Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Healthcare Inspection Report (Unannounced)

HMT Sancta Maria Hospital

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do.
We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at HMT Sancta Maria Hospital, on 31 October and 1 November 2023. The hospital is registered for the following:

- Twelve bedded inpatient ward
- Twelve bedded day patient unit.

Our team, for the inspection comprised of two HIW Healthcare Inspectors, three clinical peer reviewers and one patient experience reviewers. The inspection was led by a HIW Senior Healthcare Inspector.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of seven questionnaires were completed by patients or their carers and 25 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Patients appeared to be comfortable and cared for in a professional and dignified manner. All patients agreed that staff treated them with dignity and respect and that measures were taken to protect their privacy. Almost all patients who completed a questionnaire rated the care and service provided by the hospital as 'very good'.

There were good processes in place to enable patients to provide their views on the care they had received at the hospital. There was clear evidence that there was a commitment to improving patient and user experience. A 'you said, we did' board was also displayed in both Welsh and English.

All bar one member of the staff who completed a questionnaire were satisfied with the quality of care and support provided to patients and most would recommend the setting as a place to work.

This is what we recommend the service can improve

- The availability of information in Welsh.

This is what the service did well:

- Positive patient and staff feedback
- Ensured the privacy and dignity of patients
- The 'Freedom to Speak Up' initiative.

Delivery of Safe and Effective Care

Overall summary:
The general hospital environment was clean and in a good state of repair, including furniture, fixtures and fittings. There was a good infection prevention and control (IPC) audit system in place, that included reporting findings to staff. The anaesthetic rooms were considered to be "pristine" and the recovery ward was clean, tidy and uncluttered.

Patients had a choice of a variety of hot and cold food options.

Medicine management standards were met and to a high standard. The clinical records were of a good quality in terms of accuracy, being up to date, complete, understandable and contemporaneous.

We noted several issues that caused us concern relating to IPC within the theatre environment. This led to a non-compliance notice being issued, which was dealt with under HIW's non-compliance notice process. Action was taken or is being taken to address these issues.

Immediate assurances:

- The theatre table was not considered to be sufficiently clean to ensure IPC
- Operating table mattress had sticky glue on a large amount of its surface area
- There were cleaning solutions in the sluice that were unlabelled
- There were cardboard boxes noted on the floor in the theatre
- A surgical foot platform used by the surgeon to stand on to gain height was being stores on top of the operating table
- A positioning and support device used during a operation was torn thus breaking the clean seal. This was therefore considered to be unclean
- Footwear specific to theatre seemed to be soiled on shelves in the changing room
- The changing room for theatre staff had shared changing facilities which were cluttered and had shared products in the shower room
- The break room was shared with non-theatre staff, with staff there in outdoor clothes and from the ward.

This is what we recommend the service can improve

- Ensure that compliance with IPC audits is displayed and in date.

This is what the service did well:

- Maintaining a clean general hospital environment
- Having a good infection prevention and control audit system in place
- The choice and variety of hot and cold food options
- Medicine management standards were met and to a high standard
- The clinical records were of a good standard.

Quality of Management and Leadership

Overall summary:
Governance, management and leadership was clear at the setting. The hospital held a daily ten o'clock huddle that we considered an example of good practice. The process of dealing with incidents, including reportable instances was discussed with senior staff and staff on the ward.

The number and skill mix of staff was appropriate to meet the needs of the patients.

All staff we spoke with enjoyed working at the hospital.

Mandatory training compliance at the hospital was generally good. The recruitment of permanent staff and the employment of consultants was in order and relevant staff where able to describe the process concisely.

This is what we recommend the service can improve:

- Completing appraisals for all staff on a regular basis.

This is what the service did well:

- A strong leadership team
- Pre-employment checks were in place
- Positive staff feedback.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection we used paper and online questionnaires to obtain views and feedback from patients and carers. A total of seven were completed. As only seven responses were completed, this low number needs to be borne in mind when considering these responses. Patient comments were generally very positive with all patients agreeing that staff treated them with dignity and respect and that measures were taken to protect their privacy. Six of the seven patients agreed the service received was 'very good', with one stating that the service was 'poor'.

Staff Feedback

HIW issued a questionnaire to obtain patient views on the care at Sancta Maria Hospital for the inspection in October/November 2023. In total, we received 25 responses from staff at this setting. The response to the staff survey was mostly positive. All bar one of the respondents were satisfied with the quality of care and support provided to patients and most would recommend the setting as a place to work. Staff comments included the following:

> *"It's a small friendly hospital with high standards and patients have a safe and good experience"*
>
> *"Teams are very supportive of each other and all extremely passionate about providing the best possible care"*

Health promotion, protection and improvement
There was information displayed about how patients could help their health and well-being, this included signage and posters regarding hand washing and hand hygiene. There were also posters on smoking cessation and "eat well" guides, aimed at encouraging patients to look after their own health through lifestyle changes if needed. There was also information on a television loop in the main reception. Although this information was in English only.

The registered provider should consider expanding the selection of information available, taking into consideration the communication needs and wishes of patients using the service.

Dignity and respect
The ward was calm and staff were seen to be treating patients with kindness and respect, with staff knocking on patient doors before entry. Staff were discreet and sensitive when speaking to patients and when speaking about patients to other staff, so that they could not be overheard. Patients had individual rooms and staff ensured that doors were closed when treatment and care was taking place. Doors would be kept open if the patient wished.

Whilst there was no evidence of any discussions around Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) with patients, following discussion with senior staff they stated that they rarely had a patient who required the discussion. If there was a need for the discussion to take place, this would be carried out prior to admission.

Patients' continence needs were assessed on pre-admission and then updated accordingly during admission and following an operation. There was evidence in the individual care plans of patients' continence needs being met such as assistance given with mobility and with the use of continence equipment. The ward and the day unit environments were both conducive to allowing privacy, dignity and respect for the patients. Patients in the day unit also had their own private area to sit in.

