Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Independent Healthcare Inspection (Unannounced)

St Anne's Hospice

29 July 2015

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Digital ISBN 978-1-4734-5490-3

Contents

1. Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales.

HIW's primary focus is on:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW inspections of independent healthcare services seek to ensure services comply with the Care Standards Act 2000, requirements of the Independent Health Care (Wales) Regulations 2011 and to establish how services meet the National Minimum Standards (NMS) for Independent Health Care Services in Wales[1].

This report details our findings following the inspection of an independent health care service. HIW is responsible for the registration and inspection of independent healthcare services in Wales. This includes independent hospitals, independent clinics and independent medical agencies.

We publish our findings within our inspection reports under three themes:

- Quality of patient experience
- Delivery of safe and effective care
- Quality of management and leadership.

[1] The National Minimum Standards (NMS) for Independent Health Care Services in Wales were published in April 2011. The intention of the NMS is to ensure patients and people who choose private healthcare are assured of safe, quality services. http://www.hiw.org.uk/regulate-healthcare-1

2. Methodology

During the inspection we gather information from a number of sources including:

- Information held by HIW
- Interviews with staff (where appropriate) and registered manager of the service
- Conversations with patients and relatives (where appropriate)
- Examination of a sample of patient records
- Examination of policies and procedures
- Examination of equipment and the environment
- Information within the service's statement of purpose, patient's guide and website (where applicable)
- HIW patient questionnaires.

At the end of each inspection, we provide an overview of our main findings to representatives of the service to ensure that they receive appropriate feedback.

Any urgent concerns that may arise from an inspection will be notified to the registered provider of the service via a non-compliance notice[2]. Any such findings will be detailed, along with any other improvements needed, within Appendix A of the inspection report.

Inspections capture a snapshot on the day of the inspection of the extent to which services are meeting essential safety and quality standards and regulations.

[2] As part of HIW's non-compliance and enforcement process for independent healthcare, a non compliance notice will be issued where regulatory non-compliance is more serious and relates to poor outcomes and systemic failing. This is where there are poor outcomes for people (adults or children) using the service, and where failures lead to people's rights being compromised. A copy of HIW's non compliance process is available upon request.

3. Context

St David's Foundation Hospice Care is registered to provide an independent hospital at St Anne's Hospice, Harding Avenue, Malpas, Newport, NP20 6ZE. The service has 10 beds. The service was first registered on 7 June 2013.

The service employees a staff team which includes a Chief Executive Officer/Director of Nursing, palliative medicine consultant team, senior hospice manager, hospice manager, nursing sister, staff nurses and healthcare assistants. Multidisciplinary services are also available including social work, occupational therapy, physiotherapy and complimentary therapies. There is also a team of volunteers.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection to the service on 29 July 2015.

4. Summary

Patients made very positive comments about the quality of care provided. Overall we found that the service recognised and addressed the individual needs of patients and that staff upheld patients' rights to dignity and respect. Patients were satisfied with the provision of food and drink.

We identified several aspects of care planning and provision which needed improvements. This was around improving visibility of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and ensuring clear documentation of care planning, evaluation and execution of care.

Despite the improvements highlighted above, we were sufficiently assured that the service provided patients with safe, effective treatment and care which was based on agreed best practice guidelines. We saw that appropriate arrangements were in place to record and audit a range of practices within the service. Some areas of improvement included; ensuring specific policies and procedures were up to date; ensuring staff received up to date training in areas such as safeguarding, blood transfusion updates and competency assessments in medicines management and improved education and monitoring of hand hygiene.

We found clear lines of governance and accountability within the service and we found the management team to be open and patient focussed in their approach. There were robust recruitment procedures in place and staff supervision and appraisals happened on a regular basis to support staff in their roles. Some aspects of staff training required updating was not up to date. A plan to address this was in place.

We found improvements were needed in ensuring the service complied with the Independent Healthcare (Wales) Regulations 2011 for areas of specific governance requirements. This included ensuring all required information was provided in the Statement of Purpose and Patient Guide and that registered provider visits and annual assessments took place.

As outlined above, we identified the following areas for improvement during this inspection regarding - regulatory breaches in the statement of purpose, patient's guide and registered provider visits and annual report. These are addressed in the 'Quality of management and leadership' section of the report. 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 HIW taking action in accordance with our non-compliance and enforcement process.

