable seating and maintained privacy, with privacy glass on the door and window blinds as well as facilities to make hot drinks. Prior to COVID-19, volunteers would normally staff the reception room. Due to COVID-19, it was not currently manned. Access to the hospice was through a buzzer-operated door. We were not asked to sign in during the inspection. Visitors had to be recognised by members of staff before being admitted to the hospice.

Patient information and consent

A Patient Status at a Glance board (PSAG), which is a clear and consistent way of displaying patient information within hospital wards, was located in the nurses' office. The board was designed so that patients' names could be covered when not in use to ensure patient confidentiality.

Communicating effectively

We noted that staff were aware of the need for discretion when speaking about patients. Patients were in single rooms and doors were closed when staff were talking with patients.

Staff we spoke to said that patients and family members were given a copy of the statement of purpose and patient's guide on arrival. Both documents were available in English and Welsh.

Care planning and provision

We noted that physiotherapists and dieticians were involved in the care pathways for patients, to encourage them to be more active where possible.

We found evidence that comprehensive assessments of care needs were undertaken and that these were reviewed and updated on a regular basis. Care plans were based on individualised patient needs and detailed with regular reviews and updates undertaken. The written evaluations completed by staff at the end of each shift were comprehensive and reflective of any changes in the care provided. Care plans were also documented in the notes at the end of patients' beds.

For patients receiving respite care there were discharge arrangements in place and evidence of continuing health care documentation completed.

There were do not attempt cardiopulmonary resuscitation DNACPR[4] forms in place, signed and dated for relevant patients.

Patients and relatives spoken to said that their call bells were answered promptly. We also noted that staff answered the call bells promptly during our visit.

As far as possible, patients were involved in the planning and provision of their own care. We found that relatives were consulted and encouraged to make decisions around care provision, where patients were unable to make decisions for themselves.

Equality, diversity and human rights

We were told that social workers, counsellors and a chaplain service was available with access to the chapel in the community hospital. Patients were able to receive visitors within reasonable hours and we were shown the methods used when visitors could not visit the community hospital. There were also chairs that would convert to beds in patients' rooms to allow a relative or carer to stay overnight.

Families and carers were able to attend and provide assistance where appropriate. We saw the patient centred care that was practiced in the setting and if the patient requested family input this was accommodated. Relatives we spoke to said that the staff kept them informed and involved in the patient care decisions.

We saw an up to date equality and diversity policy and staff told us that all people were treated equally. All staff who complete the questionnaire said they had not faced discrimination at work within the last 12 months. They also agreed that staff had fair and equal access to workplace opportunities and that the workplace was supportive of equality and diversity.

Staff do not wear the 'laith Gwaith'[5] badge to identify them as Welsh speakers, although we were told that the majority of staff spoke Welsh. They said that all

[4] DNACPR means if your heart or breathing stops your healthcare team will not try to restart it.

[5] The 'laith Gwaith' ('Working Welsh') scheme and the orange speech bubble badge is used to show if a person can speak Welsh.

patients were asked their preferred language and they also agreed that they use the Welsh language in everyday conversation.

Citizen engagement and feedback

The statement of purpose included details that the hospice participated in the 'iWantGreatCare'[6] service. This service allowed NHS and private health care patients to rate individual general practitioners, hospital doctors and nursing staff on the care that they provide. We were told that there had been limited feedback requested recently and that the use of the service had ceased. The setting were looking at starting a new feedback system. There were also details within the statement of purpose about how to raise concerns and complaints as well as details about HIW and the Public Service Ombudsman Wales[7].

We also noted a number of thank you cards on display in the relative room and in the main office, with positive feedback. Whilst almost all staff who completed the survey said they received regular updates on patient experiences we did not see any evidence of this displayed on the ward.

Improvement needed

The registered manager must ensure that:

- The statement of purpose is updated with regard to the feedback system used
- Feedback is routinely collected from patients, families and carers
- Results of the feedback are displayed within the setting, together with the action taken with the feedback.

[6] https://www.iwantgreatcare.org/

[7] The Public Services Ombudsman for Wales has legal powers to look into complaints about public services and independent care providers in Wales.

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 found that the staff team were committed to providing patients with safe and effective care.

Patients' care needs had been assessed by staff and staff monitored patients to promote their wellbeing and safety.