The ward manager managed both the ward and the day unit and the staff worked between both areas. We witnessed patients being cared for in a quiet professional manner.

All but one of the staff respondents who answered felt that patients and their relatives were involved in decisions about their care. Additionally, all bar one respondent said that patients' privacy and dignity was maintained and that they were satisfied with the quality of care given to patients.

Patient information and consent
There was a uniform guide displayed in both the outpatient and ward areas to assist patients in identifying the staff who were speaking to them. All staff wore name badges, so that they could be identified by patients.

There was also clear information for patients and relatives in the outpatient's department and patients would normally be accompanied by staff to the consulting rooms. Patients were also given information leaflets regarding their procedure or treatment. Patients we spoke with said that staff always take time to answer questions and listen to any concerns they have. In the questionnaire, all bar one patient stated that staff explained what they were doing throughout, that staff

listened to them and answered their questions, and that they were involved as much as they wanted in making decisions about their healthcare.

An area of good practice was noted regarding the "You said, we did" board displayed in the reception waiting area. This board, in addition to informing patients of comments they had made and the actions taken, was also in both English and Welsh. A patient information notice board was also on display in the patient waiting area.

Communicating effectively

Staff were aware of the need for discretion in communications about personal information with patients and between staff about patients. Staff discussed care with patients in a quiet, calm and gentle manner recognising patient confidentiality. Staff also treated each other with kindness and respect. We spoke with several members of staff covering the ward and day unit, they all felt very supported by the team they worked with and management. They considered there were adequate staffing levels and they were given the time and opportunities for training. A junior staff member said:

> *"I have worked on the ward for six months and I love it, I feel 100% supported, we are like a family"*

Patients on the ward were in individual cubicles and as such privacy would not be an issue. We saw staff closing doors when going into the room to talk to patients. Patients we spoke with said that they were provided with treatment and care information pre-operatively and were given the opportunity to ask questions. When patients came back onto the ward, from the theatre, doors were closed and curtains in the cubicle were drawn.

For patients with a hearing impairment on the ward, there was no hearing loop. Staff told us that patients would either lip read or staff would write on paper for patients to read. For eyesight impairment again equipment was limited, there was no braille on bathroom doors, or magnifiers available. Although there was a lack of equipment to assist and support patients with sensory needs it was still considered that overall, the patients' needs were met. This was because staff spent time with the patient and assisting and supporting when they could. Clocks were large and easily seen.

The service aimed to identify the language and any other requirements of the patients on the initial pre-screening questionnaire. Staff who could speak Welsh were identified by wearing 'Iaith Gwaith' badges (clinical staff) or lanyards (non-clinical staff). There were four members of staff who answered the questionnaire that they were Welsh speakers. In all two of the four said they wore 'Iaith Gwaith'

badges and two of the four also said that patients were asked to state their preferred language.

We were told that whilst there was little literature available in Welsh, this could be obtained if needed. Only one patient who answered the questionnaire said that their preferred language was Welsh.

All appointments were arranged by telephone, or occasionally by walk ins. Letters were sent to patients about their appointments.

Care planning and provision
Patients we spoke with said that staff responded to their needs in a timely manner. We were told that in outpatients, patients were advised if there were delays to clinic times. During the inspection, there was an instance where a clinic was delayed by 15 minutes and patients were clearly updated on booking into reception. The information provided on the television in the reception also advised patients that if the delay was greater than 15 minutes to enquire about the delay with reception staff.

Patients were encouraged to be active and given equipment to help them mobilise. We witnessed members of the nursing and physiotherapy team supporting, assisting and encouraging patients to return or reach their pre-operative potential.

Almost all staff who completed the questionnaire said that they would be happy with the standard of care provided by this organisation for themselves or friends and family.

Equality, diversity and human rights
There were relevant policies in place that were in date and available on a shared area of the hospital intranet. In addition to the dignity at work policy there was also a disciplinary policy to deal with any adverse behaviours.

There was also mandatory training on the subject. We were told that all staff underwent equality and diversity training during their first two weeks of employment.

There were also staff nominated as champions in this area. We noted the "Freedom to speak up" initiative in place at the hospital, designed to help staff to ‘speak-up’ about workplace concerns. The staff partnership forum held at the hospital management trust (HMT) level, included a representative for a member of management and staff at Sancta Maria. A member of the group was working on a “Freedom to speak up” booklet which included details of the “Freedom to speak

up” guardians on each site. Relevant training was also to be uploaded for staff to complete.

Examples of where reasonable adjustments had been put in place for both staff and patients to ensure equality and diversity were also described. There were also relevant policies in place for transgender patients. During pre-screening and the one-to-one conversation, care planning and pronoun preference would be discussed.

All patients who completed the questionnaire and expressed an opinion felt they could access the right healthcare at the right time, regardless of any protected characteristic.

Most staff who responded to the questionnaire felt that they had fair and equal access to workplace opportunities and that the workplace was supportive of equality and diversity. One member of staff commented that:

> *“All disabilities should be taken into consideration it seems sometimes certain disabilities are taken upon and noticed.”*

Citizen engagement and feedback

There was information displayed throughout the setting on how patients and families were able to provide feedback about their care. Patients and staff advised that this feedback was collected on electronic tablets. In-patients were also given satisfaction surveys and outpatients were given patient experience pathway feedback forms.

Advocacy support and freedom to speak up information was displayed across the site to provide support and assistance to raise concerns should patients or staff need too. There was information displayed about how patients could make a complaint on the ward on the "welcome to the ward" board.

We were provided with evidence of the quarterly patient experience group meetings, where patient experience summaries, feedback and patient stories were discussed as well as the updating of the “You said, We did” boards. Included in the minutes was the hospital patient experience methodology as well as how the hospital collected and used feedback.

The majority of staff said that patient experience feedback was collected within their organisation and that they received regular updates on patient experience feedback. Whilst 64% said that feedback from patients was used to make informed decisions within your organisation, the other 36% said they did not know.