5. Findings

Quality of patient experience

Patients made very positive comments about the quality of care provided. Overall we found that the service recognised and addressed the individual needs of patients and that staff upheld patients' rights to dignity and respect. Patients were satisfied with the provision of food and drink.

We identified several aspects of care planning and provision which needed improvements. This was around improving visibility of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and ensuring clear documentation of care planning, evaluation and execution of care.

Dignity and Respect (Standard 10)

We spoke with a number of patients informally during our inspection. Conversations indicated that patients felt the service upheld their dignity and respect and patients were particularly positive about staff. Comments included;

- *'Nothing is too much trouble'*
- *'Staff are great, they do anything for you'.*

There was an up to date privacy and dignity policy in place and we observed caring and compassionate interactions between patients and staff.

There were six single bedrooms and two double bedrooms. Staff told us the double rooms were used as single occupancy to maintain patients' privacy and dignity.

The environment provided both open areas and private areas where patients could choose to meet with staff and visitors according to their preferences for privacy.

Patients' views and preferences were taken into account throughout care planning, through formal questionnaires and informally on an ongoing basis when staff provided care.

Care Planning and Provision (Standard 8)

We observed staff delivering a high standard of care to patients and patients praised the *'care and attention'* of the service.

We looked at four patients' records in detail and found care planning and in particular the admission process to be patient centred with multi-disciplinary professional input. Multi-disciplinary records were particularly well organised. Staff used the 'Integrated

Care Priorities Pathway' for the last days of life'[3] tool. This meant staff used an approved tool based on best practice to assess patients' ongoing needs.

We found there was access to 24 hour specialist palliative care advice and expertise, with appropriate on call arrangements with consultants in place. Patient records demonstrated that patients had timely access to specialist advice where needed.

We found one case where there was limited evidence of planning and execution of care, particularly around prevention of pressure ulcers. This meant that although patients' needs had been assessed, there was not always a clear care plan to demonstrate and guide staff about how to manage the patient's needs.

We looked at patients' DNACPR forms and found they were not easily visible and identified within clinical notes. This meant there was an increased risk that staff may not be alerted to patient's wishes in this regard, should a medical emergency arise.

We discussed foot and nail care with staff and although we were assured patients' needs in this regard were being managed, this was done in an informal way. This meant there was not one identified member of staff who took responsibility for ensuring the daily foot and nail care needs of patients were met, as best practice recommends.

Improvement needed

The service must ensure there are consistently clear care plans in place which document care planning, evaluation and execution of care, particularly where a patient has been identified at being at higher risk.

The service must ensure that all DNACPR forms are clearly visible.

The service should consider delegating clear accountability for the management of patients' foot and nail care.

[3] The **Integrated Care Priorities Pathway for the last days of life** document was designed for use in Wales, supported by an audit and review process. It aimed to improve care of the dying in Wales through the implementation and evaluation of guidelines.

Nutrition (Standard 14)

Patients made positive comments about the provision of food and drink. Comments included;

- *'I had porridge for breakfast, only thing I fancy. You can have whatever you want'.*

We found patients' individual nutritional and fluid needs were assessed, recorded and addressed and staff provided support with eating and drinking where needed. A choice of food was offered which was prepared safely and met the nutritional, therapeutic, religious and cultural needs of the patients we reviewed. Food was available 24 hours a day and staff told us and patients confirmed that they had access to a varied choice of food alongside the main menu.

Delivery of Safe and effective care

Despite the improvements highlighted within this report, we were sufficiently assured that the service provided patients with safe, effective treatment and care which was based on agreed best practice guidelines. We saw that appropriate arrangements were in place to record and audit a range of practices within the service. Some areas of improvement included; ensuring specific policies and procedures were up to date; ensuring staff received up to date training in areas such as safeguarding, blood transfusion updates and competency assessments in medicines management; improved education and monitoring of hand hygiene.

Safe and Clinically Effective Care (Standard 7)

We found that treatment and care was based on agreed best practice guidelines. The service was consultant led and linked with the Health Board and other external Boards and forums to ensure they had effective networks for external advice and sharing best practice.

The service used a benchmarking tool to audit and monitor its performance against similar services to identify where they could make improvements to patient care and treatment. This was an area of good practice.

We saw the minutes from clinical governance meetings where staff reviewed new policies and procedures, before they went to staff meetings and met to review service performance. We recommended the service implement a full clinical governance/clinical audit policy, which details these arrangements and also how they will meet the requirements under the regulations for registered provider visits and production of an annual report. More detail on these requirements is included under the quality of management and leadership section under Standard 1 - Governance and accountability framework.

