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Mr Bellingham,

**Re: Healthcare Inspectorate Wales unannounced visit to St Kentigern Hospice on the 14<sup>th</sup> May 2014**

As you are aware Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to St Kentigern Hospice on the 14<sup>th</sup> May 2014.

**Background**

The Inspection focused mainly on the examination of patient's records, discussion with staff and patients, reviewing a range of documentation, observation of interactions between staff and staff and patients and observing the environment, facilities and equipment.

**Overall View of the Healthcare Setting**

A hospice providing respite and palliative care for adults who suffer from life limiting conditions. It is purpose built standing in the grounds of the former HMS Stanley hospital. It provides both inpatient and day care and these were managed separately but linked by a corridor.

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 respite and palliative care establishments. The atmosphere was very positive and it was clear that staff were encouraged to develop care and enjoyed working there. The care overall 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 and staff were aware of these.

## Quality of Treatment and Care

### Patient-Centred Care

Care was person-centred, based on evidence, and of a high standard. We were informed that there were monitoring and auditing systems in place but no evidence of these was seen on the day of inspection. Care was determined according to individual patient need and assessment and documentation about patients was extensive and ongoing. Clinical procedures were explained to patients so that they understood the implications of the treatment including the potential risks and side effects, and any options there were available to them.

Patients were fully involved in decision making about their care. Patients were allowed as much choice as can be afforded them and staff appeared to be mindful of patient's rights to privacy, dignity and independence as their condition allowed.

There were care plans in place based on clear ongoing review of the patient's condition seen through the documentation. Patients documents viewed at inspection confirmed that medical, nursing, physiotherapists, and occupational therapists were involved in an individual's care. All care was reviewed and documented daily.

Patients can access their records and they were aware of this. There were clear referral processes and the hospice also worked closely with the community services and other agencies e.g. Marie Curie, Macmillan.

The hospice was nurse led with regular medical ward rounds and the patients care was discussed with the patients and relatives if the patients wished. The hospice does not provide palliative care services for children. However, children do visit the hospice to see family members and were provided with bereavement support from a trained counsellor. It was advised that training in the Protection of Vulnerable Children (POVC) should be reviewed.

The day care centre was Occupational Therapy (OT) led and a multidisciplinary team working collaboratively to provide high quality assessment, care and treatment to their patient group. The assessments were detailed and comprehensive and incorporated likes and dislikes, interests, daily routines, dietary, communication and mobility needs, cognition, capacity and psychological support needs. Following assessment, referrals can be made to a range of professionals, for therapy or other interventions and include psychology, physiotherapy, aromatherapy and a social worker is also available two days a week. Treatment plans are developed and reviewed regularly by the team.

The day care centre has a focus or theme each day, which includes physical health and mobility, anxiety management, social, fatigue management and psychological support, although patients can come any time for general support, or therapeutic

interventions. Patients can engage in a wide range of activities of their choice, or just avail themselves of the company and support of staff and other patients.

### **Assessment of Patients and Carers Needs**

Assessment was undertaken and updated by all members of the multi-disciplinary team. There were care plans in place based on evidence and clear ongoing review of the patient's condition seen through the documentation.

### **Arrangements for Care**

The information provided to patients, families and carers was clear and easily accessible. Discussion with staff revealed that patients and their families were fully involved in decision-making about their care.

### **Records of Care**

Patients and their families were involved in deciding their care and evidence-based practice was undertaken and all care was documented daily. Data protection procedures were in operation in accordance with legislation about confidentiality.

### **Delivery of Palliative Care and Care of the Dying**

The hospice followed evidence-based practice and staff were appropriately educated to deliver this. The hospice care pathway for the last days of life guide's practice and records patients wishes. Pain relief was prescribed by advanced nurse practitioners who were appropriately trained or medical staff and continuously monitored and reviewed.

Staffing numbers and skill mix were appropriate to meet the needs of the patient and their family. The terminal care of patients and their families was conducted with sensitivity, care and compassion, which provided comfort, strength and support. Volunteers supported the hospice, providing a valuable and valued service in many ways and undertake many roles which included; clerical and administrative duties, carers in the day hospital and in patient unit, complementary therapists, driver's receptionists, bereavement counsellors, art therapists and gardeners.

Policies/procedures were in place regarding overnight stays for relatives, but not for the action to be taken at the time of death, and last offices as these policies were in need of review. Arrangements were in place for advocacy, bereavement counselling and pastoral care.

## Patient Views

A number of patients told our reviewers that the care they had received was of an excellent standard. They found the team compassionate, caring and very attentive to their needs and spoke of staff being helpful, kind and “angels on earth”.

