Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Werndale Hospital
Bancyfelin
Carmarthen
SA33 5NE

Inspection 2010-2011

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Introduction

Independent healthcare providers in Wales must be registered with the Healthcare Inspectorate Wales (HIW). HIW acts as the regulator of healthcare services in Wales on behalf of the Welsh Ministers who, by virtue of the Government of Wales Act 2006, are designated as the registration authority.

To register, they need to demonstrate compliance with the Care Standards Act 2000 and associated regulations. HIW tests providers' compliance by assessing each registered establishment and agency against a set of *National Minimum Standards,* which were published by the Welsh Assembly Government and set out the minimum standards for different types of independent health services. Further information about the standards and regulations can be found on our website at: **www.hiw.org.uk**.

Readers must be aware that this report is intended to reflect the findings of the inspection episode. Readers should not conclude that the circumstances of the service will be the same at all times.

Background and Main Findings

Werndale Hospital was first registered in September 1991. An announced inspection was undertaken on the 5 November 2010. The hospital is situated in the village of Bancyfelin approximately six miles from Carmarthen. The Hospital was registered for twenty eight (28) inpatient beds and also provided outpatient facilities, theatre suite, x-ray, pathology and pharmacy departments.

The hospital appeared clean and well maintained both internally and externally. Adequate car parking facilities were available, which provided easy access to all users; this included specific disabled parking spaces. The reception area looked welcoming with adequate seating facilities for patients and visitors. The bilingual reception staff were professional and approachable in their dealings with the public.

The reception area led directly to the outpatient and the X-ray department. The Inspection team members saw patients being greeted in a professional manner by the staff in these departments.

The ward area was situated on the first floor of the hospital and was reached by means of a lift or a flight of stairs.

Prior to the inspection visit the registered provider submitted a completed pre-inspection questionnaire. The inspection visit focused upon the analysis of a range of documentation, discussion with members of the senior management team and a tour of the premises. The Inspection team had opportunities to converse with patients and staff during the visit. Patients and visitors expressed satisfaction with regard to service provision within the hospital.

The manager (designate) was interviewed with reference to her application for the registered manager's post at the end of the inspection.

Statement of Purpose & Patients Guide

It was reported that a statement of purpose which included the services offered at Werndale hospital was given to patients on request. A comprehensive bilingual patient guide was available for all prospective patients and their families. This was given to all patients as well as an information leaflet, which contained information regarding the proposed treatment/procedure they were to undertake and details of payment in a pre-admission pack. The document was reviewed annually to ensure consistent up to date information for all prospective patients.

A range of literature on services provided was also available and some were bilingual. Information on Welsh speaking staff was available when needed and there was a list of interpreters and a language line. There was a system for accessing advice and support for patients of different religious faiths this should be available in written format so that all staff could refer to this as needed.

Patient Questionnaires

In and outpatient department satisfaction questionnaires were used to obtain patients/relatives views on care provision. Each inpatient was invited to complete a patient questionnaire and make comments prior to their discharge from the hospital.

Patient Centred Care

Policies and procedures were available at the hospital in relation to patient centred care. However, please note comments under policies and procedures. All patients appeared to have received an accurate assessment and diagnosis of their health need on admission to the hospital by the admitting nurse and the relevant doctor.

Clinical procedures were explained to each patient at the outpatient consultation, followed by an information leaflet explaining any options available to them and the implications of the treatment. Written consent was obtained usually on the day of treatment, following discussion with the doctor.

Quality of Care and Management of Patient Conditions

Comprehensive nursing policies and procedures that met the requirements of the standard were present in the hospital. Nurses, with specialist skills e.g. theatre, surgical and critical care, were employed for these departments. However, there are currently vacant theatre positions which are being advertised and are currently being filled by staff working extra hours.

Well-equipped facilities were available for the close monitoring of patients following surgery, if required Intensive Therapy Unit (ITU). However it was stated that these were very rarely used. In view of this it was advised that it was important that a method was developed to ensure staff skills in this area of practice are maintained should the facilities (ITU) be required. The Inspection team were informed during the visit that the use of this facility is under review.

Staff Training

All newly appointed staff attended an induction programme and each member of staff had a continuous personal development plan, initiated by their annual appraisal. The training records were held in the individual departments. The hospital was moving to a system of on-line learning that should enable staff to undertake some aspects of their mandatory training through this medium.