Delivery of Safe and Effective Care

Managing risk and health and safety
All areas in the hospital were easily accessible, there was a lift available, patients' rooms had wide access doors and the ward area was easy to navigate. The general hospital environment was clean and furniture, fixtures and fittings were well maintained. Facilities staff were noted in the hospital undertaking repairs and maintenance to ensure the building was in a good state of repair.

The environment was fit for purpose and set up appropriately for its intended use with patients having their own personal space in both the ward and the day patient area. Key card access was required to access patient treatment areas such as consulting rooms, the day unit and ward area. The environment was generally hazard free, with no trip hazards, clutter or blocked areas observed.

The consulting room doors were closed when in use with additional privacy curtains and privacy glass in each room. Patients we spoke with were happy with the ward area and they felt it was clean and tidy.

We noted that the Control of Substances Hazardous to Health (COSHH) areas within the pharmacy room and in the sluice of both the ward and day unit were secured when not in use. The cleaner's room at the end of the ward was locked as well as being clean, tidy and organised. The chemicals used by the cleaning staff were kept within the appropriate cupboard within this room

There were resuscitation trollies on the ward and day unit, both trollies were stocked in accordance with resuscitation protocols. They were dated and signed off as being checked every day for the last 3 months viewed. Emergency drugs were stored appropriately in a locked pharmacy room.

All patient risk assessments, for example risk of falls and continence, were carried out at the pre-admission stage, updated on admission and when necessary, throughout the patients journey. This was documented in the patients' individualised care plans and on the local information technology (IT) system.

The ward also had a good call bell system, where there were three different alarm sounds and colours. When each of these buttons was pressed there was also a colour coded lighting system in the ceiling which directed staff to the area requiring assistance. These patient call bells were also noted to be answered promptly.

A total of six of the seven patients in the questionnaire said the building was accessible (i.e. wheelchair friendly and facilities for visual or hearing impairments), the other patient was not sure.

Infection prevention and control (IPC) and decontamination
There were in date infection control policies in place. There was also a policy in place on water management as well as a water safety group that met regularly. The IPC outbreak management document was seen and was in date.

We noted that in general the infection rates were low. We were told that all patients were screened for methicillin-resistant staphylococcus aureus (MRSA) as part of pre-screening questionnaire, additionally all orthopaedic patients were swabbed prior to their operation. Should there be a need, as all rooms were ensuite, staff would be able to barrier nurse any patient as required.

The hand hygiene audit scores for the theatre and the ward were all above 95% for the last three months checked (July to September 2023). Where the percentage compliance was less than 100%, the audit results showed that the members of staff concerned would be informed about the non-compliance at the time of audit, as well as informing the wider team. We were also told that face to face aseptic non touch technique (ANTT) compliance was 96% for clinical staff.

There was a good audit system in place, that included reporting findings to staff. A quality report was produced that was reported to the quality and safety group meetings. We also saw the evidence of the environmental audits and sharps audits, that also included reasons for any non-compliance and action taken. An example of this included the theatre in August 2023, with 95% compliance, due to a lack of lockers and footwear, with the comment “to be brought up in next department meeting”.

Personal protective equipment (PPE) was accessible to staff in all areas, which was well stocked and stored appropriately. The PPE on the ward was noted as being changed between each task and patient, with evidence of the correct donning and doffing to minimise the transmission of an infection. Hand hygiene was also observed on the ward as been carried out correctly. Green labels were found on all appropriate pieces of equipment in the ward including the sluice and clean utility.

However, the environment in the theatre was not free from clutter and there were areas which had become a storage area for equipment, where there was no indication of decontamination of equipment. Equipment was stored which was exposed, with no dust sheet to protect the clean surface. One piece of equipment was noted with a label on indicating it had been cleaned five weeks previously.

The danger would be that staff would see the green tag and not damp dust before use.

We visited the one theatre not in use, theatre two, on 31 October 2023 alongside Public Health Wales (PHW) Healthcare Associated Infection & Antimicrobial Resistance Programme (HARP) staff. This was to ascertain the standard of IPC as part of our inspection and whether the issues raised on a previous visit by PHW on 21 August 2023 had been addressed and that the standard of IPC ensured patient safety. The visit on 21 August 2023 was carried out following a cluster of Staphylococcus aureus (S. aureus) infections, following surgery at Sancta Maria in July 2023.

We noted several issues that caused us concern. We highlighted these to the Theatre Manager during the initial check and we subsequently informed the responsible individual and interim hospital director of these later in the day. The areas of concern were:

- The theatre table was not considered to be sufficiently clean to ensure IPC. The stand of the bed was sticky to the touch, the underside of the bed was also considered to be unclean and had streaks of fluid on the surface

- Theatre table padding had sticky glue on the surface, which may not have been removed from the previous visit by PHW

- There were cleaning solutions in the sluice that were unlabelled

- There were cardboard boxes noted on the floor in the theatre, which could result in the cross transfer of infections and may also result in the area under the boxes not being cleaned

- An item of equipment, a surgical stand used by the surgeon to stand on, was noted on the theatre table

- Padding used to hold a patient's limb during an operation was ripped and considered to be not conducive with effective cleaning

- Footwear that was stored on the shelve in the changing rooms which was specific to theatre, was assumed to be soiled as there was no indication that it had been decontaminated

- The changing room for theatre staff had shared changing facilities which were cluttered and had shared products in the shower room

- The break room was shared with non-theatre staff, with staff there in outdoor clothes and from the ward.

We were also unable to gain a strong sense of assurance from the evidence provided, that regular cleaning activity in line with infection prevention and control measures was taking place, being documented nor escalated accordingly. In particular:

- The daily theatre cleaning tasks check sheet for theatre two for October had not been completed since the 28 October 2023 (the theatre was not open on the 29 and 30 October 2023). We were told that this schedule would be completed at the end of the day, but this was not clear from the document and had not been completed for the previous day, which should have been marked as “closed”

- The daily equipment check list (to be completed prior to the day list commencing) had not been completed on nine days in October 2023

- The daily duties ‘TS’ role for October had not been completed on 13 days in October 2023

- The monthly equipment store cleaning tasks had been completed for every month in 2023, but these were monthly tasks and could mean that in theory this area would not be cleaned for up to 60 days.

