Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

St David's Hospice
Abbey Road
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Inspection report 2009/2010

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Inspection Date:	Inspection Manager and Reviewers:
18 December 2009 & 5 February 2010	Mrs P Price Ms A Astles Dr 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 inspection process consisted of an announced visit on the 5 February 2010 by Heather Davies, peer reviewer and on the 18 December 2009 a pharmacist Alison Astles. Discussions were held with the ward manager and day care manager, the administrative manager and other members of staff. The Inspector was given access to documentation and records.

The Hospice provides eleven in-patient beds and 10 day care places. Other services include complementary therapies. The out patients department is situated on ground floor, to the left of main reception. The bedrooms were all tastefully decorated and furnished and had recently been redecorated. All bedrooms were equipped with T.V./Radio, telephone and nurse call points. Some rooms had en suite consisting of W.C, bath and/or shower and wash hand basin, other rooms had a kitchen incorporated. There were also large assisted bathrooms with a walk in shower and assisted bath. Catering and laundry facilities were found on site. The laundry facilities were limited and patients families and/or carers were asked to take clothing home were possible.

On entering the building the patient is greeted at the main reception desk. It is at this point that the Receptionist will direct the patient to the various departments required. A plan of care was produced for each patient that was based on an assessment of needs and in consultation with the patient and/ or their representative.

The Hospice followed an established procedure when recruiting new staff to ensure that they were suitably qualified and experienced to carry out the duties required of them. Criminal Records Bureau (CRB) checks were also carried out. Newly appointed care staff, received induction training and were subsequently required to register for National Vocational Qualification training. The clinical lead nurse had a rolling programme of staff appraisals and these were recorded, it was recommended that this documentation is placed in the personnel records.

The Hospice was committed to training and development for all staff and there was an ongoing internal and external training programme.

Statement of Purpose & Patients Guide

St David's hospice had a clear statement of purpose and patient guide containing easily accessible information. A patient information booklet was provided to patients on admission describing the services and facilities available. The patient booklet and supplementary information leaflets were further available to prospective patients, families and visitors who were considering accessing services at the hospice. The statement of purpose was not currently placed in the patients rooms and again staff were advised to do this for patient information. There were a number of mechanisms by which the views of the patients were gained that included the complaint's framework. The information provided to patients and visitors detailed the complaint process and a record was kept of all complaints and outcomes. The establishment was operated in an open and inclusive manner and the expression of suggestions and concerns was welcomed.

The hospice did not advertise its medical services in the media.

Quality of Care

Care was person centred, based on evidence and of a high standard. There were clear monitoring and auditing systems in place and patients and staff could and did feedback about care. There were appropriate policies and procedures in place to assist staff with the provision of care. The establishment had a number of audit mechanisms that examined aspects of the care provision including the environment. The information from these audits was used to inform the ongoing development plan and annual report. The clinical governance framework also ensured that quality was maintained. Opportunities for feedback were given to patients and carers, and complaint information was also fed into the review process that was 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 available to them. Patients were required to sign a written consent prior to receiving treatment, that included the option to refuse treatment or discharge themselves, against medical advice. Patients appeared to be fully involved in decision making about their care. Patients were allowed as much choice as could be afforded them and staff appeared to be mindful of patient's rights to privacy, dignity and

independence as their condition allowed. A multidisciplinary approach to patient care was maintained. Patients documents viewed at inspection confirmed that medical, nursing, physiotherapists, and occupational therapists were involved in an individual's care. There was a pleasant and relaxed atmosphere within the hospice and staff, were observed to relate to relatives in a calm and sensitive manner.

Assessment was undertaken using a clear assessment tool and directed by the medical staff. There were care plans in place based on evidence and clear ongoing review of the patient's condition seen through the documentation. Patients were involved in deciding their care and care pathways were used, evidence based practice was undertaken and all care was documented daily. Regular audits of documentation were undertaken. 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. Privacy, dignity, and confidentiality during discussions or examinations was provided in private bedrooms, or consulting rooms, clinical rooms and sitting rooms to the choice of the patient and relative.

Delivery of Palliative Care

The Hospice followed evidence based practice and staff appeared appropriately educated to deliver this with most staff having undertaken education in palliative care. Nurses working at the hospice had a variety of qualifications relating to palliative care from Diploma level upward and a number of staff were trained in bereavement counselling. A social worker took the lead in discharge planning. In addition, there was ongoing education and training for staff and clinical governance arrangements were in place.

A clinical governance framework was also in place to ensure that care was based on current research-based best practice and this incorporated National Standards for Palliative Care. There was an ongoing audit programme for aspects of care. There were daily ward visits and the patients care was discussed with the patients and relatives if the patients wished. The centre utilised (care of the dying) Care Pathways. Assessment documentation was in place for each professional discipline providing care. The Clinical Lead Nurse had developed links with the Tissue Viability team, Occupational Therapist/Physiotherapist and the Dietician from Glan Clwyd Hospital.