All staff had access to the internet during their working day to ensure that the management of specific conditions were evidence based. However, as noted at the last review, there were lists of Consultant preferences that nurses complied to but these were not demonstrated that these were evidence based. The consultants are required to sign their practice procedures which should demonstrate that they follow good practice guidelines and the care that the consultant prescribed is evidenced based.

Quality Audit

There were Quality and Audit meetings held four times a year and attended by the manager (designate), consultants and matron. However, no audit results were provided for review and a clear audit cycle with action plans was needed. Monthly meetings were held with all heads of departments, who had responsibility for clinical governance. The Inspection team were informed that identified individuals had responsibility for gathering information in order that the quality of care could be monitored and recorded. This information would then inform the audit cycle and result in action plans with recorded outcomes.

A formal mechanism for recording 'near misses' was seen and a complaints procedure was available in the hospital and each reported incident or complaint and its' outcome was reported at the quarterly quality and audit meeting. All were reflected in the annual clinical governance report. However, there were no clear action plans seen and some complaints that had been listed as resolved were, in fact, ongoing. The manager has since informed Healthcare Inspectorate Wales (HIW) that her role now incorporates responsibility for the complaints system and processes. This would include a defined complaints system which would record, actions and outcomes. This should be reviewed on a weekly basis.

Policies & Procedures

All policies and procedures were currently under review and it was planned that corporate British Medical Independence (BMI) policies and procedures would be localised. Whilst this is happening existing policy and procedure documents were available at the hospital. However, the policies and procedures books required a written statement that these were the policies to be used until the new policies were available and this situation communicated to staff. A current up to date list of staff signatures indicating that they have read the policies was required as these were incomplete at the time of inspection. It was stated that a full index of policies was available on the intranet. Information on how to access the policies and procedures were given to all staff during their induction period.

Human Resources

A comprehensive and robust policy and procedure was available with reference to staff recruitment. All staff had Criminal Record Bureau (CRB) checks undertaken and this was recorded in their personal files. Evidence was seen of all staff being recruited according to the corporate policy. A number of staff files were scrutinised during the inspection and all files contained the relevant information, such as the individual application form, an interview record, two appropriate references and Criminal Record Bureau checks. An up to date work permit was seen in the individual files of the employees who required them. However, consultant appraisal documents were absent from some files and there was a need to rectify this.

Each member of staff received a staff handbook, which set out the company's expectation of staff conduct. Monthly monitoring was seen of staff sickness and absence. All registered nurses had their registration verified with the Nursing & Midwifery Council (NMC). The nurses were supported to meet their professional updating requirements by the appraisal process, which identified their training needs. Records were maintained of continuous professional development. There was a need for all relevant staff to undertake training in the Mental Capacity Act and managing challenging behaviour.

Comprehensive nursing policies and procedures that meet the requirements of this standard were present in the hospital. Nurses with specialist skills e.g. theatre, surgical and critical care, were employed for these departments. However, there were currently vacant theatre positions which were being filled by staff working extra hours.

Medical Practitioners/Consultants

There were written policies and procedures on allowing practising privileges. The application and Curriculum Vitae of any new practitioner were reviewed by the full Medical Advisory Committee (MAC) and signed off by the Chairman and appropriate specialist member.

Child and Adult Protection

Protection of Vulnerable Adults (POVA) and Protection of Vulnerable Children (POCA) training had been undertaken. However, not all staff had attended the training. There was no evidence of a corporate policy and/or procedure with regard to managing challenging behaviour.

Whistle-blowing

The hospital had policies and procedures for 'Whistle-blowing' and staff were aware of whom to contact should they have any concerns in respect of the clinical performance of a staff member; this included contacting the relevant professional bodies.

Catering

All kitchen staff had the required qualifications. A record of training and copies of certificates were available within the department. Manuals of policies and procedures and audit reports were available within the department. Staff were encouraged to keep up to date with any changes to existing policies and sign when they had read and understood them.

An excellent choice of menu was offered each day, which included; healthy eating, vegetarian, light snacks, light menu, visitor's menu and specialist diets. There was a choice of starter, main course and dessert. Patients and visitors spoken with were complimentary regarding the choice and quality of food available. The chef visited each patient each day and received feedback on the food provided.

The menus were rotated every three weeks and records of daily meals taken by patients were kept for a six-month period. Dietary advice was available from the local Health Board hospital. A dietician visited the hospital periodically to give advice and training.