The hospice was clean and tidy and arrangements were in place to reduce cross infection.

Suitable equipment was available and being used to help prevent patients developing pressure sores and to prevent patient falls.

There were formal medication management processes in place. However, we found that whilst patient care records were generally good there were elements that require attention.

Managing risk and health and safety

The hospice is on a single floor with level access and there were facilities for those with mobility difficulties. The environment ensured the privacy of the patients as all rooms were self-contained and staff could speak to patients without being overheard.

We noted that there were risk assessments in place for COVID-19. Additionally there was an environmental risk policy in place and an environmental risk assessment had been completed in the last year. However, whilst there were action plans in place, these had not been updated as actions had been carried out, to ensure that the relevant risks were mitigated.

There were fire and health and safety posters on display in the ward corridor.

Staff who completed our survey said that they believed their organisation encouraged them to report errors, near misses or incidents. They also said they agreed their organisation treated reports of errors, near misses or incidents, raised by staff, confidentially and that staff involved would be treated fairly. Three members of staff said they had seen errors, near misses and incidents in the last month and they said it had been reported.

They also confirmed that when errors, near misses or incidents were reported, the organisation would take action to ensure that they did not happen again. Staff confirmed they were informed about errors, near misses and incidents that happened in the organisation and the majority were given feedback about changes made in response.

All staff who completed the survey said they would know how to report any concerns about unsafe clinical practice. They felt secure in raising concerns about unsafe clinical practice and were also confident that their organisation would address their concerns. Staff agreed that they could make suggestions to improve the work of their team and were involved in deciding on changes introduced that affect my work area. All staff agreed they were satisfied with the quality of care and support they gave to patients.

There were good housekeeping and maintenance arrangements in place. The communal areas, bedrooms and grounds were clean, tidy and well maintained.

Improvement needed

The registered manager must ensure that the environmental risk assessment action plans are completed and that the assessment is kept up to date, with the actions carried out.

Infection prevention and control (IPC) and decontamination

It was clear that staff practiced a high standard of care in terms of IPC and this was witnessed during the inspection.

We noted that all relevant staff had received IPC training up to level two. Staff we spoke to were aware of the infection prevention policy and needlestick injury[8] policy that was accessible on the IT system. They also said that they received updated COVID-19 guidance as and when there were any changes received.

As the hospice was opened during the pandemic, the design took account of COVID-19 requirements, with wide corridors and spacious rooms. The arrangements in place because of the pandemic were described. These included donning and doffing posters and personal protective equipment (PPE) available

[8] A needlestick injury is the penetration of the skin by a hypodermic needle or other sharp object that has been in contact with blood, tissue or other body fluids before the exposure.

outside each room. Patients were required to have take a Polymarase Chain Reaction (PCR)[9] test on arrival and then two tests per week, Staff were required to take two LFTs per week. We were also told that there had not been any hospice acquired infections since the setting had opened. When patients were admitted, they would be assumed to have COVID-19. They would be barrier nursed, in their single rooms with appropriate PPE, until confirmed clear of the infection.

Regarding COVID-19 compliance, all staff agreed that the organisation had implemented the necessary environmental and practice changes. They all agreed there had been a sufficient supply of PPE and there were decontamination arrangements for equipment and relevant areas. With regard to patient care, all staff agreed that there were appropriate infection prevention and control procedures in place.

We saw staff wearing appropriate PPE when administering care to patients and witnessed them donning and doffing the PPE appropriately on entering and leaving patient rooms. The relevant hands-free clinical coded bins were accessible to dispose of PPE after use. FFP3[10] masks were used for high risk aerosol generating procedures[11] and staff were fit tested for these masks.

Patients were allowed up to two visitors per room, the testing regimes had changed through the pandemic depending on Public Health Wales guidance at the time.

The results of IPC audits would be presented to the corporate leadership group every two weeks and lessons learned passed onto staff. The results of the IPC audits were displayed on the ward.

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[9] A COVID-19 PCR test looks for the COVID-19 virus on a swab sample collected from the back of the throat and nose.

[10] The need for FFP3 Mask (oral nasal disposable mask respiratory protection) to be worn is identified through clinical risk assessment. The mask is used to protect against respiratory borne pathogens. To use these masks, relevant staff must be 'face fit tested' to ensure that they can achieve a suitable face fit of the mask and that it operates at the required efficiency.