Whilst not specifically related to the theatre visit, we noted that there was not an IPC lead at the hospital. This responsibility was shared with the IPC lead for another HMT site in the Northeast of England.

These issues were dealt with under HIW’s non-compliance process.

We also visited the area, without PHW, on the second day of the inspection and noted that:

- Theatre corridors were clear and free from clutter, but there were still boxes on the floor, we were told these would be moved in the next 24 hours and there was a plan in place for the future

- Staff had been told that the break room was now only for theatre staff

- The changing room had been thoroughly cleaned and all shared products had been removed

- Footwear had been thoroughly cleaned and a footwear washer was on order

- All liquid products had been labelled and dated.

We were told that the theatre table had been removed (this has now been reconditioned) and a new bed had also been ordered. The theatre was closed until a new bed had been delivered. We were also told that the padding had been removed from the theatre.

In the theatre we noted that the cleaner's cupboard was locked. In the sluice, one COSHH cupboard was being used as a storage unit for paper documents. The main COSHH cupboard was locked and the key stored in a key safe within the room. This was considered good practice.

The ward was very clean and tidy, sluice and cleaner's cupboards were organised appropriately, with segregation of cleaning equipment. Domestic staff were interviewed on the ward and were all aware of their duties, with all cleaning products stored correctly. The ward cleaning schedules were shared for the ward and were all up to date.

Regarding sharps, in the theatres most sharps boxes were labelled correctly and were stored with the lid closed apart from one device which had been left open in theatre two, which was not in use. In the ward all sharps were stored, labelled and stored correctly.

In addition to the posters on eat well and smoking cessation, information was also displayed on who were the first aiders, about washing hands and bare below the elbows for staff. Whilst information was displayed on hand hygiene scores in the outpatient and ward areas these were dated 2022 and needed to be updated. Information on up-to-date infection rates were not displayed in the theatre and ward to inform staff, patients and visitors of compliance in this area.

The registered provider must ensure that all information displayed for the benefit of both staff and patients is up to date using the latest information or guidance.

All staff we spoke with on the ward and in theatre were aware of IPC precautions and practice. They were all aware of how to access relevant documentation, but they could not recall when they last accessed or why they needed to gain access. All staff could accurately describe the hand hygiene regime and knew what the process was for a needlestick injury.

The environmental cleaning schedule was in date and all relevant certifications required were up to date. The laminar flow cleaning tool for the theatres was seen and was detailed and in dated as well as the certificate for laminar flow compliance.

The anaesthetic rooms were considered to be “pristine”, well stocked and all appropriately labelled.

The recovery ward was clean, tidy and uncluttered. However, the sluice was in an unfortunate position behind the door, but was easily accessed when the main door was closed (automatically).

All bar one patient who answered the questionnaire considered that the setting was ‘very clean’, with four patients saying that IPC measures were always being followed, two said sometimes and one did not know. The scores from staff in the questionnaires were also positive across IPC areas, most respondents stated that the organisation implemented an effective infection control policy. All bar one member of staff felt that appropriate PPE was supplied and used. All staff agreed that there was an effective cleaning schedule in place and all staff said that the environment allowed for effective infection control. Staff commented that:

> *“It’s a small friendly hospital with high standards and patients have a safe and good experience”*

> *“Teams are very supportive of each other and all extremely passionate about providing the best possible care”*

Nutrition

There were nutritional risk assessments completed for all patients within 24 hours of admission, with the intake of food and fluid monitored appropriately. Patients had a choice of a variety of hot and cold food options. Water was also readily available for patients.

We observed the catering staff ensuring that patients were sat up and had their bed tables cleared, cleaned and placed within reach of patients before they had their meal. Meal trays were also available and food was served with hand wipes. Food was noted to be served promptly when it arrived on the ward. Food looked very appetising and hot meals were checked for the appropriate temperature. Patients we spoke with said they were very happy with the food and that there was plenty of choice and any requests were accommodated.

Patients’ needs were individualised by what operation they had, for example, if it was hand surgery, toast would be buttered. Where required the All-Wales Nutrition

pathway was completed. Some patients were also served food "on demand" which meant they ordered food prior to surgery and had their food two hours after the operation. Menus were also available for vegan and vegetarian patients and could be tailored to patients' needs.

Medicines management
Medicine management standards were met and to a high standard. The medicines management policy was available to staff electronically.

All prescription charts were signed and dated correctly, medication prescribed was legible and clear, with no concerns identified. Patient names and identity were recorded throughout the charts and it was clear what had been administered including any self-administered medication. The documentation was clear and the reasons if medication was not administered, were listed.

The ward has access to a dedicated external pharmacy and pharmacist, who would visit twice a day during the week. They would also carry out all the pharmacy stock checks and take-home medication.

Staff stated that they rarely required out of hours medication, but if they did, they had an emergency stock in the pharmacy room based on the ward. Staff on the ward stated that they rarely used the drug trolley as most patients self-administered medication. Where they did not, staff carried the medication to the individual patient.

The medication fridge and the blood fridge were both locked and kept in the locked pharmacy room, as was the controlled drugs cupboard. Fridge temperatures were monitored daily. There was clear evidence to show controlled drugs were signed for correctly. There was a regular stock check of controlled drugs against the logbook, that was performed correctly every 24 hours.

There was also evidence for a post operative patient, that oxygen was prescribed on the All-Wales Medication Administration Record (drugs chart) as well as on the national early warning score (NEWS) chart. Additionally, intravenous fluids were prescribed on the drugs chart for the post operative patient and recorded on the All-Wales Fluid Balance charts, kept at the bottom of patients' bed.

All patients wore patient identity (ID) bands and when we witnessed the drug round, we noted that patients ID bands were checked. We noted that "when required" (PRN) medication such as analgesia was given appropriately, timely and documented in conjunction with the pain score. Patients also, where required, received medication at designated times.

