Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Marie Curie Hospice
89 Bridgeman Road
Penarth
Cardiff
CF64 2AW

Inspection report 2009/2010

Healthcare Inspectorate Wales
Bevan House
Caerphilly Business Park
Van Road
CAERPHILLY
CF83 3ED

Tel: 029 2092 8850
Fax: 029 2092 8877

www.hiw.org.uk

E6130910

Inspection Date:	Inspection Manager and Reviewers:
6 October 2009	P Price H Davies

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. The 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

The hospice had an unannounced inspection on the 6 October 2009. The hospice was first registered 25 July 1986. There were 30 registered beds and a day unit. It is situated in a residential part of Penarth.

The hospice provided palliative care for adults and was owned and operated by Marie Curie Cancer Care. Management of the hospice was of a democratic and open style with clear auditing procedures in place that assessed the care and provision both within the hospice and against other Marie Curie establishments. The atmosphere was very positive and staff, were encouraged to develop care and enjoyed working there. The care met the National Minimum Standards and there were aims to ensure continual improvement of care. The treatment provided was person centred and needs assessments were thorough and based on recognised evidence. Palliative care provision was based on All Wales Standards that staff were aware of and the standards were constantly monitored and audited. Care pathways were in place for a number of different patient problems. Procedures and policies were available to, and used by, staff to guide in care provision.

The views of the patients regarding all aspects of the care provision were gained through surveys, audits and formal interviews. The results were fed back into the service.

The registered manager was an experienced social care professional with a wealth of experience management. General management of the establishment was satisfactory and staffing, recruitment and retention procedures were appropriate and effective. The registered nurses and the other professionals working at the hospice had the appropriate skills and experience to provide quality care.

The Inspection team members had the opportunity to speak with patients and family members/relatives who were all very positive about all aspects of the care provision, which included dignity and privacy and their participation within all processes.

Quality, treatment and care

Care was person centred, based on evidence and of a high standard. There were clear monitoring and auditing systems available. Patients and staff could and did feedback about care given. There were appropriate police and procedures in place to assist staff with the provision of care. The palliative care handbook (All Wales Minimum Standards) was provided to all staff on commencement of their employment. This document was used to set the standard for the care provided.

A clinical governance framework was also in place to ensure that care was based on current research-based best practice. This incorporated National Standards for Palliative Care. This underpinned the speciality and incorporated the National Institute for Clinical Excellence guidance. The service was audited annually and the results were sent to the Cancer Services. The centre utilised care of the dying Care Pathways. Assessment documentation was in place for each professional discipline that was providing care.

The establishment had a number of audit mechanisms both external and internal that fully examine all aspects of the care provision including the environment. The information from these audits were fed into the ongoing development plan and annual report. The clinical governance framework also ensured that quality was maintained. Opportunities for feedback given to patients, carers and complaint information was also fed into the review process that was ongoing.

There were a number of mechanisms by which the views of the patients were gained this included the complaint's framework. These included an annual national help the hospice survey. A questionnaire and stamped address envelope was given to all patients, which included patients who attended the day hospital. The results were then fed-back to the centre. An external auditor from another Marie Curie centre also undertakes an internal audit of all systems on an annual basis. The research co-ordinator based in the centre was also undertaking random interviews with patients and families with regard to their experience within the centre. The information provided in these reports was then fed into the development programme.

All staff that did not have palliative care qualifications on commencement of their employment completed the Principles of Palliative Care course. Nurses working at the hospice had a variety of qualifications relating to palliative care from Diploma level upward. A number of staff were trained in bereavement counselling, the social worker was the designated lead person in this area. The majority of trained nurses had also undertaken the Department of Health Communications Skills course.

Policies were also reviewed in line with national guidelines, best practice and any change in legislation. Policies were time-dated. The manager stated that staff had to sign with regard to reading key policies. A memo was sent to the ward sisters who would lead in ensuring that staff read identified key policies and signed stating that they had done so.

Management and personnel

There were appropriate personnel policies and procedures in place. The staff personnel files were held in Newport. The manager received written confirmation that all appropriate checks had been undertaken, prior to the person commencing employment. A separate visit will be undertaken in this inspection cycle to view staff files.

There were systems for ongoing education of staff. Ongoing staff professional development was promoted at the centre. There was a system for group clinical supervision and individual supervision is available but this was not taken up by all the staff. Agency staff when utilised, were obtained from appropriate agencies. Where possible the same staff were used to ensure continuity of care for patients.

All the registered nurses were given encouragement and assistance in maintaining their registration requirements relating to ongoing training and development. Re-registration requirements were held on a computer base, with a flag up system. Annual staff appraisals were ongoing and staff development plans were put in place. All medical practitioners working within the establishment were recruited using appropriate policies and procedures.

After employment on going professional practise and development was monitored by the clinical governance committee and registration was checked on a routine basis dependent on the length of time between registration and renewal. All staff were provided with a handbook that clearly identified their responsibility to work within the requirements of their professional code of conduct or equivalent. Time and or funding was provided to staff to assist them in meeting the requirements for continued registration with regard to ongoing training and development.