[11] An aerosol generating procedure (AGP) is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract when treating someone who is suspected or known to be suffering from an infectious agent transmitted wholly or partly by the airborne or droplet route.

Hand hygiene was noted as being appropriate and effective. Hand hygiene audits were carried out monthly and the results displayed for all to see on the wall at the entrance to the ward. We were told that if poor practice was witnessed the member of staff was spoken to and a re-audit completed over the following days.

All sinks seen were hands free and easily accessible throughout the ward. We noted that sharp bins were in use, which were not overfilled, with the appropriate signature and date. However, we noted during the inspection that safety cannulas[12] were not used thereby increasing the possibility of needle stick injuries. We were subsequently informed that all cannulas at the setting were checked and were found to be in date and there were not any non-safety cannulas in stock.

The environment appeared visibly clean, free from clutter, enabling effective infection control and was in a good state of repair. However the radiators were covered by a grill that needed to be removed by the estates department before the radiator could be cleaned. There were also very high level window ledges and windows. We were told that neither the radiators nor the high window ledges and windows had been cleaned since the setting had opened.

All storage areas were well organised with a separate cleaner's cupboard that was locked. All cleaning equipment was appropriately segregated and colour coded in accordance with healthcare guidelines. The relevant cleaning paperwork was available for inspection. Fridge temperatures were checked for both staff and patient food fridges. The housekeepers were fully aware of their role and were able to describe and demonstrate the cleaning schedules. There was clear evidence that when the housekeepers were in attendance deep cleaning could be carried out appropriately, if required. The housekeepers worked six hours per day and this role would pass onto nursing staff, outside these hours. We saw the cleaners on site during the inspection and observed the cleaner cleaning the unit regularly, with all areas kept clean tidy and clutter free, with no hazards noted.

[12] A cannula is a tube that can be inserted into the body, often for the delivery or removal of fluid or for the gathering of samples.

Improvement needed

The registered manager must ensure that:

- The cleaning of the radiator grills and the high level windows and ledges are risk assessed and cleaned on the basis agreed in the risk assessment
- Safety cannulas are used to reduce the possibility of needle stick injuries.

Nutrition

Catering facilities were provided by the main hospital. Patients we spoke to said that the food was good and staff helped them to eat food and drink liquids if necessary. Water was in easy reach of patients. Staff would also try to source any specific food required by the patient. The relationship between the catering department and the hospice appeared to be good.

Meals were served to patients in a timely way with meal times adequately spaced during the day. We saw that the hospice had purchased individual food containers to keep the food hot until the meal was ready to be served.

The patient care records we checked showed that there was an initial nutritional risk assessment completed and a nutritional care plan that was adequately completed. The hospice used the community hospital dietician service, where required. However, fluid and food intake charts were not used to measure how much a patient ate and drunk. Additionally, the hospice did not use an oral care plan, it was evaluated as part of the patient notes in their daily record. Speech and Language Therapy (SALT) referrals were used if the patient needed assessment for swallowing or communication difficulties.

Improvement needed

The registered manager must ensure, for all patients, that:

- Food and fluid intakes are measured
- An oral care plan is completed and regularly updated.

Medicines management

All Wales drug charts were used, consistently signed and dated by a doctor, this included the administration of oxygen prescribed. The patients' name was clearly written with the relevant information. It was clear what had been administered

and when, medication refused was also recorded correctly. The administration of medication was recorded consistently and contemporaneously.

The hospice used the pharmacy service of the hospital and they attended twice a week. General practitioner and palliative care were available on call during out of hours times. If medication was required, we were told that the palliative care clinician would email a script to the hospice for the nurse to dispence the items. Additionally, a system was in use to be able to obtain items from an outisde pharmacy.

There was a medicines management policy available to staff on the IT system that covered the self administration of medication and the safe storage, prescription, administration and dispensing of drugs.

All drugs, including controlled drugs were stored securely in a well organised locked cupboard within a locked treatment room. There was a locked fridge in the treatment room. Medicines trollies were not used as patients medication was locked in secured cupboards in patients rooms for nurses to dispense directly. There were regular stock checks of controlled drugs against the logbook, with two nurses completing the checks, and fridge temperatures were monitored. However, there were some gaps in the fridge temperature checks. These need to be carried out on a daily basis.