We found that some policies required updating. Staff had implemented a system to review these policies on an ongoing basis.

Improvement needed

The service should implement a full clinical governance/clinical audit policy which demonstrates how the service will meet regulatory requirements.

Policies and procedures must be updated on an ongoing basis to reflect current practice.

Safeguarding Children and Safeguarding Vulnerable Adults (Standard 11)

The service had up to date safeguarding policies and procedures in place which were clear and detailed. These outlined staff responsibilities and actions for identifying and reporting abuse. Staff told us there had been no safeguarding concerns or incidents within the last few years. Most staff had not received up to date safeguarding training. Staff told us this had been identified and 'train the trainer' training had recently been carried out so that training could be disseminated to the staff team and updated on an ongoing basis.

Improvement needed

All staff must receive up to date training in safeguarding on an ongoing basis.

Infection Prevention and Control (IPC) and Decontamination (Standard 13)

We found the environment to be visibly clean and there were clear daily cleaning schedules in place. There were suitable infection prevention control policies and staff followed agreed protocols to minimise the risk of healthcare associated infections. For example, all patients were screened for MRSA[4] on admission. All staff we spoke with had a good knowledge of a range of aspects of infection prevention and there were links to specialist advice where needed.

We looked at the waste management arrangements and found appropriate processes were in place to minimise risks to patients, carers, staff and visitors.

There was limited hand hygiene information on display and we recommended that hand hygiene audits should be carried out in order to maintain high standards of infection control.

Improvement needed

The service must ensure there are sufficient hand washing facilities and clearly visible information displayed to encourage patients, carers, staff and visitors to maintain high standards of hygiene.

The service should carry out hand hygiene audits and ensure that all infection control data is monitored on an ongoing basis to maintain high standards of hygiene.

[4] **MRSA** is a type of bacteria that is resistant to a number of widely used antibiotics

Medicines Management (Standard 15)

There was a medicines management policy in place and we observed staff administering medicines in a safe and appropriate manner. Medicines were stored securely to prevent unauthorised access. We found that Medicines Administration Record (MAR) charts were not always fully completed to demonstrate when medicines had been administered. We discussed this with the registered manager who told us that reporting of medicines errors was an area they had identified that needed improvements and were working to improve and encourage reporting. We saw that staff had implemented a system to ensure medicines errors were addressed with individual staff members and monitored on an ongoing basis to try to prevent further errors.

We found that IV fluid and oxygen prescriptions were not included on MAR charts. We suggested the service use All Wales prescription charts which incorporate these aspects to ensure they are prescribed safely and monitored effectively.

We found that the service did not currently assess staff competency before permitting staff to administer medications independently. This could increase the risk of staff making medicines errors.

Improvement needed

The service should ensure there is a system in place for assessing staff competence in administering medicines with new staff members at the start of their employment and with existing staff members on an ongoing basis.

The service should consider implementing prescription charts which incorporate provision for IV fluid and oxygen prescriptions.

Blood Management (Standard 17)

There was a pathology laboratory on site which oversaw the governance around blood products to ensure compliance with legislation on the supply and use of blood products. Appropriate policies and agreed protocols were in place for the transport and storage of blood and staff used specific care plans where needed, to assess patients' needs. This meant systems and processes for blood management were in place and recorded both on an organisational and individual patient level. We found that staff did not receive blood transfusion update training and we have asked the service to address this to ensure staff are aware of current safe practice and guidance.

Improvement needed

The service must ensure that there is an ongoing programme of education, training and competence assessment for all staff involved in the blood transfusion process, specifically that all staff receive ongoing blood transfusion update training.

Managing Risk and Health and Safety (Standard 22)

There was a comprehensive risk management policy in place which explained how risks to patients were managed and minimised within the service. However, the policy was dated 2006 and required updating to ensure it complied with current legislation and guidance.

Appropriate risk assessments were available, for example, fire safety and Control of Substances Hazardous to Health (COSHH).

We saw staff completed risk assessments for individual patients and risks were discussed in multidisciplinary meetings. When we spoke with staff it was clear they had a good understanding of how to manage individual risks to patients and we were assured this happened in practice. However, we found documentation was sometimes difficult to follow due to the way it was organised. From the documentation we saw, it was not consistently clear - when a risk had been identified - what the agreed plan was to manage the risk.