Policies & Procedures

The establishment had a comprehensive and appropriate set of policies and procedures to guide staff in all areas of activity in the hospice. A policy for Self Administration of Medicines had been developed and it was stated that a pilot study had commenced in February 2010.

Staff had to sign with regard to reading key policies. There was a need for a central database with staff signatures to indicate that they had all read and understood St David's policies.

Human Resources

There was a clear organisational and management structure for St David's hospice. St David's Hospice Ltd is the registered provider of this establishment with an operational manager who managed the establishment on a day to day basis. The manager of the hospice had appropriate qualifications and experience to ensure satisfactory care.

A Human Resource policy was in place. The scope of the policy was commensurate with regulatory requirements and National Minimum Standards. Medical questionnaires were completed prior to employment and there was system for occupational health. The establishment had a whistle-blowing policy and procedures and there were channels available for staff to raise concerns. The clinical governance committee monitored all aspects of practise, to ensure that professional standards were maintained. All medical, nursing and allied therapeutic staff were registered with the appropriate professional organisation, confirming registration to practice.

There were systems in place to ensure that all staff were up to date with their professional qualifications. All newly employed staff and volunteers followed an induction programme that included health and safety issues. Registered and experienced nurses led nursing care both in the ward and day centre supported by health care support workers. The ward duty roster confirmed that the number and skill mix of staff on each shift over a 24 hour period was appropriate to the number and needs of inpatients at the time of inspection.

All 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 central database, with a flag up system. Annual staff appraisals were ongoing and staff development plans put in place. There are systems for ongoing education of staff. Ongoing staff professional development was promoted at the hospice and recently a new programme of multi disciplinary education discussion sessions had been introduced. 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. There were plans for the employment of a Palliative Care Clinical Nurse Specialist who would take forward education and training of staff working within St David's hospice and develop nurse led clinics.

A large number of volunteers were engaged and provided a valuable service in a variety of roles both within the Hospice and through fundraising. Volunteers do not provide personal care. In determining suitability for engagement at St David's Hospice, volunteers submitted to the same procedures as staff recruited for employment. Volunteers were provided with induction and ongoing training opportunities.

All medical practitioners working within the establishment were recruited using appropriate policies and procedures. However, at the time of inspection there were no records of medical indemnity or appraisal in the medical personnel files, this was discussed with the managers at the time and required rectification. There were two sessions a week of Palliative Care Consultant time at the hospice.

Protection of Vulnerable Adults and Children

Protection of vulnerable adults procedures were in place. Confidentiality was maintained appropriately and staff members were fully 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 mechanism's, in the establishment. The hospice cares for adult's only but visiting children were welcomed into a safe environment of care.

Facilities

The environment was clean and entered via a reception foyer. Patients and visitors could access all areas of the hospice. Clinically the environment supported good standards of care with up to date equipment available.

There was a rolling programme of maintenance and refurbishment within the hospice and there was currently ongoing work to upgrade some of the patient facilities. All equipment including medical equipment, lifts and hoists, electrical equipment and systems, gas, water and fire safety systems were serviced under external contracts according to manufacturer instructions. Contracts for the supply of equipment and maintenance are in place and contract monitoring ensured a good standard of service. Maintenance persons were employed to address day to day checks and general repairs. The hospice was compliant with fire safety regulations. A fire risk assessment was available and weekly fire test were carried out. Annual checks of fire extinguishers were carried out. Emergency lighting checks recorded.

Catering

Menu plans were provided on a rotational basis. The menus provided appeared to be varied and appropriate to the patients needs and there was a clear indication of choice in the main lunchtime and evening meals. Meals could be adjusted to meet the needs of the patients. Adequate numbers of cooks and kitchen assistants were employed to manage the kitchen all of whom had basic food hygiene certificates. Volunteer staff, who currently served patient food also had food hygiene training.

The kitchen was examined for general cleanliness and maintenance. The establishment had a preparation and main kitchen area and both were found to be clean and well maintained. Cleaning schedules were in place and appeared to have been followed appropriately. Food temperatures and the temperatures of the fridges and freezers were recorded on a daily basis and indicated that they were within the appropriate range. There were adequate and appropriate stocks of food in the store areas. Food was stored appropriately and time-dated where applicable. The recent addition of a cafe to the establishment had proved to be big success.

Health & Safety and risk management

Risk management training was being provided to staff. Accident records were maintained appropriately and all accidents requiring referral under the RIDDOR rules were reported to the Health and Safety Executive locally.