All patients seen had identification (ID) bands that were checked prior to the administration of medications. Patients were positioned appropriately in readiness for medication. Medicines were seen to be checked and administered to patients appropriately. The ID band was checked when the patient could not communicate or lacked capacity, otherwise the patient was asked their details that was checked against the medication chart. We were told that patients did not self-medicate.

Improvement needed

The registered manager must ensure that the daily checks of the medication fridge temperatures are completed and that the checks are appropriately recorded.

Safeguarding children and safeguarding vulnerable adults

There were written safeguarding policies and procedures in place and staff had undertaken appropriate training on this subject. Staff we spoke to had a clear understanding of the mental capacity act and the safeguarding requirements. Patients we spoke to said they felt safe in the hospice and felt able to speak to staff if they were worried.

The patient care records checked showed there was a mental capacity assessment in place on admission, using a nursing delirium screening scale[13].

The hospice had access to social workers, which was detailed in the patients guide, who were the safeguarding leads for the hospice. The social worker we spoke to said that they were the Deprivation of Liberty assessor for the local authority and was able to give appropriate advice to the hospice as needed.

Nursing staff and the social worker would act as advocates and stated that they would report any concerns to the local health board safeguarding service.

Blood management

We were told that the hospice did administer blood products, which would be delivered if needed from Ysbyty Gwynedd, the nearest district general hospital. Training records were not available at the time of the inspection. Subsequent examination of the training records showed that seven of the 13 staff had completed the blood transfusion theory in the last three years. However, none of the staff had completed the blood transfusion competency training.

We saw a blood transfusion policy was in place, which stated that all staff involved in the blood transfusion process required three yearly documented training and competency assessment in the relevant procedures. The hospice must not administer any blood products until the staff have received the relevant training.

Improvement needed

The registered manager must ensure that blood transfusions are not carried out at the hospice until staff have received the relevant training and competency assessments on the administration of blood products.

Medical devices, equipment and diagnostic systems

The resuscitation and defibrillator equipment were shared with the adjacent ward of the community hospital. Checks were carried out on the equipment during the

[13] The Nursing Delirium Screening Scale is composed of five categories: disorientation, inappropriate behavior, inappropriate communication, illusions/hallucinations, and psychomotor retardation.

week by the community hospital ward and by the hospice on the weekend. We were told that only basic life support was given at the hospice as staff were not trained in intermediate life support. The training records showed that less than 60 percent of staff had completed the relevant resuscitation training.

All rooms were fitted with hoists above each bed, to aid in the lifting of patients. The maintenace of the hoists was carried out by the company that supplied the equipment.

We were told that all equipment was decontaminated between patient use. Nurses were responsible for the cleaning of the beds. ‘I am clean’ stickers were used to show that equiment had been cleaned. Staff we spoke to were aware of the need to thoroughly clean equipment after use. They were also aware of the need to clean observation machines such as the blood pressure cuff between each use and how to clean this equipment.

Safe and clinically effective care

From our discussions with staff and examination of patient care documentation, we found that patients were receiving safe and clinically effective care. Patients we spoke to were very positive in terms of staff having time to care for the patients. Staff we spoke to felt they had enough time to provide care safely and they were very positive about having time to care for the patients.

There was evidence of very good multi-disciplinary working between the nursing, medical staff and therapy staff.

We saw that hospice monitored patient observations such as blood pressures, temperature, pulse was taken on admission, but they were not recorded daily thereafter, unless the patient was ill. We were told this was because patients were documented as not for escalation of treatment, transfer or DNACPR. For instance, if patients were documented as not for escalation of care as part of end of life pathway by a clinician then daily observations would not be appropriate. However, our position is that if a patient has a DNACPR in place, they are still eligible for fluid resuscitation and sepsis care and therefore daily observations should be monitored. Additionally, some patients may have dementia or lack capacity and would not be able to say if they were feeling unwell. By completing a set of daily observations, an early indication of sepsis could be identified, treated and reversed. Not completing the observations could result in sepsis being undetected for a few days and possibly be irreversible.

Whilst staff had not received specific training on sepsis[14], all staff had been trained in the theory element of aseptic anti-touch technique training[15] and they had received training on recognising deteriorating patients. We also noted that sepsis screening was not included within the patient care plans. National early warning score[16] (NEWS) charts or the sepsis six[17] pathways were not used.