Improvement needed

The service must ensure an up to date risk management policy in place.

The service must ensure that there are clear risk management plans in place for patients, once risks have been identified, to provide evidence of the way risks are managed to keep patients safe.

Dealing with Concerns and Managing Incidents (Standard 23)

We looked at complaints documentation and found there was a detailed, up to date, complaints procedure in place which gave clear guidelines about how complaints were managed within agreed timescales. We discussed this with staff and they explained how they managed complaints in a patient focussed way. We found that the complaints procedure in the patient guide listed an old address for Healthcare Inspectorate Wales and we asked staff to update this so that patients had up to date contact details for escalating any complaints.

We found that other incidents and concerns were managed appropriately and the setting was submitting appropriate notifications to HIW when reportable incidents occurred as outlined in the regulations.

Some policies and procedures were under review and being updated at the time of the inspection. The staff handbook was also being updated. There wasn’t an easily accessible whistleblowing policy available and we saw that this was not currently included in the staff handbook. Staff told us this was available online. This should be easily available and communicated to staff so that staff are aware how to report any concerns they may have about poor staff practice.

Improvement needed

The service must update the address for the regulation authority (HIW) in the patient guide.

The service must ensure there is an easily accessible whistleblowing policy available for, and communicated to, staff.

Quality of management and leadership

We found clear lines of governance and accountability within the service and we found the management team to be open and patient focussed in their approach. There were robust recruitment procedures in place and staff supervision and appraisals happened on a regular basis to support staff in their roles. Some staff training was not up to date. A plan to address this was in place.

We found improvements were needed in ensuring the service complied with the Independent Healthcare (Wales) Regulations 2011 for areas of specific governance requirements. This included ensuring all required information was provided in the Statement of Purpose and Patient Guide and that registered provider visits and annual assessments took place.

Governance and accountability framework (Standard 1)

We found that there were clear lines of governance and accountability within the service and the service was overseen by a Board of Trustees. Staff provided service performance data to Welsh Government and the Health Board for monitoring purposes.

There was a statement of purpose in place but it did not include all required information. There was an information leaflet available for patients about the inpatient unit which staff used as the patient guide. This document did not include all information required for a patient's guide under regulation 7.

Although we were assured that staff monitored the quality of a wide range of aspects of the service, we found that formal, 6 monthly registered provider visits were not taking place as specified under regulation 28 of the Independent Health Regulations. We also found that staff did not produce a written annual assessment of the service as specified in regulation 19 (3).

Improvement needed

The Statement of Purpose must include all information as listed under Schedule 1 of the Independent Healthcare (Wales) Regulations.

The Patient's Guide must include all information as listed under Regulation 7.

The setting must carry out and document 6 monthly registered provider visits.

The setting must produce an annual assessment including information as specified under Regulation 19 (3).

Workforce Recruitment and Employment Practices (Standard 24)

Eight staff completed HIW questionnaires which asked a range of questions about the working environment, employment practices, training and support. A summary of the results can be found below:

- All staff stated that the training they had completed had helped them to do their job more effectively or deliver a better patient experience.
- All staff stated that they felt involved in deciding on changes introduced that affected their department.
- All staff stated the organisation is supportive either always or usually.
- Three out of the 8 staff that responded stated that they were aware of the Independent Healthcare (Wales) Regulations and National Minimum Standards.
- All staff stated that they were satisfied with the quality of care that they gave to patients.
- None of the staff who responded had personally experienced discrimination at work from other staff or service users in the last 12 months.

We found that management staff had an open and supportive manner when communicating with staff.

We looked at a sample of staff files and found that the setting undertook appropriate recruitment and employment checks to ensure staff were fit to work in the service before starting employment.

We saw that staff had access to regular appraisals where training needs and any performance issues were raised and addressed. We also saw that staff had access to monthly clinical supervision.

Staff told us the staff handbook was under review. The current handbook outlined what was expected from staff and we saw that volunteers were also provided with a code of conduct. We were assured that where staff performance caused concern, this was dealt with in an appropriate manner.

We found that some staff training was not up to date. The management team were aware of this and were implementing plans to ensure a rolling programme could be put in place. Staff told us they had, within the last month, implemented study days for all staff, four times per year to cover all mandatory training. We also saw that other methods of providing updates to staff had been put in place such as monthly ‘research and development’ meetings and staff meetings where new policies were signed off to show that staff had read and understood them.