One patient said that nothing could be improved and had found the experience of coming to the day service every week had helped her and her family tremendously. She was able to do some gardening, have her hair and nails done and speak to other patients in similar circumstances, which she found very supportive. Aromatherapy massage was also available and the experience had generally helped patients sense of well being each week.

Another patient said that her family were able to come to the hospice and join her for meals, receive complementary therapies and they also got a great deal of support from staff, volunteers and other families.

A patient who had been coming to the hospice regularly for respite care, spoke of staff being attentive, being treated with respect and that her and everyone’s dignity was respected at all times. She said she “felt listened to” and the support she received at St Kentigern had made all the difference to the way she dealt with her illness, she felt more positive and was able to enjoy aspects of her life again with complete peace of mind.

Patients spoke of using their room call bells at any time and staff attending immediately. Staff would always knock and on entering the room there is a second curtain to enhance their privacy further. All patients and family members spoken to said family support was excellent. One patient said that the only improvement to be made was if there was a family room where relatives can stay overnight sometimes.

One patient said that he had extensive experience as a chef for two decades and he had found the food at St Kentigern first class. Another patient described St Kentigern as being “paradise”, the staff were fabulous and being able to come to St Kentigern was an answer to his prayers.

There is a family support worker and also bereavement support is made available for patients and their families from trained counsellors. There were a large number of thank you cards from patients and their families around the hospice.

## Privacy and Dignity

All staff were mindful of respecting the patients privacy and dignity, which clearly underpins the ethos of St Kentigern hospice. One patient said that the bed rooms are considered theirs during their stay. Staff knock at the door and do not enter until they get a response and that all patients were treated with dignity and respect, always.

Inside the patient's rooms is a secondary privacy screen, so staff do not walk directly in to the patient's room.

### **Patient Confidentiality**

From observation and discussion patient confidentiality was clearly integral to patient care and professional practice. Privacy, dignity, and confidentiality during discussions or examinations was provided in private bedrooms, or the use of consulting rooms, clinical rooms and sitting rooms to the choice of the patient and relative.

### **Patient feedback and complaints**

Opportunities for feedback were given to patients and carers, and complaint information was also fed into the review process that was ongoing. Clear systems were in place for complaints management, however the policy for complaints was found to be in need of review.

The hospice Statement of Purpose and Patient's Guide contained information in relation to complaints. Records of complaints were maintained within St Kentigern Hospice and were regularly audited. Outcomes were acted upon. Complaints were treated positively in order to improve the care and service provision.

### **Communications and Information**

There was an extensive amount of up to date and helpful information available for patients and their families. Regular meetings are held and staff were encouraged to identify agenda items in advance of the meetings.

Information from clinical governance and other meetings were shared with all staff. Managers were seen as approachable and promoted "an open door" policy. There was a complaints process and information about how to complain is available for patients and their families. Patient's satisfaction surveys were provided for patients and acted on where relevant and possible.

### **Management and Personnel**

There was a clear organisational and management structure for St Kentigern. The manager of the hospice had appropriate skills and experience to ensure satisfactory care. Other staff working at the hospice were also suitably qualified. There was a mixture of staff disciplines within the hospice. The clinical Lead Nurse of the hospice had appropriate qualifications and experience to ensure satisfactory care for the patients.

All staff had relevant qualifications and training to undertake their roles. Nursing staff maintained their practice in accordance with their registration body - the Nursing and Midwifery Council (NMC). The annual system for ensuring that all registered staff were still on the register required review and inspection team members were unable to determine that all relevant staff were registered although we were informed that this was the case.

The ward 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 inpatients at the time of inspection.

There were systems in place to ensure that all staff members were up to date with their professional qualifications. The inspection team members were informed that there was an ongoing system of education and personal development for each member of staff. However, we were unable to see evidence of this as the database required updating.

There was a system for group and individual clinical supervision for staff. Staff were expected to keep themselves up to date with both clinical and professional practice and with the policies and procedures used within the hospice. There was a need for the development of central databases indicating that staff have read and understood St Kentigern policies, for mandatory education and training requirements and for Disclosure Barring Service (DBS) and professional registration checking.

### **Clinical Leadership and Teamwork**

All staff on the day of the Inspection were observed to be professional, caring and compassionate, their interactions with patients and their families respectful, warm and friendly and their approach to delivering care was positive and highly motivated. Staff were energetic and enthusiastic about their work, their patients and making every effort to continually improve service provision. One member of staff said “St Kentigern was an amazing place to work and it was an honour to work there”.

There was evidence of strong and inspired clinical leadership and effective multidisciplinary teamwork. Staff spoken with felt empowered in their approach to patient care and were encouraged to continually look at ways of improving quality of care and service. A team of volunteers are very much seen as part of the team and provide an excellent service. Both staff and patients said they were invaluable.

