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4th June 2014

Dear Ms Burrows,

**Re: Healthcare Inspectorate Wales unannounced visit to Shalom House, St David's, on 29th May 2014**

As you are aware Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to Shalom House, St David's on 29th May 2014.

**Overall View of the Healthcare Setting**

The hospice provides day care facilities Monday to Thursday. The hospice closed the five beds to inpatients in November 2013 but had recently started to take respite patients on a Monday to Friday basis. This new system will be reviewed at the end of 2014. It was hoped to continue this respite service once a month during July, September and November.

Day care mainly focuses on social care, anxiety management and symptom assessment. The hospice became nurse led at the time of the bed closures and medical support was now accessed through the patients General Practitioner. There was a system for referral and discharge and the hospice works closely with local NHS facilities and charities. However, written information with regard to this process was unavailable. This process needs to be formalised and made available. Referrals generally come from the persons' General Practitioner or Clinical Nurse Specialist.

The Statement of Purpose was found in the main reception area but the Patients Guide did not contain all the required information. The Registration documents for the hospice

were available, but requiring updating and the hospice had contacted HIW and were awaiting a response.

**Quality of Treatment and Care**

It was clear that care was person centred, based on evidence and of a high standard. There were clear monitoring and auditing systems in place. Opportunities for feedback were given to patients and carers, and complaint information was also fed into the review process. There had been no complaints since the hospice opened, and there was evidence of patient satisfaction surveys as part of 'I want great care' and these were found to be good.

The reviewers were informed that any clinical procedures were explained to patients so that they understand the implications of the treatment, including the potential risks and side effects. The patients were informed of the options available to them and were fully involved in decision making about their care. However, the patient documentation viewed lacked evidence of this and the need for patient involvement and engagement was discussed during the visit.

Patients choice was encouraged were possible and staff appeared to be mindful of patient's rights to privacy, dignity and independence as the individual patient's condition allowed. A Multidisciplinary (MDT) approach to patient care was maintained. There was a pleasant and relaxed atmosphere within the hospice and staff members were observed to relate to relatives in a calm and sensitive manner.

Assessment was undertaken using a clear assessment tool but there was no evidence that this was regularly updated and care plans were found to be out of date although we were told that ongoing monitoring of the persons condition takes place and actions would be taken as needed.

A comprehensive range of leaflets was available to assist, guide and inform patients, relatives, carers and any other person and this information was clear and easily accessible.

There was a Do Not Resuscitate (DNR) system in place but there was no clear evidence of advanced care planning, although care plans showed that discussions about care had taken place with the patient and families.

No interviews took place with staff or patients at this visit.

**Clinical Governance**

It was noted that there were a number of policies and procedures that required updating and these are outlined below. The establishment had a number of audit mechanisms that examined aspects of the environment and information from these audits but there were no action plans in evidence following these audits and the need for these plans was discussed at the time of the visit. The clinical governance framework to ensure that quality was maintained was not well developed and there was no strategy available to further develop this framework. Mandatory education and training currently required attention as outlined below.

There was a need for a central database with staff signatures to indicate that they have all read and understand policies and procedures. There was no medical gases policy and this was required.

There were no up-to-date policies and procedures in place to reduce infection and no evidence of ongoing infection control audits. Protections of Vulnerable Adults (POVA) procedures were not in place and there was no Deprivation of Liberty policy. The hospice cared for adults only but visiting children were welcomed into a safe environment of care.

There was adequate equipment for staff.

**Management and Personnel**

There was clear organisational and management structure for the hospice which was nurse led with an operational nurse manager managing the establishment on a day to day basis.

The human resources policies were seen but many were in need of updating. Personnel records were reviewed and found to be missing Criminal Records Bureau/Disclosure and Barring Service (CRB/DBS) checks, staff photographs and evidence of up-to-date registration where required.

All newly employed staff and volunteers followed an induction programme that included health and safety issues. Qualified and experienced nurses lead nursing care in the day centre supported by health care support workers. Whilst the nurses have had palliative care experience they did not hold specialist palliative care qualifications.

The duty roster confirmed that the number and skill mix of staff on each shift over a 24 hour period were appropriate to the number and needs of respite and day care patients at the time of inspection. When the hospice had respite patients bank staff were employed as needed. An Occupational Therapist is employed at the hospice two days per week.

Volunteers provided a valuable service in a variety of roles both within the hospice and through fundraising. Volunteers did not provide personal care. In determining suitability for engagement at Shalom House, volunteers submitted to the same procedures as staff recruited for employment. Volunteers were provided with induction and ongoing training opportunities.

**Premises, Environment and Facilities**

The environment was clean and entered via a reception foyer. Patients and visitors can access all areas of the hospice, and a shaft lift to the first floor was available.

The bedrooms were all tastefully decorated and en-suite and were a mixture of single rooms equipped with TV/Radio, telephone and nurse call points. There was also an assisted bathroom. Catering facilities were available on site. The hospice's laundry was

taken off site. However, a washing machine and tumble dryer were available for personal clothing.

Clinically the environment supported a good standard of care with up to date equipment available. Some storage areas required review as currently laundry is being dried in the boiler room which also acts as a sluice and the laundry room required cleaning materials removing from the area.

A recent repair to the staff toilet had resulted in an incorrect siphon unit being fitted, which effected the efficient operation of the cistern. There was a rolling programme of maintenance and refurbishment within the hospice.

Accident records were maintained appropriately and all accidents requiring referral under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) rules were reported to the Health and Safety Executive locally.

Catering takes place on site but we were unable to see records, policies and procedures relating to this aspect of care as they were not available on site on the day of inspection. It was advised that the Environmental Health Officer had visited the premises some two years ago, and only picked up on one minor point.