Patients were risk assessed at pre-admission to see if they were able to safely self-administer the medication. All patients on the ward at the time of inspection were able to self-administer medication. Patient medication was kept in a draw by the side of the patient's bed with a key lock and patients were responsible for the key. However, during the inspection, when we checked, the drawers were unlocked with the key in the drawer. When the patient was in the room this was not an issue, but this was not always the case. This was brought to the attention of the nurse in charge who acted on this on the same day and ensured they were always securely locked. Additionally, a request was put to the maintenance team for the locks on the draws to be changed so that there was only one key for all the drawers and this would be always with the nurse in charge.

The registered manager must ensure that the patient drawers are secure when the patient is not in the room.

Safeguarding children and safeguarding vulnerable adults
Patients we spoke with said that they felt safe on the ward and felt able to talk to someone if they were worried. They advised that if they had concerns or worries then they felt confident they would be dealt with.

Staff we spoke with said that it was rare to have a patient on the ward who lacked capacity. This would be assessed on pre-admission and the appropriate steps to care for that patient would be undertaken, including a best interest meeting to establish power of attorney and consent.

Staff we spoke with understood what was meant by Deprivation of Liberty Safeguards (DoLS) and when they would be required. Again, this was not considered relevant at the hospital as they would not treat patients who would require a DoLS.

All staff we spoke with were aware of the policies and procedures in place for safeguarding children and vulnerable adults. We were told that all clinical staff were trained up to safeguarding level two and the safeguarding leads were trained to level three.

Medical devices, equipment and diagnostic systems
Staff we spoke with all said they had sufficient equipment to give the care required. An external company was responsible for maintaining equipment, they performed the relevant checks on the equipment and medical devices as well as the servicing. Ward staff checked the service dates when cleaning the equipment. When the equipment was noted to be near the date of servicing or required repair, onsite maintenance staff were informed who would then inform the company. This was arranged by electronic mail (email). There was clear evidence on equipment

to show when they were last serviced and when they were next due to be serviced and all seen were in date.

The equipment dates were also discussed at the daily huddle meeting which heads of departments, including maintenance staff, attended. At the daily huddle meeting, which took place every weekday at 10 am, all incidents were discussed, including investigation of incidents and outcomes. At the Monday huddle there would be a recap of what was discussed, action plans and outcomes from the previous week.

Additionally, at the 10am huddle, as well as any maintenance issues, staff were also informed who the resuscitation team was for the day. This huddle meeting was witnessed during the inspection and was considered to be very productive.

We noted that the ward was currently in the process of changing over the intravenous pumps and staff were being trained on the new pumps prior to them being introduced.

Safe and clinically effective care
There was a patient status at a glance board in the nurse's office which showed basic information including names of patients, date and time of discharge as well as names of patients due to be admitted and the time due. These were up-to-date, accurate and obscured from view by passing patients or visitors.

Sepsis six information leaflets and a notice board showing the six steps of the sepsis pathway was noted on the ward. Sepsis training was carried out online, additionally the hospital used outside trainers to support staff as well as link nurses for support and updating staff. All staff we spoke with had received training on sepsis and had a good understanding of the sepsis process and six step pathways.

The NEWS score was used very proactively on every patient and was monitored and acted upon accordingly on every patient. At the time of the inspection there were no patients identified with an infection or sepsis. NEWS scores were also recorded post-operatively and acted on accordingly.

All staff we spoke with knew how to access the relevant clinical policies and procedures. There were also some hard copies which were used as a quick reference tool such as the blood policy, but otherwise staff knew where the policies were on the intranet. The registered nurses we spoke with also knew how to access the Nursing and Midwifery Council Record Keeping Guidance for Nurses and Midwives.

All staff said that they had enough time to provide care safely and to meet the needs of the patients. Patients we spoke with were very happy with their overall care. They praised the kindness and helpfulness of staff. No negative feedback was received from patients we spoke with.

Risk assessments were completed on patients prior to admission and updated throughout their stay. These risk assessments were comprehensive and included the Visual Infusion Phlebitis score (VIP), nutrition, mobility and falls. There was also evidence that risks were monitored with the situation, background, assessment, recommendation (SBAR) technique used as a prompt with appropriate communication.

The hospital ensured that staff were up to date with guidelines through safety alerts, notices and discussion at monthly and quality meetings.

Bloods
Staff we spoke with knew how to store and manage bloods and blood components, with the relevant documentation being available. An emergency supply of blood was kept in the blood fridge in the pharmacy, all patients were cross matched prior to going to theatre and the local general hospital contacted if blood was needed post operatively.

All-Wales guidelines were followed to monitor the safe and appropriate use of blood, components, and products. We were told that all staff involved in the transfusion process were fully trained and competent, through completing mandatory training. This was evidenced in files kept in the office where the blood was stored. The arrangements in place for reporting events relating to blood transfusions internally and to external bodies, included generating an event on Datix as well as sending a yellow card alert and contacting the blood bank in the hospital. Staff were aware of the need where necessary to use a Serious Hazards of Transfusion (SHOT) report.

Records management
There was clear accountability and evidence of how decisions relating to patient care were made. The records were of a good quality in terms of accuracy, being up to date, complete, understandable and contemporaneous.

There was easy access to the records when required. The notes for discharged patients were stored in a medical records area and were easily accessible by day and through porters at night. The records were securely stored in compliance with the Data Protection Act 2018.

Notes were kept in a trolley outside the nurse's office alongside the nurse's station. Throughout the inspection we noted that the notes trolley was never left unattended.

We checked a sample of six patient records and noted that all were organised, structured and legible. Nursing, medical and physiotherapist documentation were all together within the one set of notes. This allowed easy reading and enhanced the delivery of care. At the front of the notes there was a staff signature form. Within these notes there was also an in-depth individualised care plan which commenced at the pre-admission clinic, updated on admission and throughout the patients' stay. These also contained all risk assessments such as continence, falls, skin, nutrition and venous thromboembolism. The physiotherapist also documented within these individualised care plan.