### **Human Resources**

Some personnel policies and procedures were in place but there was a requirement for review and updating of others as outlined below. A representative sample of staff personnel records was viewed and found to be missing staff photographs, evidence of DBS clearance, appraisals and professional registration.

Policies and procedures were in place in relation to (whistle-blowing) in order for staff to be comfortable with reporting concerns on poor care practices to senior staff. Information on raising concerns was contained within the staff handbook.

The Protection of Vulnerable Adult (POVA) policy and procedure required updating. Records demonstrate that Adult Protection training had been provided.

## **Clinical Governance**

There were clinical governance arrangements in place and these had been reviewed and restructured recently after an absence of regular meetings. The inspection team members were able to see minutes of recent meetings which showed evidence of discussion and action plans to improve and monitor quality of care. The new clinical governance framework will ensure that quality was maintained, although the education and training and risk management aspects of this framework currently require attention as outlined below.

## **Policies and Procedures**

There were some appropriate policies and procedures in place to assist staff with the provision of care but unfortunately there were a number of policies and procedures that required updating and these are outlined below.

## **Ordering, Storage, Use and Disposal of Medicines**

All medicines were stored appropriately according to legislation. There were clear prescription charts. Records were kept of all medicines received and of those disposed of or returned to the family at the end of the patients stay.

Storage arrangements were good with a dedicated room with cupboards for this purpose. There were locked cupboards in each patient's room for their individual medicines. However these were not used as, despite having a self medication policy, patients preferred staff to dispense their medication.

Controlled drugs were stored and handled in accordance with the misuse of drugs act and its regulations. There were some facilities for staff to obtain the medicines information but no ongoing educational programme and it was recommended that all staff involved with medicines administration undergo training over the coming year. A review of controlled drugs records showed that these were managed appropriately.

## **Storage and Supply of Medical Gases**

There was a medical gases storage area but this was found to be full of mattresses and redundant equipment, which was a fire hazard. This was rectified at the time of

the visit by removing the oxygen cylinders to a smaller dedicated area opposite the nurse station. Externally, improvements were required to the safe storage of small medical gas cylinders, by providing suitable racking.

There was no medical gases policy and this was required.

## **Risk Management**

Clinically there were systems in place to reduce risks to both staff and patients, such as moving and handling policies and education and training in the use of intravenous devices. The policies and procedures with the hospice take into account and recognise good practice and health and safety requirements and laws. Hazard notices were forwarded to the manager and then disseminated by formal process to all staff.

## **Health and Safety**

Health and Safety policies/procedures were in place. Information was disseminated to all staff within the organisation. Control of Substances Hazardous to Health Legislation (COSHH) data sheets were continuously reviewed and updated and were held in all departments.

A record of patient/visitors/staff accidents was maintained, records were held securely and were audited to analyse trends. Requirements in relation to Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) were undertaken. A communication policy was in place regarding responsibilities for informing HIW of serious incidents.

## **Infection Control**

Policies/procedures were in place regarding systems for decontamination processes, health and safety and infection control. There were some appropriate policies and procedures in place to reduce infection but others required review and this was discussed at the time of the visit.

There was adequate equipment and education for staff. It was recommended that regular infection control audits were undertaken. The sluice and laundry systems were unsatisfactory as these were in the same room with dirty and clean items close together creating an infection control risk. Additionally at the time of the visit the bedpan washer was broken and a new one was expected within 6 weeks. In the meantime bedpans were been washed by hand in the sluice hopper. This situation presents a significant infection control risk and this was discussed with the management of the hospice at the time of the visit. Action was taken by the senior management team the day of the visit. Confirmation of action taken was sent to HIW on the 15<sup>th</sup> May 2014.



## **Staff Fire Training**

There was a current Fire Risk Assessment in place, but there were inadequacies in its content. It is important that a Fire Risk Assessment is produced by a technically competent person, and regularly reviewed. There was a nominated person responsible for fire safety of the premises. Staff have attended fire training.

## **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 were clear and up to date and all members of the multidisciplinary team used the same record system.

Patients can access their records and they were aware of this.

## **Research**

There was no research policy to ensure appropriate conduct and research is undertaken with the patients consent and this was required.

## **Premises, Environment, Facilities and Services**

The environment was very pleasant, clean and well maintained and every effort is made to make it as homely, comfortable and as relaxed as possible.

There are a number of homely sitting and dining areas, patients have their own bedrooms, however there is no family room where patient's families can stay overnight. There was a very pleasant garden that is well maintained by volunteers. Bedroom accommodation was all in single bedded rooms, some with en-suite facilities. Bedrooms 3,5,6 and 7 were not inspected, due to occupation. The remaining bedrooms were inspected, and found to be pleasantly furnished, clean, well decorated, and provided with a hygienic washable floor covering.