Staff told us there wasn’t any kind of induction documentation to provide evidence of the induction training and competencies assessment for new staff.

Improvement needed

The service must ensure there is a formal induction in place for new staff and that records for induction training and competency assessments are maintained.

The service must ensure all staff complete ongoing mandatory training and that this is monitored to ensure staff knowledge and skills are kept up to date.

6. Next Steps

This inspection has resulted in the need for the service to complete an improvement plan in respect of patient experience, delivery of safe and effective care and quality of management and leadership. The details of this can be seen within Appendix A of this report.

The improvement plan should clearly state how the improvement identified at St Anne's Hospice will be addressed, including timescales.

The improvement plan, once agreed, will be published on HIW's website and will be evaluated as part of the ongoing inspection process.

Appendix A

Improvement Plan

Service: St Anne's Hospice

Date of Inspection: 29 July 2015

Page Number	Improvement Needed	Regulation / Standard	Service Action	Responsible Officer	Timescale
Quality of Patient Experience					
7	The service must ensure there are consistently clear care plans in place which document care planning, evaluation and execution of care, particularly where a patient has been identified at being at higher risk. The service must ensure that all DNACPR forms are clearly visible. The service should consider delegating clear accountability for the management of patients' foot and nail	Standard 8, Regulation 15 (1) Standard 8, Regulation 15 (1) Best practice within			

Page Number	Improvement Needed	Regulation / Standard	Service Action	Responsible Officer	Timescale
	care.	Health and Care Standards			
Delivery of Safe and Effective Care					
9	The service should implement a full clinical governance/clinical audit policy which demonstrates how the service will meet regulatory requirements. Policies and procedures must be updated on an ongoing basis to reflect current practice.	Standard 7, Regulation 9 (1) (o) Standard 7, Regulation 15 and 9 (5)			
10	All staff must receive up to date training in Safeguarding on an ongoing basis.	Standard 11, Regulation 16			
10	The service must ensure there are sufficient hand washing facilities and clearly visible information displayed to encourage patients, carers, staff and visitors to maintain high standards of hygiene.	Standard 13, Regulation 9, 15 (7), (8)			

Page Number	Improvement Needed	Regulation / Standard	Service Action	Responsible Officer	Timescale
	The service should carry out hand hygiene audits and ensure that all infection control data is monitored on an ongoing basis to maintain high standards of hygiene.				
11	The service should ensure there is a system in place for assessing staff competence in administering medicines with new staff members at the start of their employment and with existing staff members on an ongoing basis. The service should consider implementing prescription charts which incorporate provision for IV fluid and oxygen prescriptions.	Standard 15, Regulation 15 (5) Standard 15, Regulation 15 (5)(a)(b)			
11	The service must ensure that there is an ongoing programme of education, training and competence assessment for all staff involved in the blood transfusion process, specifically that all staff receive ongoing blood transfusion update training.	Standard 17, Regulation 15, 20			

Page Number	Improvement Needed	Regulation / Standard	Service Action	Responsible Officer	Timescale
12	The service must ensure an up to date risk management policy in place. The service must ensure that there are clear risk management plans in place for patients, once risks have been identified, to provide evidence of the way risks are managed to keep patients safe.	Standard 22, Regulation 9 (e), 19, 26			
13	The service must update the address for the regulation authority (HIW) in the patient guide. The service must ensure there is an easily accessible whistleblowing policy available for, and communicated to, staff.	Standard 23, Regulation 24 Standard 23, Regulation 23			
Quality of Management and Leadership					
14	The Statement of Purpose must include all information as listed under Schedule 1 of the Independent	Standard 1, Schedule 1 of			

Page Number	Improvement Needed	Regulation / Standard	Service Action	Responsible Officer	Timescale
	Healthcare (Wales) Regulations. The Patient's Guide must include all information as listed under Regulation 7. The setting must carry out and document 6 monthly registered provider visits. The setting must produce an annual assessment including information as specified under Regulation 19 (3).	Regulations Standard 1, Regulation 7 Standard 1, Regulation 28 Standard 1, Regulation 19			
16	The service must ensure there is a formal induction in place for new staff and that records for induction training and competency assessments are maintained. The service must ensure all staff complete ongoing mandatory training and that this is monitored to ensure staff knowledge and skills are kept up to date.	Standard 24, Regulation 20, 21			

Service Representative:

Name (print): .....

Title: .....

Date: .....