Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Setting Name:

St Joseph's hospital

Activity date:

25 August 2020

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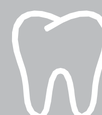

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of St Joseph's hospital as part of its programme of assurance work.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Care Standards Act 2000, Independent Health Care (Wales) Regulations 2011 and other relevant regulations. Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks capture a snapshot of the standards of care within healthcare settings. This quality check focussed on four key areas: COVID-19 arrangements; environment; infection prevention and control; and governance. More information on our approach to inspections can be found here.

We spoke to the registered manager on 25 August 2020, who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How do you ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care?
- How do you ensure that the risk of infection is assessed and managed to keep patients, visitors and staff safe?
- How do you ensure that the ward environment is safe and protects patients from harm, and how do you ensure that patient dignity is maintained?

COVID-19 arrangements

During the quality check, we considered how the service has responded to the challenges presented by COVID-19; what changes they have made to ensure they can continue to provide a safe, effective and person centred service. We reviewed key policies, including the use of personal protective equipment (PPE).

The following positive evidence was received:

We were told at the peak of the pandemic, all private patient treatments were postponed. Instead the hospital was contracted to provide urgent treatment for NHS patients who were

only admitted in conjunction with the local health board.

The registered manager explained the process of access to the building. Access was controlled by limiting the entrances available for use, and any admissions to the premises were controlled by staff. When either a member of staff or patient arrived at the hospital they were required to wash their hands and wear a mask. A risk assessment was also undertaken which included a temperature check and confirmation that they did not have any signs and symptoms of COVID-19. We were told that the hospital ensured that there were adequate hand washing facilities for staff and patients, and areas where staff could don and doff PPE.

We were told that there were screens placed in reception and where staff meet patient to limit the potential transmission of COVID-19, as well as sneeze screens for use during consultations. In addition to developing the new ways of working, management also said there had been additional training for all staff including donning and doffing[1] Personal Protect Equipment (PPE), resuscitation training including arrangements for PPE, and a half day training session when staff returned from furlough, to familiarise them with these practices.

The types of surgery carried out at the hospital were limited during the height of the pandemic, to only emergency procedures for NHS patients. Aerosol generating procedures[2] are not being undertaken to date, and this is being reviewed regularly in line with national guidelines.

No areas for improvement were identified.

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments, incident reviews and any pressure or tissue damage which has occurred. We also questioned the setting on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

We were told that risk assessments were undertaken to identify specific needs. During the height of the pandemic we were told that significant number of services were stopped, including all aerosol generating procedures and non-urgent surgeries. We saw risk assessments had been conducted prior to departments re-opening to the public.

[1] Donning and doffing is the process of putting on or removing personal protective equipment.
[2] An aerosol-generating procedure is a medical procedure that results in the production of airborne particles or respiratory droplets, which may be pathogenic.

Hospital Management stated that the access to the hospital had been limited to ensure every member of staff and the public were screened before entering the hospital. Patients and staff were screened via a temperature check and a COVID-19 questionnaire, then patients were escorted to the waiting room in the relevant department.

We were told that gaps between appointments had been lengthened to allow for deep cleaning, and there was the opportunity to cycle the air to minimise the risk of airborne infection. They also told us that screens were placed in waiting areas and at reception desks. We were told that there were systems in place to keep staff safe within the hospital, including agreed pathways to the theatres and around staff areas. Sneeze guards were also provided for all consultations to protect staff and patients during closer examinations.

No areas for improvement were identified:

Infection prevention and control

During the quality check, we considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments.

The following positive evidence was received:

The registered manager stated that PPE was obtained via the health board, if their own supplies ran low. At the time of the quality check the registered manager confirmed that PPE stock levels were suitable for the needs of the hospital. We saw evidence of the IPC Policy and Principles that had been adopted from Aneurin Bevan University Health Board (ABUHB).

We were told that in anticipation of admitting and caring for COVID-19 patients in the hospital, all staff had undertaken additional training including Infection Prevention and Control (IPC), PPE and resuscitation with COVID-19. We saw evidence that staff compliance was 100%. All staff returning to work from furlough were also asked to attend the hospital for a half day of training to integrate them in to the new ways of working. Any updates to guidance from Public Health Wales and NICE was made known to staff through regular meetings and the all staff newsletter.

We saw evidence of current COVID-19-19 infection rates being at 0%. We were told that this was also the case for other healthcare associated infections and reported incidents.

The following areas for improvement were identified:

Evidence of the IPC audits, including hand hygiene, were only completed until May 2020. These should continue to be undertaken on at least a monthly basis.

Governance

As part of this standard, HIW explored whether management arrangements ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care.

We reviewed staffing and patient levels, staff training and absences, management structures, ward functions and capacity, incidents and a variety of policies (such as escalation).

The following positive evidence was received:

We were told that staffing levels were planned in advance based on patient acuity, to maintain the quality of the service and professional judgement. This was done in addition to the minimum staff numbers required, based on patients on the ward.

There were currently no staff on sick leave within the hospital. Should there be insufficient staff on the ward to manage any future patients, then the procedure would be postponed.
We saw evidence that staff compliance with mandatory training throughout the hospital was at 100%. The service had recently begun a new training contract, and as such all staff had received all of the appropriate training. We were told that in addition to mandatory training, additional training had been arranged to include non-clinical staff in chaperone training, as well as additional training for COVID-19 arrangements.

Performance and development annual review levels for the ward were 97%. The registered manager believed that staff supervision was good, and managed effectively at ward level. Staff had been supported during the pandemic by departmental managers, as well as occupational health support which was accessed via HR services. We also saw that a clinician's handbook had been created in order to further support them in their roles.

We were told that incidents were reported onto an electronic incident management system, and we saw evidence that a log was kept. The incidents were investigated and improvement plans were put in place. Individual teams were briefed on what happened and why and any lessons learned. Where relevant, incidents would be escalated onto the risk register.

We were told and saw evidence of the process in place to provide a medical practitioner with practising privileges. This included the evidence that the hospital requires, and the checks undertaken, before an individual is given practising privileges. These included medical checks, professional registration checks and proof of indemnity insurance. There was on-going monitoring of the medical practitioner by means of appraisals and reviews. During the COVID-19 period, we were told that several new medical practitioners used the surgical facilities at the premises for specific procedures on behalf of the NHS who contracted them to work. However, this was minimal and only completed on an urgent basis with agreement from the local health board.

No areas for improvement were identified.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed below:

Where an improvement plan is required, it should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the Quality Check.

As a result of the findings from this quality check, the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

Improvement plan

Setting: St Joseph's Hospital

Ward/Department/Service: Whole hospital

Date of activity: 25 August 2020

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	The service must ensure that hand hygiene audits are undertaken on a regular basis.	The Independent Health Care (Wales) Regulations 2011 Standard 26	Reinstate monthly clinical audit programme which includes hand hygiene audits from September 2020 and complete clinical audit dashboard demonstrating compliance.	Jan Green Director of Clinical Services	September 2020

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Name: Jan Green Date: 7/09/2020