The clinical governance committee, monitored all aspects of practise to ensure that professional standards were maintained. The establishment had an occupational health service, bought in from the local NHS Trust, which undertook health screening. Policy and procedures were in place.

Children were not treated at Holme Tower. However, due to the nature of care provided some bereavement counselling of children was conducted by the social worker who was fully aware of the Children Act. Protection of vulnerable adult's procedures and training were in place.

Confidentiality was maintained appropriately and staff were aware of the need to report any breaches of this and any other poor practice or abuse. Staff appeared to be fully aware of the range of actions that might constitute abuse and were clear on the reporting mechanisms in the establishment. There were systems for ongoing education of staff, many of which were on line and central Marie Curie education.

Complaints management

Clear systems were place for complaint's management. The information provided to patients and visitors detailed the complaint process. Independent advocacy was available for patients, family and carers.

A record was kept of all complaints and outcomes. The complaints were collated and analysed by the Assistant Director of Clinical Governance, Marie Curie Cancer Care, 89 Albert Embankment, London, SE1 7TP. Learning outcomes were fed back to the service manager and/or other service managers as appropriate.

The establishment was operated in an open and inclusive manner and the expression of suggestions and concerns were welcomed. There were monthly staff meetings at which staff can air their views regarding all aspects of the care provision and other matters. The establishment had a whistle-blowing policy and procedures and there were channels available through the social work department for staff to raise concerns. The chaplain at the home was available to provide informal support to staff.

Facilities and environment

Clinically the environment supported good standard of care with up to date equipment available. Nursing staff, who served patient food, had food hygiene training.

Risk management

Clinically there were systems in place to reduce risks to both staff and patients. The policies and procedures within the hospice took into account and recognised good practice and health and safety requirements and laws.

Detailed health and safety risk assessments were completed. Risk Management policies were examined and were appropriate. All accidents, near misses etc were discussed at quarterly meetings and action taken to address any issues raised.

Individual risk assessments of patients as well as general risk assessments of the environment were completed and acted upon. Risk management training was being provided to staff. Accident records were maintained. Infection control policies and procedures were in place and appeared to be appropriate. There were infection control manuals in the ward areas, and there were clear guidelines on hand-washing and barrier nursing in place within the clinical areas. Cleanliness of the clinical areas was maintained appropriately, with audits undertaken on a regular basis. There was an ongoing programme of education to ensure that all clinical staff are up to date in resuscitation procedures.

Records and records management

Patient's records were clear and up to date and all members of the multidisciplinary team used the same record system. Multi-disciplinary records were maintained at the hospice. Patients could access their records and they were aware of this. There were computerised systems for personnel, education and policies that staff were aware of and used. There was a back up system in place. The centre had contracted externally for its archiving system.

Policies and procedures were in place. Data protection and Caldicott guidance was followed and the management of information was observed to be satisfactory. Storage was appropriate. Issues of data protection and confidentiality were discussed with staff during their induction into employment.

Research

The hospice had and clear and appropriate research policy, protocols and guidelines to ensure appropriate conduct and research is undertaken with the patients consent.

The Inspection team would like to acknowledge the co-operation, time and courtesy of the patients, staff and family throughout the inspection.

Achievements and Compliance

There were no outstanding regulatory requirements from 2008-2009.

Registration Types

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

Description
Independent Hospital
Independent hospital service type: • **Palliative care - Hospice for adults**

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.	The number of persons accommodated at any one time shall not exceed thirty two (32).	Compliant
2.	The categories of care are as follows: - Persons in receipt of Specialist Palliative Day Care	Compliant

Assessments

The 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. The 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, the 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 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 met

Number	Standard Topic	Assessment
C14	Children receiving treatment are protected effectively from abuse	Standard met
C15	Adults receiving care are protected effectively from abuse	Standard met
C16	Patients have access to an effective complaints process	Standard 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
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 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 met
C24	Measures are ion 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	Hospice Standards	Assessment
H1	Arrangements for care in hospices	Standard met
H2	Palliative care expertise and training for multi-professional teams	Standard met
H3	Assessment of patient's and carer's needs	Standard met
H4	Delivery of palliative care	Standard met
H5	Records of care	Standard met
H6	Infection control	Standard met
H7	Resuscitation	Standard met
H8	Responsibility for pharmaceutical services	Standard not inspected
H9	Ordering, storage, use and disposal of medicines	Standard not inspected
H10	Administration of medicines	Standard not inspected
H11	Self administration of medicines	Standard not inspected
H12	Storage and supply of medical gases	Standard not inspected
H13	Assessment and care of children	Standard not inspected
H14	Qualifications and training for staff caring for children	Standard not inspected
H15	Environment of care for children	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. The 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 breach.

There are no requirements at this time.

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
C20, C22, H7	A defibrillator for resuscitation of people suffering with cardiac arrest is not available. A risk assessment framework needs to be available in the event that a person sustains a cardiac arrest.
C15	All staff should undertake training in handling aggressive behaviour and notices should be placed throughout the hospice warning people that aggressive or abusive behaviour will not be tolerated.