Risk Management policies were examined and were appropriate. All accidents, near misses 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. Clinically there were systems in place to reduce risks to both staff and patients, such as moving and handling policies. Mandatory training in moving and handling had previously been provided by personnel from the hospice but a change in staff has led to arrangements being made for a local college to undertake this. Fire drills and training were in place for staff.

Medicines management

There was no pharmacy on site but a service level agreement (SLA) with Glan Clwyd hospital provided pharmaceutical services. There were policies and procedures in place for medicines recording, storage and administration. However, there was no medical gases policy and this was required. There was no piped gas, but there was some cylinder oxygen. The clinical manager stated that they are looking into entonox use, but this was not used at present. There were facilities for staff to obtain medicines information as needed and an educational programme. Medicines records were adequately completed as was the system for checking drugs expiry. Equipment for the storage and administration of medicines was satisfactory and for treatment of anaphylaxis as required. A selection of medication, administration and recording (MAR) charts was examined. All those examined were correctly completed with no gaps. The clinical manager described a process for possibly standardising drug chart design across the local networks. The clinical manager also stated that an audit of completion of MAR charts was planned for the next couple of months (forms were shown).

The Trust pharmacist visited once a week and attended the multidisciplinary team (MDT) where patients' care was reviewed. Evidence of pharmacist review of medical administration record charts was present. After discussion, it seems that whilst the pharmacist was experienced in palliative care, he/she was not a specialist in the subject. The clinical manager said the network is looking to commission a specialist pharmacist to work across the hospices in the area.

Infection Control

There were appropriate policies and procedures in place to reduce infection. There was adequate equipment and education for staff. There was an infection control link person and links to the National Health Service (NHS) infection control teams. There was infection control information in the ward area. There were clear guidelines on hand-washing and barrier nursing in place within the clinical areas and staff appeared to be aware and understood the concepts of infection control.

Adequate sluicing was available in the clinical area. Cleanliness of the clinical areas was maintained appropriately, with audits completed regularly to ensure that this was the case.

Policies and procedures were available regarding the decontamination of medical devices such as syringe drivers. Single use/ disposable equipment was used.

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. Policies and procedures were in place. All data protection and Caldicott guidance was followed and the management of information was observed to be satisfactory. There were computerised systems for personnel, education and policies that staff were aware of and use. There was a back up system in place. Storage was appropriate. Specific personnel were nominated to ensure that the Caldicott requirements were implemented and followed in practice.

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 plans to review the nursing care plan and documentation and a working group had been established to achieve this aim.

Issues of data protection and confidentiality were discussed with staff during their induction into employment.

Research

A clear and appropriate research policy, protocols and guidelines to ensure appropriate conduct and research was undertaken with the patients consent is required.

Achievements and compliance

There was no regulatory requirement from the 2008-2009 inspection report.

A policy for self administration of medication is now available. However, this requires ratification and dating.

Registration Types

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

Description
Independent Hospital providing 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.	You are registered to accommodate a maximum of eleven (11) patients who require palliative care.	Compliant
2.	Only patients aged eighteen (18) years and above requiring palliative care are to be admitted to St David's Hospice.	Compliant
3.	Patients up to a maximum of ten (10) who require palliative care can attend the day hospital at St David's Hospice.	Compliant
4.	All required documentation, including end of life decisions must be available for all day care hospital patients attending St David's Hospice, day hospital.	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 clear 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
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

Number	Standard Topic	Assessment
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 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	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 Met
H9	Ordering, storage, use and disposal of medicines	Standard Met
H10	Administration of medicines	Standard Met
H11	Self administration of medicines	Standard almost met

H12	Storage and supply of medical gases	Standard met
H13	Assessment and care of children	Standard Met
H14	Qualifications and training for staff caring for children	Standard Met
H15	Environment of care for children	Standard Met

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 almost 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.

Standard	Regulation	Requirement	Time scale
C9 (6)(7) C11 (2) A 3 (2)	Regulation 18(2)(d)	**Findings:** No personal indemnity insurance copies in Consultant personnel records. **Action required:** Personal indemnity records to be available in personnel	Twenty working days from receipt of report (Awaiting confirmation from manager)
C9(6)(7)	Regulation 17(2)(a)	**Findings:** No copies of appraisal in Consultant personnel records. **Action required:** Consultants to confirm in writing that they are not prohibited from any areas of practice and that they are up to date with their continuing professional development.	Five working days from receipt of report (Completed, March 2010. Confirmed by manager)
H11(1)	Regulation 14(5)	**Findings** A draft policy for self medication was available, undated. The policy also required ratification. **Action required** The registered person is required to ratify and date the policy on self-medication.	One month from receipt of report (Completed, April 2010. Policy requires dating. New copy to be sent, confirmed by manager)

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
C7	It was recommended that a central database be made available with staff signatures to indicate that staff have all read and understand St David's policies.
C9	It was recommended that staff appraisal documentation is placed in the personnel records.