Risk Management

There was a nominated individual with responsibility for health and safety and risk assessment. Heads of Departments had responsibility for ensuring that policies and procedures were adhered to and any risks identified, were dealt with.

Medication

There were policies and procedures for the handling and management of medicines including their ordering, receipts, supply, administration and disposal. All medication was stored appropriately. It is recommended that a policy and system for self administration of medicines is developed.

Infection Control

There were links to the local Health Board hospital with clear lines of accountability and a functioning infection control committee supported by an infection control doctor. Arrangements for microbiological advice and support from the local NHS were clear. MRSA screening was done at pre-assessment for at risk patients or on admission. The patient would be nursed in isolation pending results. Links to the clinical governance strategy were clear.

Facilities

There was an on-going programme of refurbishment in place. This included new carpeting in patient areas. It was anticipated that the kitchen floor would be replaced by December 2010.

Some clinical and storage areas including the outpatients and theatre department were very cluttered and required review in order to maintain Health and Safety standards and Infection Control. It was also noted that theatre storage areas required shelving, renewal of cupboards and worktop.

Resuscitation

The resuscitation policy covering ethical considerations, living wills, advanced directives and a very useful flowchart to explain the procedure in a simplified way was available.

All staff were trained and updated annually in basic life support techniques. Resuscitation equipment was available, checked daily and a record maintained. All staff were aware of the location of the resuscitation equipment. There was a policy to transfer patients to the nearest facility if required.

Health Records

Comprehensive patient records were maintained and stored appropriately. However, it was again noted that some prescription charts still had abbreviations and it was recommended that this practice be reviewed in line with the appropriate guidance and recommendations.

Confidentiality

The hospital had written policies and procedures to ensure patient confidentiality which met Caldicott requirements. Staff were aware of their responsibilities under the Data Protection Act.

Children's Services

Children over the age of five (5) years were cared for at the hospital and there were paediatric policies and procedures that staff complied with. Surgery was planned around the availability of a Registered Sick Children's Nurse (RSCN)/Registered Nurse (RN) (Child), if a children's trained nurse was not available, the child's surgery was rescheduled. Pre admission visits were encouraged to enable the child to be familiar with the environment and staff. Children had a room affording 'high observation'; during their stay and there were facilities for parents/carers to be resident. A range of suitable, age appropriate gowns, bed linen, toys and pastimes were available. There was a cleaning and safety inspection policy for the toys. Children were invited to bring in their own, familiar possessions to help make their stay more 'homely'.

The Consent Policy was seen in the policy folder. Policies and procedures were in place to ensure safe and appropriate surgical treatment of children. There were signs displayed in public and clinical areas to advise parents/carers of their responsibility for the supervision and safety of their 'Visiting Children' whilst on hospital premises.

Feedback to the manager, management team members was undertaken throughout and at the end of the inspection.

The inspection team wish to thank the management team, staff and patients for their assistance, time and co-operation during the inspection process.

Achievements and Compliance

There were two outstanding regulatory requirements from 2009-2010 inspection cycle. However, it is noted that the manager and management team have been proactive in actioning and completing regulatory requirements.

Registration Types

This registration is granted according to the type of service provided. This report is for the following type of service:

Description
• **Independent Hospital providing listed service: medical treatment under general anaesthesia or intravenous sedation**

Conditions of Registration

This registration is subject to the following conditions. Each condition is inspected for compliance. The judgement is described as Compliant, Not Compliant or Insufficient Assurance.

Condition number	Condition of Registration	Judgement
1.	Up to twenty eight (28) persons of either sex.	Compliant
2.	No child under the age of 5 years should be admitted under any circumstances.	Compliant
3.	The premises are registered for the use of Class 3B and 4 Laser under the Registered Homes Act 1984. The equipment shall only be used by an authorised user whose name appears on the register kept at the hospital.	Compliant
4.	The staffing notice issued by Dyfed Powys Health Authority must be complied with.	Compliant

Assessments

Healthcare Inspectorate Wales carries out on site inspections to make assessments of standards. If we identify areas where the provider is not meeting the minimum standards or complying with regulations or we do not have sufficient evidence that the required level of performance is being achieved, the registered person is advised of this through this inspection report. There may also be occasions when more serious or urgent failures are identified and the registered person may additionally have been informed by letter of the findings and action to be taken but those issues will also be reflected in this inspection report. Healthcare Inspectorate Wales makes a judgment about the frequency and need to inspect the establishment based on information received from and about the provider, since the last inspection was carried out. Before undertaking an inspection, Healthcare Inspectorate Wales will consider the information it has about a registered person. This might include: A self assessment against the standards, the previous inspection report findings and any action plan submitted, provider visits reports, the Statement of Purpose for the establishment or agency and any complaints or concerning information about the registered person and services.