All staff who completed the survey agreed they were able to meet all the conflicting demands on their time at work. They agreed that there were enough staff working with an appropriate mix of skill in the department to allow them to do their job properly. Also all staff agreed they were able to access information technology systems to provide good care and support for patients. The majority of staff agreed they had adequate materials, supplies and equipment to do their work. Staff we spoke to knew how to access the relevant clinical policies and procedures and qualified staff knew how to access the record keeping guidance for nurses and midwives.

We saw that appropriate staffing levels were maintained and equipment was readily available to ensure safe care could be delivered. We saw evidence of a number of audits in place, the results of the audits would be discussed with staff, no trends were identified in the audit checks. The following audits were noted:

- Commode checks
- Hand hygiene
- Pressure ulcer and falls risk assessments
- Nutritional risk assessments

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[14] Sepsis is a life-threatening reaction to an infection. It happens when your immune system overreacts to an infection and starts to damage your body's own tissues and organs.

[15] Aseptic Non Touch Technique is a method of working where the practitioner follows the principles of asepsis to ensure that the sterile component (key part), for example, a needle, does not come into contact with non-sterile surface.

[16] The National Early Warning Score (NEWS2) is a system for scoring the physiological measurements that are routinely recorded at the patient's bedside. Its purpose is to identify acutely ill patients, including those with sepsis.

[17] The sepsis six care pathway is a part of the UK Sepsis Trust's recommended approach to diagnosing and treating sepsis.

- Manual Handling
- Care plans
- Mouth care.

A family of one patient that we spoke to, said they were very happy with treatments, were kept well informed and they said that their family member was much happier since moving to the hospice. They said that in the hospice, staff had more time to care and talk to the patient. There had been discussions about the next stage of the care and they were given a list of nursing homes available to visit and make enquiries. Another family member of another patient said that they had received considerable support from the staff, particularly when they felt overwhelmed.

There was evidence that pain was managed, actioned and evaluated appropriately using pain assessment tools. Pain management charts were kept with patients' medication administration charts so that they could be referred to and amended at the point of administration of pain relieving medication. We saw staff responding in a timely fashion when patients expressed discomfort and requested pain relief.

We were told that the hospice followed the pressure ulcer prevention strategy for Wales. Any pressure ulcers above grade two would be reported to the tissue viability nurse at the local district general hospital. In addition, they would be reported to the two weekly clinical management meetings and subsequently the clinical governance meetings held quarterly. There were good processes and appropriate support from the tissue viability team to ensure that pressure and tissue damage was checked, investigated and reported. On examination of a sample of patients' care records we found that pressure area risk assessments were being undertaken on admission and were being reviewed on a regular basis. There was evidence on the turning charts to show that there was frequent repositioning of patients throughout the day and night.

The ward was calm but industrious during our time at the setting and there were an appropriate number of staff on duty, with a staffing level that was considered to be safe. We were told that during various stages of the pandemic, there were staffing shortages, with staff absences and staff shielding. Staff said that due to the excellent team spirit, they were always happy to cover shortages as a team.

Improvement needed

The registered manager must ensure that:

- All observations are taken of patients on a daily basis

- Staff are trained in the sepsis and the sepsis six pathway
- Appropriate NEWS and sepsis six bundle checks are carried out as required.

Records management

The patient care records were comprehensive and contemporaneous. The quality of the patients' care records we looked at was generally good. The nursing evalauation was thorough for the care delivered on each shift. They were up to date, signed and dated. Dividers were used to easily identify the different sections of the records. Risk assessments were used in addition to care planning, although as described above some areas were missing, such as daily observations, oral care plan and fluid and food intake. There was evidence of the multi-disciplinary team contributing to the patient care plans.

The patient care records were kept in a locked cabinet in a locked office. We were told there was a plan to become a paper lite system, but this was not well advanced.

Appropriate falls prevention assessment and care processes were in place and well documented. The falls pathway was embedded into the care pathway for all patients and all falls were audited and reported to HospiceUK[18]. We were told that beds were fitted with falls alarms to alert staff of patient movements and as a preventative measure.

We also saw evidence of good intentional rounding[19] in the care records.

However, we noted one set of notes from the two checked where the admission nursing assessment document (Green) part were not completed until 24 hours after admission.