Quality of Management and Leadership

Governance and accountability framework
The statement of purpose was available and contained all the relevant information in accordance with the Independent Health Care (Wales) Regulations 2011. The services provided were also in accordance with the statement of purpose and compliant with the conditions of registration.

Senior management we spoke with were aware of the need to report notifiable incidents and were aware of those that had been received by HIW, particularly in relation to serious injury as required by the above regulations. We were told that staff were encouraged to report errors.

Governance, management and leadership was clear at the setting. There was a board of directors that oversaw the management and business of the wider hospital management trust (HMT). Internally there were a number of committees and reports to ensure that all levels of management were aware of the running of the hospital. We were provided with minutes from various meetings at the hospital that showed the information flow.

The hospital also held a daily ten o'clock huddle that we considered an example of good practice, where they discussed any serious incidents, staffing issues and building work.

However, we did speak to members of the cleaning staff, who said they asked for monthly meetings which were not happening. They also asked for training on how the room should be cleaned and they felt that they weren't communicated with.

The registered manager is required to inform HIW of the actions taken to ensure that cleaning and domestic staff views are noted.

Regarding the organisation, staff responses by percentage in the questionnaires, were as follows:

- Care of patients and service users was the organisation's top priority - 87%
- Staff were content with the efforts of the organisation to keep themselves and patients safe – 87%
- Their organisation was supportive – 83%
- Their organisation supported staff to identify and solve problems -76%

- The organisation took swift action to improve when needed -72%

- They would recommend the organisation as a good place to work -83%

With regard to management, staff responses were:

- Their immediate manager asked for their opinion before making decisions that affected their work -72%

- Their immediate manager could be counted on to help with a difficult task at work – 79%

- Gave clear feedback on staff work – 75%

- Senior managers were visible – 72%

- Senior managers were committed to patient care – 91%

A smaller proportion of respondents felt that communication between senior management and staff was effective – 64%.

Dealing with concerns and managing incidents
The complaints policy was seen and was in date, with a review date and a person responsible for the review. In addition to including reference to HIW we also noted that the policy referenced the Independent Healthcare Sector Complaints Adjudication process.

Incidents were investigated by heads of department and senior management; these were then discussed at the weekly leadership meetings. Incidents and information would be shared with staff at ward level, at monthly ward team meetings, handovers and group emails. There was a policy of the month notice board, which meant that if an incident had occurred or a Datix put in the place around that subject, this would be printed and put on the notice board for staff to read. All incidents, investigations and outcomes were also shared with the wider HMT who were then included in quality reports.

The process of dealing with incidents, including reportable instances which resulted in serious injury was discussed with senior staff and staff on the ward. Any adverse events would be reported onto Datix and evidence was seen for the use of this system. This included the reporting of the incident, identifying the issue, any lessons learned, which were discussed at various meetings and made known to

staff. Complaints were also shared with staff and there was sharing of learning across the ward and service.

There was also clear leadership evident on the ward. The senior staff nurse in charge of the ward believed there had not been any recent or recurring complaints about the ward, apart from patients complaining about the clock in their cubicles having a loud ticking noise which they found irritating. The ward was looking at purchasing digital clocks.

There was a laminated copy of the complaint's procedure in the ward office and on the patient information board at the entrance to the ward. Staff also carried out their own feedback questionnaire with all patients. This involved a few simple questions that the patients were asked on an electronic tablet device, which patients were encouraged to fill in themselves.

There were records kept centrally of the complaints made, both closed and current complaints, with information on the complaints as well as supporting documents. The complaints would also be entered on Datix. There were reasons noted for any complaints over the 20-day resolution limit. The complaints process was documented and explained well by staff at the hospital. This included involving the consultant if the complaint was in relation to them.

We were told that the common themes appeared to be delay in receiving results, consultants and secretaries' responses to communications and not being satisfied with plastic surgery results.

There was also an Organisational Learning Group. The terms of reference included the aim, which was to identify issues that required organisational learning to enhance patient care and their experience of being a patient at the hospital. This would be accomplished through the sharing of experience, knowledge and skills across clinical departments within the hospital.

We also noted the quarterly staff newsletter which highlighted the positive work at the hospital and included that Sancta Maria Hospital was named as a National Joint Registry (NJR) Quality Data Provider for 2022/23 after successfully completing a national programme of local data audits.

Staff feedback in the questionnaires regarding incidents, concerns and safeguarding was also positive, as follows:

- The organisation encouraged staff to report errors, near misses or incidents – 92%

- Staff involved are treated fairly – 96%

- The organisation takes action to ensure that errors, near misses or incidents do not reoccur – 83%

- Feedback was given in response to reported errors, near misses or incidents -75%

- They knew how to report a concern - 92%

- Felt secure in doing so - 84%

- Were confident that the organisation would address their concerns should they need to be raised – 68% (However, 24% said that they 'did not know').

Workforce planning, training and organisational development
From a check of the three months staff rotas provided, the number and skill mix of staff was appropriate to meet the needs of the patients, staff we spoke with agreed.

We were told that there were regular appraisals at the hospital, the percentage compliance currently was an overall total of 74%, this was being pursued by the senior leadership team. The heads of department knew that they had to increase this level.

The registered provider is to provide HIW with an update of the compliance with the annual appraisals and the actions taken to ensure this is increased to 100%.

All staff we spoke with enjoyed working at the hospital. They also did not have a problem in reporting concerns and believed that these would be dealt with and responded to. Mandatory training compliance at the hospital was generally good. This included:

- IPC 88% ANTT and hand hygiene

- Health and Safety 87%

- Information governance 71%

- Medicines Management 79%

- Fire safety 94%

- Manual handling 89%

- Resuscitation 73% compliance, including 85% in the ward and 81% in outpatients, but only 59% in theatres.

Staff we spoke with said there were training opportunities available to them. Additionally, most of the staff who responded in the questionnaire said they felt they had appropriate training to undertake their role.