Certificates and records for the routine maintenance of service installations were viewed and generally found to be in order. However, the testing of the electrical wiring installation was out of date, as was the six/twelve month discharge tests of the emergency lighting system.

The last inspection report from the West Wales Fire Service had made comment on the adequacy of fire alarm testing and a review of the Fire Risk Assessment for the premises. Both of these areas still required to be actioned. There was evidence of Fire Training for staff, but no fire drills appeared to have been made for some time. It was recommended that at least two fire drills a year be held and recorded, and that one of these should be a simulated drill during the silent hours.

A contract was viewed for servicing of the sluice machine, but no service reports were available.

Servicing of all patient lifting hoists was satisfactory, and it was advised that consideration was being given to the purchase of some overhead fixed tracking systems.

**Records Management**

All records required by legislation were in place and all documentation was maintained securely in line with the principles of the Data Protection Act. All data protection and Caldicott guidance was followed and the management of information was observed to be satisfactory.

Patient’s records required review and ongoing completion and this was discussed at the time of the visit. Patients can access their records and they were aware of this.

The visit highlighted the issues below and these were provided in a verbal overview to the acting registered manager at the end of the visit.

**New requirements from this inspection discussed at the time of inspection:**

| Action Required | Timescale for completion | Regulation Number |
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| A number of policies were found to be out of date and required review. Some policies were under review and this work requires completion | 48 Hours | Regulation 9 (1) |
| Medical Gases policy was not available. | 48 Hours | Regulation 9(1)(d) and 15 (5) (a) (b) |
| Laundry policy was not available. | 48 Hours | Regulation 9 (1)(n) & (3) &15(8)(c) |
| Housekeeping policy was not found. | 48 Hours | Regulation 9(1)(c)(n) |
| Deprivation of Liberty policy was not found. | 48 Hours | Regulation 20 (2) (a)(b) |
| Mandatory training of staff was found to be out of date and incomplete and there were no clear records of training delivered to personnel. | Immediate and ongoing | Regulation 9(m) and 20(2) (a)(b) |
| There was no Medicines Management policy. | Immediate and ongoing | Regulation 9 (1)(b)(m)& 15(5)(a)(b) |
| Storage areas require review as they were an infection control and safety risk to users. Cleaning supplies were not in locked cupboards. | Immediate and ongoing | Regulation 9(1)(e(k))(n)&15(1)(b) |
| The Patients Guide required review | 48 Hours | Regulation (8)(a) |
| The Child Protection Policy was not available. | 48 Hours | Regulation 9(1)(e) (f)& 16 (3)(a) |
| Lone Working policy was not available. | 48 Hours | Regulation 9 (1) (e) (k) |
| Records Management Policy was | 48 Hours | Regulation 9(1)(f) |

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| found to be out of date and in need of review. | | |
| Whistle-blowing Policy was found to be out of date in need of review. | 48 Hours | Regulation 19(1)(a)(b)&(2)(c)(d)(e) |
| Clinical Governance Policy was not available. | 48 Hours | Regulation 9(1) (e) (f) (o) &15 (1)(c) |
| The Consent policy was found to be out of date in need of review. | 48 Hours | Regulation 16(1)(a) & 17(1) |
| Health and Safety Policies was found to be out of date and in need of review. | 48 Hours | Regulation 9(1)(e)(k)& 15(1)(b) |
| There were no records of staff appraisals having taken place | Six months | Regulation 20(2) (a) |
| Human Resources Policies were found to be out of date and in need of review. | 48 Hours | Regulation 9(1) (e)(f)(h) &21(2)(d) |
| Manual Handling policy was found to be out of date and in need of review. | 48 Hours | Regulation 9 (1) (e)(f))(k) |
| Resuscitation Policy was not found. | 48 Hours | Regulation 9(1)(b)(f)&15(1)(a)(b)(c) |
| A risk management system was not evidenced | Immediate and ongoing | Regulation 9(1)(e)&16 (1) (a)(b)&19(1)(a)(b) |
| Patient's records required review to ensure contemporaneous assessment, care planning and record keeping. | Immediate and ongoing | Regulation 9 (1)(f)&23(1)(a)(i) |
| A waste management policy was not available. | 48 Hours | Regulation 9 (1) (n) |
| The Protection of Vulnerable Adults policy was not available. | 48 Hours | Regulation 16(3)(a) |
| The Challenging Behaviour policy was not available. | 48 Hours | Regulation 9(1)(e)&15(1)(b) |

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| Referral and discharge policy was not available. | 48 Hours | Regulation 9(1)(a) |
| Arrange for a periodic re-inspection of the electrical wiring installation. | 2 weeks | Regulation 26 (4)(e) |
| Arrange for a full three hour discharge test for the Emergency Lighting installation. | 2 weeks | Regulation 26 (4)(a) |
| Carry out an annual review of the Fire Risk Assessment, and record findings accordingly. | 2 weeks | Regulation 26 (4)(a)&(f) |
| Ensure adequate testing of the fire alarm installation at 3/6 month and 12 month intervals. | 2 weeks | Regulation 26 (4)(a)&(e) |
| Carry out regular fire drills at six monthly intervals, and record results | 2 weeks | Regulation 26 (4)(c)(d) |

| **Good Practice Recommendations:** |
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| Development of a system for clinical supervision. |

Healthcare Inspectorate Wales would like to thank all members of staff for their time and co-operation during the visit.

Please do not hesitate to contact me should you wish to discuss the content of this letter.

A copy of this letter is being sent to Mr Bryan Rees, Responsible Individual, Shalom House.

Yours sincerely

**Phil Price**
Inspection Manager