In assessing each standard we use four outcome statements:

Standard met	No shortfalls: achieving the required levels of performance
Standard almost met	Minor shortfalls: no major deficiencies and required levels of performance seem achievable without extensive extra activity
Standard not met	Major shortfalls: significant action is needed to achieve the required levels of performance
Standard not inspected	This is either because the standard was not applicable, or because, following an assessment of the information received from and about the establishment or agency, no risks were identified and therefore it was decided that there was no need for the standard to be further checked at this inspection

Assessments and Requirements

The assessments are grouped under the following headings and each standard shows its reference number.

- Core standards
- Service specific standards

Standards Abbreviations:

C = Core standards
A = Acute standards
MH = Mental health standards
H = Hospice standards
MC = Maternity standards
TP = Termination of pregnancy standards
P = Prescribed techniques and technology standards
PD = Private doctors' standards

If the registered person has not fully met any of the standards below, at the end of the report, we have set out our findings and what action the registered person must undertake to comply with the specific regulation. Failure to comply with a regulation

may be an offence. Readers must be aware that the report is intended to reflect the findings of the inspector at the particular inspection episode. Readers should not conclude that the circumstances of the service will be the same at all times; sometimes services improve and conversely sometimes they deteriorate.

Core Standards

Number	Standard Topic	Assessment
C1	Patients receive clear and accurate information about their treatment	Standard met
C2	The treatment and care provided are patient - centred	Standard met
C3	Treatment provided to patients is in line with relevant clinical guidelines	Standard almost met
C4	Patient are assured that monitoring of the quality of treatment and care takes place	Standard met
C5	The terminal care and death of patients is handled appropriately and sensitively	Standard met
C6	Patients views are obtained by the establishment and used to inform the provision of treatment and care and prospective patients	Standard met
C7	Appropriate policies and procedures are in place to help ensure the quality of treatment and services	Standard met
C8	Patients are assured that the establishment or agency is run by a fit person/organisation and that there is a clears line of accountability for the delivery of services	Standard met
C9	Patients receive care from appropriately recruited, trained and qualified staff	Standard met
C10	Patients receive care from appropriately registered nurses who have the relevant skills knowledge and expertise to deliver patient care safely and effectively	Standard met
C11	Patients receive treatment from appropriately recruited, trained and qualified practitioners	Standard met
C12	Patients are treated by healthcare professionals who comply with their professional codes of practice	Standard met
C13	Patients and personnel are not infected with blood borne viruses	Standard not inspected
C14	Children receiving treatment are protected effectively from abuse	Standard almost met
C15	Adults receiving care are protected effectively from abuse	Standard almost met
C16	Patients have access to an effective complaints process	Standard almost met
C17	Patients receive appropriate information about how to make a complaint	Standard met
C18	Staff and personnel have a duty to express concerns about questionable or poor practice	Standard met

Number	Standard Topic	Assessment
C19	Patients receive treatment in premises that are safe and appropriate for that treatment. Where children are admitted or attend for treatment, it is to a child friendly environment	Standard almost met
C20	Patients receive treatment using equipment and supplies that are safe and in good condition	Standard met
C21	Patients receive appropriate catering services	Standard met
C22	Patients, staff and anyone visiting the registered premises are assured that all risks connected with the establishment, treatment and services are identified, assessed and managed appropriately	Standard met
C23	The appropriate health and safety measures are in place	Standard almost met
C24	Measures are in place to ensure the safe management and secure handling of medicines	Standard met
C25	Medicines, dressings and medical gases are handled in a safe and secure manner	Standard met
C26	Controlled drugs are stored, administered and destroyed appropriately	Standard met
C27	The risk of patients, staff and visitors acquiring a hospital acquired infection is minimised	Standard met
C28	Patients are not treated with contaminated medical devices	Standard met
C29	Patients are resuscitated appropriately and effectively	Standard met
C30	Contracts ensure that patients receive goods and services of the appropriate quality	Standard met
C31	Records are created, maintained and stored to standards which meet legal and regulatory compliance and professional practice recommendations	Standard met
C32	Patients are assured of appropriately competed health records	Standard met
C33	Patients are assured that all information is managed within the regulated body to ensure patient confidentiality	Standard met
C34	Any research conducted in the establishment/agency is carried out with appropriate consent and authorisation from any patients involved, in line with published guidance on the conduct of research projects	Standard met