There had been a change of the system used by staff to undertake their mandatory and other training. This had resulted in some training module results not being compatible with the new system, but HR management had records of both systems.

All but one of the respondents to the staff questionnaire felt they had appropriate training or partial training to undertake the role and most said they had an appraisal, annual review or development review in the past 12 months. Some comments we received on training included:

> *"Need more training on new paperless procedures just rolled out."*
>
> *"No training programme really in place it's more learn on the job or learn as you go"*

Workforce recruitment and employment practices
We spoke with staff regarding the employment of permanent staff and medical staff with consultant privileges. They were able to explain the process concisely and had the relevant records in place to support these processes.

There were relevant recruitment and employment policies in place which were in date. We spoke to the staff involved in the process of providing consultant privileges and for the sample of 5 consultants checked, we noted that there were the relevant documents on file. This included evidence of licence to practice from the General Medical Council (GMC), evidence of an enhanced DBS check and professional indemnity. Annually there was a requirement for a copy of evidence of the appraisal from their full-time employer. The process ensured that the relevant checks were in place before the consultant privileges were in place and annually that the relevant information was received to remain as consultants at the hospital. The relevant documentation was also on file.

Regarding permanent staff, we checked a sample of the employment records of five members of staff. There were appropriate pre-employment checks completed

for all staff and they all had a contract of employment. Additionally, records were up to date regarding DBS as well as a requirement to complete an annual declaration. Staff had up-to-date job descriptions which reflected their level of responsibility.

We were told that support and access to occupational health for staff was through the HMT and there were a number of free mental health and wellbeing services for all staff to access, including an employee assistance programme and a telephone counselling service. Most respondents who answered our questionnaire felt that the organisation took positive action on health and wellbeing and that they could achieve a good work-life balance from their current working pattern. Almost all staff also thought that their job was not detrimental to their health and were aware of the occupational health support available.

Staff comments included:

> *"Management are friendly and approachable but not visible enough. When reporting a concern verbally. This usually isn't acted on."*
>
> *"Lovely place to work. Patients are always the number one priority as they should be. Essential and beneficial information is shared between departments, the hospital works together as a whole."*
>
> *"Sancta Maria has changed to what it used to be years ago. A lot of these changes are because of the how the hospital is run."*
>
> *"There are worst places to work but most people do enjoy working in Sancta Maria but I do feel certain things need to be taken into consideration as so many good members of staff have left."*
>
> *"Pay should be looked at in some areas of the hospital for example Admin staff are paid low for what they do. Management do not give time to find out about people's job roles and the hard work they do. Without admin staff, the hospital would not have patients. The admin staff are not valued enough."*

Additionally, other staff responses were:

- They could meet the conflicting demands of their work – 84%
- There were enough staff to do their job properly – 76%
- Staff had adequate materials, supplies and equipment to do their work – 84%

- Staff were able to access information communication technology systems to provide good care and support for patients -95%

- Involved in deciding on changes introduced that affected their work area – 75%.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans 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 inspection.

As a result of the findings from this inspection 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.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.			

Appendix B - Immediate improvement plan

Service: HMT Sancta Maria Hospital

Date of inspection: 31 October and 1 November 2023

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
Infection Prevention and Control The registered provider must ensure that the relevant regular safety and compliance checks are carried out and monitored in line with local and national guidelines. These must include:	Regulation 26(2)(a) Fitness of Premises and 40(1) Surgical Procedures	Immediate actions have been taken to ensure the relevant regular safety and compliance checks are carried out and monitored in line with local and national guidelines	Jude Hall (Hospital Director) Tracy Ace (Head of Clinical Services) Rhian Bennallack (Head of Theatres for all actions unless specified.)	See Below
The cleanliness of the theatre bed and associated equipment.		The identified theatre bed has been removed and replaced.	Jude Hall (Hospital Director) Tracy Ace (Head of Clinical Services)	Completed 02/11/2023 with ongoing audits.

		Mandatory cleaning training sessions for theatre staff are being introduced. Cleaning competencies for all theatre staff have been updated. The “theatre operational procedure” to reflect current cleaning requirements and expectations from team is being updated. The theatre daily huddle is being continued and will incorporate cleanliness feedback. A weekly IPC email to all staff is being introduced. A new weekly environmental audit is being introduced by the Head of Theatre and the Theatre Manager.	Rhian Bennallack (Head of Theatres for all actions unless specified.)	December 2023 January 2024 November 2023 November 2023 November 2023 Visual audits commenced, to be transferred to electronic audit system December 2023.

		Monthly IPC environmental audit is in place. Unannounced IPC audit to be led by organisational IPC lead. Enhanced training for IPC links offer both level 5 training and develop towards level 6 (IPC lead) Audit results are reported to Head of Clinical Services & Hospital Director via local governance and IPC meeting.		In place and ongoing. December 2023. Establish training programme by December 2023 to be enrolled by end of March 2024. November 2023.
The cleaning solutions in all areas are correctly identified, dated, and labelled.		Cleaning solutions are to be correctly identified, dated, and labelled using the correct IPC technique at point of production. To be monitored via check sheets and included on weekly audit.	Rhian Bennallack (Head of Theatres)	Complete. Check sheets in place. Visual audits commenced, to be

		This will be reinforced by the Head of Theatre and Theatre Manager via daily huddle and weekly communication.		transferred to electronic audit system December 2023.
Items of equipment that would normally by kept on the floor are not stored on top of other clean equipment.		Immediate action taken to remove equipment All staff informed not to store equipment on top of other clean equipment via email and face to face	Rhian Bennallack (Head of Theatres) Housekeeping Manager	Complete. Complete.
All padding is serviceable and clean.		Padding that was identified during the inspection has been removed from the department. Padding integrity to be added and monitored via daily check sheets.	Rhian Bennallack (Head of Theatres)	Complete. November 2023.