[18] Hospice UK is the national charity for hospice and end of life care. They work to ensure everyone affected by death, dying and bereavement gets the care and support they need, when needed.

[19] Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs.

Improvement needed

The registered manager must ensure that all elements of the patient care records are completed in full, in a timely manner.

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.

We found good management and leadership within the hospice, with staff commenting positively on the support they received from the management team.

Staff told us they were treated fairly at work and an open and supportive culture existed. Staff also told us they were aware of the senior management structure within the organisation and the communication between senior management and staff was good.

Senior nurses and other managers were working diligently in order to promote the safe and effective care and treatment of patients attending the department.

Some areas need to be addressed regarding policies and procedures, training compliance, staff appraisal and safeguarding referral, as described below.

Staff we spoke to seemed happy in their work and stated that they had a lot of job satisfaction from working at the hospice, mainly due to the fact that they felt well supported and had time to treat and engaged with the patients There appeared to be a very good team spirit and everyone was approachable.

Governance and accountability framework

During the inspection we noted that there was clear leadership evident on the ward from the sister in charge. In addition, the registered manager who was also a registed nurse, attended the hospice on two or three days a week.

All staff agreed that the hospice encouraged teamwork, was supportive, was effective in working as a partnership and took swift action to improve. All bar one said that the hospice supported staff to identify and solve problems.

We saw a number of policies and procedures and noted that some of these were overdue for review such as the Emergency and Business Continuity Plans, Clinical Audit Policy and the Blood Transfusion Policy.

All staff agreed with the following statements in the survey:

- Care of patients is my organisation's top priority
- My organisation acts on concerns raised by patients
- Overall I am content with the efforts of my organisation to keep me / patients safe
- I would recommend this hospice as a place to work
- If a friend or relative needed support I would be happy with the standard of care provided by this hospice.

Improvement needed

The registered manager must ensure that all policies and procedures are up to date and reviewed as required.

Dealing with concerns and managing incidents

We viewed the incident and near miss file. The file was well organised with dividers clearly showing which cases were ongoing or completed. We noted that all incidents were investigated by the line manager with the relevant forms completed. Any actions or issues identified for learning were discussed with the relevant members of staff and discussed at clinical meetings. During the check of the paperwork we noted one case where the patient had not been referred to safeguarding following an admission to the hospice with a grade 4 pressure ulcer. The hospice believed that the district staff referring the patient should have completed the safeguarding. However, there was no reporting noted of this to HIW. The hospice should ensure that patients are referred to safeguarding and reported to HIW even if the incident occurred outside the hospice. The hospice was also part of the local health board strategic event reporting for palliative care quarterly.

We were told that a number of services were provided by the local health board via service level agreements.

Senior staff we spoke to told us that there had not been any complaints made about the care and treatment at the hospice. If there was a complaint made, the setting would follow the same process as the incident reporting systems. Whilst the complaints and concerns process were detailed in the patient guide, there

was nothing displayed on the ward. The process should be prominently displayed in the ward.

Improvement needed

The registered manager must ensure that:

- Patients are referred to safeguarding and HIW regardless of where the incident occurred
- The complaints and concerns process is prominently displayed on the ward.

Workforce planning, training and organisational development

All staff bar one said they had appropriate training to undertake their role. One member of staff said that they would like further training in the palliative care field. Another member of staff suggested more in-depth specialist palliative care topics. All staff said that training, learning and development helped them do their job more effectively to stay up-to-date with professional requirements and to deliver a better patient and service user experience.

Regarding their professional development, only five out of the eight staff said they had an appraisal within the last 12 months. Training and development needs would be identified in these meetings and that their manager would support them to receive this training and development. Staff we spoke to said that the hospice was supportive with training requirements and with their development. They said that time was allocated as protected time to undertake training.

We were told that reminders about training due were sent out from the main hospice. However, the compliance seen varied from eight percent for blood transfusion training to 100 percent for health and safety. Two further areas of training were below 70 percent, these were resuscitation and medical devices. We were told that the these three areas were accessed through the local health board and due to the pandemic the training had been unavailable at times or there had been restricted access.

Staff told us that the service supports staff to develop, maintain and ensure they have the right knowledge and skills. All staff were positive with their comments in the survey about their immediate manager. They were also positive in their comments about their senior managers.

We saw evidence that two out of 18 staff had not received an appraisal in the last 12 months, this included one member of staff who was on probation.