The day lounge was pleasantly laid out with soft furnishings and choices of games and books, should they be required. The heating radiators were suitably protected, but the main heating distribution pipe and control valve at low level were unprotected. Although tepid at the time of inspection, during the main heating season, these could well be above a safe surface temperature, and should be suitably protected or boxed in for safety.

The provision of electrical sockets was limited for the equipment provided, and some trailing electrical sockets were in use. In Bedroom 4 the lead was tangled around the bed wheel, and it was recommended that this be wall mounted for safety.

The visitor's toilet was a little odorous, as the fan over-run mechanism was not working.

As the former hospital boiler plant has closed, 2 new independent boiler units have been installed in the plant room. One of these was showing a fault mode at the time of inspection.

Much of the serving testing information was not available at the hospice, as this was carried out under a service level agreement with BCUHB Estates. It was advised that this was all expected by the 23<sup>rd</sup> May, and a further inspection will be made after that date to review the information.

Hot water temperatures were taken at random, and generally found to be within safe limits, except for Bedroom 8, where the reading was taken at 50.8 degrees Celsius. A warning notice has now been placed in the room. HIW informed on the 15<sup>th</sup> May 2014.

**New requirements from this inspection:**

Action Required	Regulation Number
A number of policies were found to be out of date and require review	Regulation 9 (1) (3) (4)
The Non Medical Prescribing Policy was found to be out of date in need of review	Regulation 9(m) and 15 (5) (a) (b)
The Child Protection Policy was not found.	Regulation 16(1)(a)(b)
A number of Human Resources Policies were found to be out of date and required review.	Regulation 9(1)(e)(h) & 20(3)(a)(b) & 20(4)
Medical Gases policy was not found and medical gases training is required for key personnel	Regulation 9(1)(d) & 15 (5) (a) (b)
Improvements required to external safe storage of medical gas cylinders,	Regulation 9(1)(d)

Action Required	Regulation Number
Clinical Governance policy was not found.	Regulation 9(1)(o) & 19(1)(a)(b)(c)(d)(e) & 26(1)(a)
Laundry policy was not found.	Regulation 26(1)(a)
Housekeeping policy was not found.	Regulation 9(3)(a)(b)(c)(d) & 17(1)
Deprivation of Liberty policy was not found.	Regulation 38(1)
Sharps policy was not found and there was no evidence of recent changes to legislation in this regard having been adopted	Regulation 9(1)(e)(k)
A policy for privacy and dignity was not found.	Regulation 18(1)(a)(b) Regulation 18(2)(a)(b)
No records of mandatory training of staff was not found	Regulation 9(m) and 15(5)(a)(b)
There were no records of staff appraisals having taken place since 2012	Regulation 20(1)(a)(b) and 20(2)(a)(b)
Laundry practices failed to ensure safe practice to prevention spread of infection and safety to staff and patients	Regulation 20(1)(a)(b) and 20(2)(a)(b)
A written Fire Risk Assessment should be prepared by a technically competent person.	Regulation 26(4)(f)
There were no ongoing infection control audits nor ongoing training being undertaken	Regulation 9(1)(n) H6(4)
Infection control policies were in need of review	Regulation 9(1)(n)
Blood transfusion policy was in need of review	Regulation 15(6)

Action Required	Regulation Number
The Complaints policy was in need of review	Regulation 24 (1)
Policy for Cleaning, disinfection and sterilisation was in need of review	Regulation 9 (1) (n)
The staff files were missing information	Regulation 9 (1) (i)
There was no system for ensuring that staff have DBS and current registration	Regulation 9 (1) (i)
Provide suitable protection to exposed sections of heating circulation pipe.	Regulation 26(2)(a)
Reposition trailing electrical lead to avoid bed wheel in bedroom 4. Relocate to safe position on wall	Regulation 26(2)(a)
Attend to defective fan in Visitors Toilet	Regulation 26(2)(a)
Ensure that fault mode on one heating boiler receives attention	Regulation 26(2)(b)
Collate all outstanding servicing information for future inspection	Regulation 26(2)(b)
Adjust hot water temperature in bedroom 8 to a safe level	Regulation 26(2)(a)

### Good Practice Recommendations

A family room would clearly make a difference for patients and their families

Healthcare Inspectorate Wales would like to thank the staff members 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.

Yours sincerely



**Phil Price**  
Inspection Manager

SICRHAU  
GWELLIANT  
TRWY  
AROLYGU ANNIBYNNOL  
A GWRTHRYCHOL

DRIVING  
IMPROVEMENT  
THROUGH  
INDEPENDENT AND  
OBJECTIVE REVIEW

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