Footwear to be used in the theatre is stored to prevent cross-contamination, is clean and serviceable.		Theatre staff are to store all outdoor footwear on outdoor specific shoe rack and clogs to be stored within individual lockers or on provided clog shoe rack. These will be clearly labelled. To be monitored via daily cleaning schedules by housekeeping team and feedback to the Head of Theatres/ Theatre Manager. Clog washer model is being reviewed for suitability, however in the interim all clogs are cleaned at the end of the day by the individual and inspected as part of the audit process. Information provided to staff/Consultants regarding frequency of cleaning of clogs and use of clog washer machine. This will be monitored via the theatre attire audit	Rhian Bennallack (Head of Theatres)	November 2023. November 2023. Suitable products are under review due to space constraints. Plan to order in December 2023. November 2023, once Clog washer is onsite information will be updated. Already in place-ongoing.

The changing room for theatre staff is kept, clean, clutter free with no shared products.		Theatre staff have been reminded via weekly email and face to face that any personal items left are to be stored in personal lockers, failure to do this will result in the items being disposed of by the housekeeping team.	Rhian Bennallack (Head of Theatres)	November 2023.
The break room is used by theatre staff only.		This has now been implemented the break room is used by theatre staff only.	Rhian Bennallack (Head of Theatres)	Complete.
The actions on the relevant checklists are completed as required and evidenced on the checklist.		This will be captured via the new electronic weekly audit undertaken by the Head of Theatres/Theatre manager. Action plan will be shared with Head of Clinical Services/ Hospital Director.	Rhian Bennallack (Head of Theatres)	Visual audits commenced, to be transferred to electronic audit system December 2023. Verbal updates November 2023.Electronic updates December 2023.

		IPC audit results are captured within the monthly quality report and shared via SMT and the wider teams and compliance to be reported via monthly IPC meeting minutes.		In place and ongoing.
In addition, the setting would benefit from a dedicated onsite IPC lead.		We acknowledge this recommendation, noting that recruitment in this current climate may be challenging therefore, it is essential we ensure our current provision is robust and substantial until we can confirm the recruitment position. we are reviewing and re-establishing the IPC Link Nurse role and increasing the central provision for IPC, which includes the following measures: - Review of JD with roles & responsibilities. Enhanced training for IPC links offer both level 5 training and develop towards level 6 (IPC lead) Confirmation of protected time.	Sam Marsh IPC Lead HMT (Hospital)	Establish training programme by December 2023 to be enrolled by end of March 2024.

		Dedicated clinical supervision with HMT IPC organisational Lead. Outcome measurement through audit and formal feedback session with organisational IPC lead Head of Clinical Services and Hospital Director.		

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.

Service representative:

Name (print): **Andrew Willcocks**

Job role: **Executive Director of Nursing, AHP & Quality**

Date: **10 November 2023**

Appendix C - Improvement plan

Service: HMT Sancta Maria Hospital

Date of inspection: 31 October and 1 November 2023

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The registered provider should consider expanding the selection of information available, taking into consideration the communication needs and wishes of patients using the service.	Independent Health Care Regulations (Wales) 2011, Regulation 9 (1) (g)	We acknowledge this comment although welcome your comment regarding the availability of EIDO leaflets in the outpatient clinic. We will however further review this along with external health literature including Macmillan, British Heart foundation, Alzheimer's society, to ensure these are visible in the patient areas. Where possible, these will include a Welsh Language and large print option. In terms of In-patient and Day cases, individual patient needs are	Judith Hall, Hospital Director/ Tracy Ace, Head of Clinical Services	January 2024 Ongoing

		identified at pre assessment or through the health questionnaire. As appropriate accessibility adjustments are made prior to admission to ensure we meet these individual needs. In addition to this we do have hearing loops available at reception areas but will review the options for a more portable device that can be utilised in patient bedrooms and consultations rooms. Additionally, we will purchase magnifying glasses and will consider the use of Braille when replacing bathroom door signs in bedrooms.		January 2024 Ongoing
The registered provider must ensure that all information displayed for the benefit of both staff and patients is up to date using the latest information or guidance.	Independent Health Care Regulations (Wales) 2011, Regulation 9 (1) (g)	We recognise the hand hygiene audit information that was on display in OPD was out of date, this was an oversight on our part and rectified with the most recent information available. The importance of up-to-date information has been discussed with the team.	Tracy Ace, Head of Clinical Services	Completed

The registered manager must ensure that the patient drawers are secure when the patient is not in the room.	Independent Health Care Regulations (Wales) 2011, Regulation 26 (2) (a)	This was actioned during the inspection with a new process being implemented. The patient medications are taken from them on admission and are locked away in their bedside lockers. There are individual keys for each locker that are kept in the safe or with nurse in charge until required.	Tracy Ace, Head of Clinical Service	Completed
The registered manager is required to inform HIW of the actions taken to ensure that cleaning and domestic staff views are noted.	National Minimum Standards, Standard 1 - Governance and Accountability Framework	The team does have regular meetings, there will now be a formal agenda and minutes taken moving forward. However, we acknowledge that the team does not feel they are 'listened to'. We have recently implemented a Freedom to Speak up process along with regular staff forums. Therefore, the team does have additional avenues to communicate with the senior management team regarding any concerns they may have. In demonstration of this we have organised practical training	Helen Rees-Byrne, Head of Commercial Services	Q1 2024

		for the Housekeeping Supervisor which will be cascaded to the team. The Training will be organised in conjunction with the IPC Lead. We will also use the Tork interactive education for hospital training which will be available for the housekeeping team.		
The registered provider is to provide HIW with an update of the compliance with the annual appraisals and the actions taken to ensure this is increased to 100%.	Independent Health Care Regulations (Wales) 2011, Regulation 20 (2) (a)	We acknowledge our appraisal documentation is at 78%. This will be discussed with our SMT leaders with the aim to achieve 100% compliance for 2024 by end of Feb 2024.	Judith Hall, Hospital Director	February 2024

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.

Service representative

Name (print): Judith Hall

Job role: Hospital Director

Date: 8 January 2024