Improvement needed

The registered manager must ensure that:

- All staff have an annual appraisal in a timely manner
- Staff training is improved to ensure that all staff have completed their mandatory training and all competency training as required in a timely manner.

Workforce recruitment and employment practices

Staff we spoke to confirmed that there was always a good skill mix of staff on duty. Due to this they believed that staff had sufficient time to see to patients needs and to speak and engage with patients. The staff rotas were checked for the three months up to 20 March 2022 and we saw that the service covered the shifts up to the minimum staffing levels. We were told that there was one vacancy at the setting currently that had been advertised.

Relating to staff health and wellbeing at work, all bar one member of staff agreed that in general their job was not detrimental to their health. They all agreed with the following statements:

- My organisation takes positive action on health and wellbeing
- I am offered full support when dealing with challenging situations
- I am aware of the Occupational Health support available
- My current working pattern/off duty allows for a good work life balance.

We saw the notices for confidential councelling serives. Additionally, senior staff stated that occupational health support was available through the local health board and there was also private occupational health provision for staff.

We were provided with evidence of the last two staff meetings dated September 2021 and February 2022. The topics included any issues identified, training, visiting, work patterns and various clinical items. Ideally staff meetings should be held on a monthly basis.

Improvement needed

The registered manager must ensure that staff meetings are held on a regular basis, ideally monthly.

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 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, measurable, 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 were identified on this inspection.			

Appendix B – Improvement plan

Service: St David's Hospice Satellite Unit

Date of inspection: 22 and 23 March 2022

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 registered manager must ensure that the statement of purpose is updated with regard to the feedback system used.	5. Citizen engagement and feedback Independent Healthcare Regs (2011) Wales (IHR) Schedule 1 part 8.	The hospice will update the current statement of purpose, patient guides and information leaflets, this will be a bi-lingual printed document that can be secured to the current literature. Future prints of all literature will be updated to include the information.	Glenys Sullivan Matron	4 weeks
The registered manager must ensure that feedback is routinely collected from patients, families and carers.	5. Citizen engagement and feedback IHR 19 (2) (e)	Feedback forms/envelopes to be available in patient rooms and family room.	Glenys Sullivan Matron Emma Owen Admin Manager	6 weeks

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Patients' carers will be randomly sent a feedback form through the postal system.		
The registered manager must ensure that the results of the feedback are displayed within the setting, together with the action taken with the feedback.	5. Citizen engagement and feedback IHR 19 (2) (b) (i)	Notice Board to be placed on the corridor to display feedback.	Susan Griffiths Unit Sister	
Delivery of safe and effective care				
The registered manager must ensure that the environmental risk assessment action plans are completed and that the assessment is kept up to date, with the actions carried out.	22. Managing risk and health and safety IHR 26 (2) (a)	Risk assessment to be updated before end of May 2022 and actions carried out.	Susan Griffiths, Unit Manager Kirsten Foster-Alexander, Quality and Safety Manager	6 weeks
The registered manager must ensure that the cleaning of the radiator grills and the high level windows and ledges are risk assessed and cleaned on the basis agreed in the risk assessment.	13. Infection prevention and control (IPC) and decontamination IHR 26 (2) (a)	The Hospital maintenance team have agreed to clean have windows and radiators. External contractor contacted by BCU facilities to agree date. The Facilities team will continue to support	Susan Griffiths, Sister	Immediate affect

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		the hospice to clean areas regularly as per Service Level Agreement.		
The registered manager must ensure that safety cannulas are used to reduce the possibility of needle stick injuries.	13. Infection prevention and control (IPC) and decontamination	The cannulas used on the unit are supplied through the NHS stores, stock checked and all cannulas used are safety cannulas.	Susan Griffiths Sister	Immediate effect
The registered manager must ensure for all patients, that food and fluid intakes are measured.	14. Nutrition IHR 15 (9) (a)	Following assessment for each individual patient, those patients identified as taking food and fluid will have a food /fluid chart completed daily.	Susan Griffiths Sister	Immediate effect
The registered manager must ensure an oral care plan is completed and regularly updated.	14. Nutrition IHR 23	All patient care records will include an oral /mouthcare care plan appropriate to the daily mouth risk assessment (existing assessment is in place).	Susan Griffiths Sister	Immediate effect
The registered manager must ensure that the daily checks of the medication fridge temperatures are completed and that the checks are appropriately recorded.	15. Medicines management IHR 15 (5)	All staff have received an email reminding them of the importance of checking fridge temperature. Susan Griffith Sister to check weekly	Susan Griffiths Sister	Immediate effect