Service specific standards - these are specific to the type of establishment inspected

Number	Acute Hospital Standards	Assessment
A1	Patients receive clear information about their treatment	Standard met
A2	Patients are not mislead by adverts about the hospital and the treatments it provides	Standard met
A3	Patients receive treatment from appropriately trained, qualified and insured medical practitioners	Standard almost met
A4	Medical practitioners who work independently in private practice are competent in the procedures they undertake and the treatment and services they provide	Standard met
A5	Patients receive treatment from medical consultants who have the appropriate expertise	Standard met
A6	Patients have an appropriately skilled and trained doctor available to them at all times within the hospital	Standard met
A7	Patients receive treatment from appropriately skilled and qualified members of the allied health professionals	Standard met
A8	Patients receive treatment from appropriately qualified and trained staff	Standard met
A9	Health and safety	Standard met
A10	Infection control	Standard met
A11	Decontamination	Standard met
A12	Resuscitation	Standard met
A13	Resuscitation equipment	Standard met
A14	Meeting the psychological and social needs of children	Standard met
A15	Staff qualifications, training and availability to meet the needs of children	Standard met
A16	Facilities and equipment to meet the needs of children	Standard met
A17	Valid consent of children	Standard met
A18	Meeting children's needs during surgery	Standard met
A19	Pain management for children	Standard met
A20	Transfer of children	Standard met
A21	Documented procedures for surgery - general	Standard met
A22	Anaesthesia and Recovery	Standard met
A23	Operating Theatres	Standard met
A24	Procedures and Facilities Specific to Dental Treatment under General Anaesthesia Facilities	Standard not inspected
A25	Cardiac Surgery	Standard not inspected
A26	Cosmetic Surgery	Standard met
A27	Day Surgery	Standard met
A28	Transplantation	Standard not inspected

Number	Acute Hospital Standards	Assessment
A29	Arrangements for Immediate Critical Care	Standard met
A30	Level 2 or Level 3 Critical Care within the Hospital	Standard met
A31	Published Guidance for the Conduct of Radiology	Standard not inspected
A32	Training and Qualifications of Staff Providing Radiology Services	Standard not inspected
A33	Published guidance for the conduct of radiology	Standard not inspected
A34	Training and qualifications of staff providing radiology services	Standard met
A35	Responsibility for pharmaceutical services	Standard met
A36	Ordering, storage, use and disposal of medicines	Standard met
A37	Administration of medicines	Standard met
A38	Self administration of medicines	Standard not met
A39	Medicines management	Standard met
A40	Management of Pathology Services	Standard met
A41	Pathology Services Process	Standard met
A42	Quality Control of Pathology services	Standard met
A43	Facilities and Equipment for Pathology Services	Standard met
A44	Chemotherapy	Standard not inspected
A45	Radiotherapy	Standard not inspected

Schedules of Information

The schedules of information set out the details of what information the registered person must provided, retain or record, in relation to specific records.

Schedule	Detail	Assessment
1	Information to be included in the Statement of Purpose	Standard met
2	Information required in respect of persons seeking to carry on, manage or work at an establishment	Standard met
3 (Part I)	Period for which medical records must be retained	Standard met
3 (Part II)	Record to be maintained for inspection	Standard met
4 (Part I)	Details to be recorded in respect of patients receiving obstetric services	Not applicable
4 (Part II)	Details to be recorded in respect of a child born at an independent hospital	Not applicable

Requirements

The requirements below address any non-compliance with The Private and Voluntary Health Care (Wales) Regulations 2002 that were found as a result of assessing the standards shown in the left column and other information which we have received from and about the provider. Requirements are the responsibility of the 'registered person' who, as set out in the legislation, may be either the registered provider or registered manager for the establishment or agency. Healthcare Inspectorate Wales will request the registered person to provide an 'action plan' confirming how they intend to put right the required actions and will, if necessary, take enforcement action to ensure compliance with the regulation shown.

Standard	Regulation	Requirement	Time scale
C3 (1) (2) (3)	Regulation 14(1)(a)(b)	**Findings:** Sign off of all consultant care preferences required. **Action Required:** The registered person is required to ensure that all consultant procedures are evidence based, agreed and signed by consultants. This information should be kept in a central folder accessible to clinical staff.	(Advised on day of visit) Completed February 2011 (Confirmation of action forwarded to HIW)
C7(2)(4) (5)	Regulation 8(3)	**Findings:** Policy folders did not contain all current policies and many did not have valid review date. **Action Required** • Make available interim guidance that clarifies that Werndale hospital will use current un-reviewed policies and procedures until reviewed. • All policies and procedures to be reviewed in line with Werndale identified timescales.	(Advised on day of visit) Completed 8 November 2010 (Confirmation of action forwarded to HIW) Ongoing. To be completed May 2011 (Confirmation of action forwarded to HIW)

Standard	Regulation	Requirement	Time scale
C23 (3)	Regulation 17(2)(a)	**Findings:** There was no evidence of a corporate policy and/or procedure with regard to managing challenging behaviour. There was a need for all relevant staff to all staff undertake training in managing challenging behaviour **Action Required** The registered person is required to ensure that there is a corporate policy and procedure available with regard to managing challenging behaviour and that staff awareness/training is made available.	(Advised on day of visit) (Policy now available). Training on-going as from November 2010) (Confirmation of action forwarded to HIW)
C14.4 C15.1 C15.3		**Findings:** Not all staff had undergone training in POVA and POVAC. **Action Required:** The registered person is required to ensure that all staff undertake training in POVA and POVAC.	(Advised on day of visit) (Policy now available). Training on-going as from January 2011) (Confirmation of action forwarded to HIW)
C23 (3)	Regulation 17	**Findings:** There was no evidence of corporate policy and/or procedure with regard to managing Mental Capacity. There was a need for all relevant staff to undertake training in both areas. **Action required:** The registered person is required to ensure that there is a corporate policy and procedure available with regard to managing Mental Capacity and that staff awareness/training is made available.	(Advised on day of visit) (Policy now available). Training on-going as from January 2011) (Confirmation of action forwarded to HIW)

Standard	Regulation	Requirement	Time scale
C4 (1)	Regulation 19 (a)(b)	**Findings:** There was a lack of evidence if a robust Clinical Governance system with no evidence of ongoing audit or quality control. **Action required:** The registered person must regularly assess and monitor the quality of services provided.	(Advised on day of visit) Completed December 2010.
C16(6)	Regulation 24 (4)	**Findings:** The system for managing complaints was incomplete with no clear action plans. **Action required:** The registered person must maintain a record of each complaint with any action taken in consequence and action taken to improve quality of treatment services.	(Advised on day of visit) Completed December 2010.
C19	Regulation 26, 2 (a)	**Findings:** Theatre stores were cluttered with many items no longer in use and storage areas difficult to reach. **Action required:** The registered person is required to provide a clean, safe and secure environment in accordance with current legislation and best practice.	(Advised on day of visit) Completed 8 November 2010. (Confirmation of action forwarded to HIW)

Standard	Regulation	Requirement	Time scale
C19	Regulation 26, 2 (a)	**Findings:** Theatre sluice had broken cupboards and missing lamination on work surfaces. **Action required:** The registered person is required to provide a clean, safe and secure environment in accordance with current legislation and best practice.	(Advised on day of visit) Temporary repairs effected 12 November 2010 Refitted January 2011. (Confirmation of action forwarded to HIW)
A3	Regulation 17(2)(a)	**Findings:** It was noted that consultant appraisal documents were absent from some files and there was a need to rectify this. **Action required:** The registered person is required to ensure that annual appraisals are available on staff files.	Three months from receipt of report

Recommendations

Recommendations may relate to aspects of the standards or to national guidance.

They are for registered persons to consider but they are not generally enforced.

Standard	Recommendation
C1	It is recommended that the system for accessing advice and support for patients of different religious faiths this should be available in written format so that all staff could refer to this as needed.
C24	It is recommended that a policy and system for self administration of medicines is developed.
C24	Some prescription charts still had abbreviations and it is recommended that this practice be reviewed in line with the appropriate guidance and recommendations.

Healthcare Inspectorate Wales exists to promote improvement in health and healthcare. We have a statutory duty to assess the performance of healthcare organisations for the NHS and coordinate reviews of healthcare by others. In doing so, we aim to reduce the regulatory burden on healthcare organisations and align assessments of the healthcare provided by the NHS and the independent (private and voluntary) sector.