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered manager must ensure that blood transfusions are not carried out at the hospice until staff have received the relevant training and competency assessments on the administration of blood products.	17. Blood management IHR 20 (2) (a)	All Staff are already on a waiting list for Blood Transfusion Training. The training team at BCUHB are aware of urgency, Sister is awaiting dates from them. Hospice staff are dependant on NHS staff for training which has been on hold throughout the pandemic. No blood transfusions will be delivered until training is completed.	Susan Griffiths Sister	6 months
The registered manager must ensure that all observations are taken of patients on a daily basis.	7. Safe and clinically effective care IHR 23	The clinical leadership team with the Palliative Care Consultant have discussed the daily observations. The medical team have reviewed the documentation to reflect the individual needs of the patient. Patients being admitted to the hospice will be identified: - a) Those who are admitted for end-of-life care who will have observations	Dr Gwyn Griffiths Medical Director	4 weeks

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		completed on admission only as per All Wales Guidance: Care Decision for the Last Days of Life (version 11 June 2021). b) Patients identified for escalation of care will be clearly documented in the medical and nursing notes. c) We recommend that the NEWS 2 is used to improve the following: 1. The assessment of acute illness severity 2. The detection of clinical deterioration 3. The initiation of a timely and competent clinical response 4. When the clinical teams decide that the routine recording of NEWS 2 not appropriate, e.g for patients approaching end of life, such decisions will be discussed with the patient (or their family		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		/carer as appropriate) and recorded in the clinical notes.		
The registered manager must ensure that staff are trained in the sepsis and the sepsis six pathway.	7. Safe and clinically effective care IHR 20 (2) (a)	Staff will be given access to online training.	Glenys Sullivan Matron	6 months
The registered manager must ensure that appropriate NEWS and sepsis six bundle checks are carried out as required.	7. Safe and clinically effective care IHR 23	Patients identified for escalation will be clearly identified in new documentation and observations performed as required.	Dr Gwyn Griffiths Medical Director	6 months
The registered manager must ensure that all elements of the patient care records are completed in full, in a timely manner.	20. Records management IHR 23	All staff to be informed of the importance of completing all patient documentation in a timely manner. Documentation to be audited to check all elements of patients care record are completed in a timely manner.	Susan Griffith Sister	3 months
Quality of management and leadership				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered manager must ensure that all policies and procedures are up to date and reviewed as required.	1 Governance and accountability framework IHR 9 (5)	Clinical leadership informed, all policies to be checked and updated as appropriate.	Glenys Sullivan Matron	2 months
The registered manager must ensure that patients are referred to safeguarding and HIW regardless of where the incident occurred.	23 Dealing with concerns and managing incidents	Discussed with hospice social workers all safeguarding incidents following investigation to be reported to HIW via Objective Connect.	Glenys Sullivan Matron	Immediate effect
The registered manager must ensure that the complaints and concerns process is prominently displayed on the ward.	23 Dealing with concerns and managing incidents IHR 24	Hospice to put up a notice board on the corridor.	Susan Griffiths Sister	6 weeks
The registered manager must ensure that all staff have an annual appraisal in a timely manner.	25. Workforce planning, training and organisational development IHR 20 (2) (a)	Sister to be supported by HR and Matron to facilitate appraisals for all staff.	Glenys Sullivan Matron	Immediate Effect
The registered manager must ensure that staff training is improved to ensure that all staff have completed their mandatory training and all	25. Workforce planning, training and organisational	Staff are encouraged to complete mandatory training /competencies.	Susan Griffiths Sister	3 months

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
competency training as required in a timely manner.	development IHR 20 (2) (a)	Time to complete practical training allocated on Rota.		
The registered manager must ensure that staff meetings are held on a regular basis, ideally monthly.	24. Workforce recruitment and employment practices	Sister to send out invitation 6 months in advance to monthly ward meetings, virtual attendance via Teams to be encouraged.	Susan Griffith Sister	4 weeks

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): Glenys Sullivan

Job role: Matron / Registered Manager

Date: 23/05/2022