Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Sancta Maria Hospital
Ffynone Road
Uplands
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Inspection 2009/2010

Healthcare Inspectorate Wales
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Inspection Date:	Inspection Manager and Reviewers:
16 September 2009 & 18 December 2009. 15 January 2010 & 25 February 2010	Ms P Price Mrs J Davies 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

Sancta Maria Hospital was first registered in 1958 under the auspices of the Ursulines of Jesus. In 1988 the Hospital Management Trust (HMT) a registered health care charity became the registered provider. The hospital had an unannounced visit in September 2009, followed by an announced inspection in December 2010. There were two further follow-up visits, one in January and one in February 2010.

The hospital is situated in a residential location in the Uplands area of Swansea and a short journey from the city centre. The building is set in its own grounds, with service and administrative areas situated in the basement. Most of the ground floor accommodates an outpatients department, theatre and endoscopy suites, x-ray, pathology, administration and catering areas. The hospital has accommodation for up to thirty three in-patients, within twenty seven single rooms and four shared rooms, several rooms are en-suite and have views over Swansea Bay. Some rooms are large enough for a parent to stay with a child. Four- day chairs have now been installed for day surgery.

Children are normally only admitted for day surgery, although some may stay overnight after surgery. Each child is anaesthetised by a paediatric anaesthetist and operated on by a paediatric surgeon. Registered Sick Children's Nurses (RSCN) were responsible for planning the overall care of children and an RSCN attended theatre during a child's operation. Children were always first on the operating list and must have a parent or guardian present in the ward. Two rooms were particularly equipped and decorated for children. Children were only admitted to the room's that had been assessed as safe and suitable.

The standard of information provided to patients about the facilities, care and treatment was very satisfactory.

Statement of Purpose & Patient Guide

The statement of purpose and patients guide was available and accessible to patients. A patient information folder was available in each in–patient's room. The folder was very informative in respect of the day to day running of the hospital. It also included the aims and objectives of the hospital, details of the facilities and the procedure for making a complaint. Information leaflets were provided prior to or on admission, which were treatment or condition specific. Each patient was given the opportunity to make comments and suggestions following treatment by completing a survey form or speaking to a nurse.

All advertising appeared to comply with Advertising Standards Authority standards and the BMA Guidelines for Advertising. The senior management had responsibility and accountability for the quality of promotional materials and campaigns.

Additional Information

Separate brochures were available for specific services. Pre operative information was also provided to patients prior to admission. In and outpatient satisfaction questionnaires were used to obtain patient/relatives views on care provision. The results of these was available to the public. The outcome of these demonstrated a high level of satisfaction with the service received.

Quality of Care

Patient Care Pathways and Pre-assessment patient information were viewed during inspection and were found to be satisfactory. Protocols, policies and procedures demonstrated up to date evidence based information. However there was a need for updating and clarifying Consultant care preferences. A clinical audit programme ensured good practice was maintained. There was a policy in place if palliative care or terminal care was required. Pastoral care was available and provided where appropriate and the involvement of relatives and friends was encouraged. Bereavement counselling would be arranged for family or staff if required.

Arrangements for Immediate Critical Care

Policies and procedures indicated that the arrangements for immediate critical care were suitable. The senior nursing staff and duty doctor were trained and experienced to deal with emergencies. There were level 1 critical care facilities available for patients who received treatment under general anaesthetic. Patients who required level 2 or 3 critical care would be transferred immediately to Singleton Hospital where it would be provided, as indicated by the relevant policies and procedures.

Staff Training

A formal and extensive induction day was arranged on a regular basis for new staff, which covered in detail the policies and procedures used within the hospital. The Royal Marsden Hospital Manual of Clinical Nursing Procedure Book was used to direct nursing practice.

Quality Audit

Clinical audit was undertaken on a regular basis with an on-going programme undertaken by the matron and the Medical Advisory Committee (MAC). A clinical effectiveness committee met every two months to audit a sample of care records and instigate change in practice if the need was identified. A clinical governance policy and strategy was in place.

Policies and Procedures

A comprehensive policy and protocol files were available although many of these required updating and review. There was a signed statement within each individual staff member's file to evidence that they had read the hospital policies. The hospital had a Clinical Governance strategy and a Critical Incident reporting system in place. The Hospital collected individual consultant performance indicators as part of quality assurance.

Registered Manager

The interim manager had the required skills, knowledge and extensive management experience within the Independent Healthcare sector. There was a clear system of clinical support and oversight within the management system and there was a clear line of accountability for the delivery of services.

Human Resources

Human Resource policies reflected current employment legislation. Criminal Record Bureau (CRB) checks, verification of professional fitness to practice and recent references were evident in a sample of personnel records. The job descriptions reflected relative roles and responsibilities. All staff received a handbook on commencing employment at the hospital.

Induction/training, continual professional development and performance management for staff was also demonstrated. There were systems in place for verifying Nursing and Midwifery Council (NMC) registration. Arrangements were in place to support staff for training and continuous professional development. Staff-training and performance review was evidenced during the inspection and staff annual appraisals were undertaken.

A clinical supervision policy and procedure was in place and supervision was documented.

Medical Practitioners/Consultants

Medical practitioners who wished to apply for admitting rights must complete a formal application and submit it to the hospital manager. Practising privileges were then dependent upon approval by the Medical Advisory Committee (MAC). Consultants were required to demonstrate that they were on the Specialist Register of the GMC, their Hepatitis B status and that they had adequate indemnity insurance with a medical or dental defence organisation. This was required in the event of a claim against medical practitioners and dentists. There was a voluntary induction programme for new Consultants. Enhanced Criminal Records Disclosure Clearance was obtained for all Consultants and a system will be developed for flagging up when these are due.

There was a Clinical Governance Committee that had links to the MAC. There was also a Clinical Effectiveness Committee. Minutes of the meetings of the MAC were viewed during the inspection. Consultants were required to submit evidence of satisfactory annual appraisal. A Resident Medical Officer (RMO) was available 24 hours a day, 7 days a week with access to a Consultant Physicians/Anaesthetists for the hospital if advice was required in the management of postoperative complications. Many consultants had no up to date appraisal and this must be rectified.

Allied Health Professionals

There was a part time Physiotherapist who provided an in patient service mainly to Orthopaedic patients, on a Service Level Agreement (SLA) and details in respect of communications, including details of CPD and training needs were recorded in the personnel file.

A radiography service was provided on a 24/7 basis through four radiographers sharing the work-load and cover. Radiographers worked to specific standards and there was a professional network of radiographers across Wales which provided peer support. An on call system was in operation. CT and MRI scans were not carried out within the hospital. Radiographers worked in a regulated environment and the hospital had access to a Radiation Protection Advisor (RPA). The radiographers had been trained in risk assessment and along with all clinicians in basic life support and use of equipment.

The operating department practitioners (OPD) work closely with the anaesthetists and other consultants in their specialist role of theatre practice.

Staff Occupational Health

Human resource policies and records indicated that the 'occupational health' nurse screened new staff for Hepatitis B, C and HIV. Immunisation to Hepatitis B was available to all staff in accordance with Department of Health guidance. There was also a policy guiding practice regarding those staff who undertook exposure prone procedures.

Children's Services

A review of the child's journey as an outpatient or inpatient was undertaken. The review assessed whether appropriately trained and qualified staff were available to care for children and the environment of care provided for children as patients and visitors. Staff were interviewed and a random audit of health records undertaken.

Appropriate information was provided for both young and older children by means of an interactive booklet and children's views were listened to, this was good practice. The leaflets required the statement of 'This information is available in other languages and formats on request' to be added. Children had their own appropriate menus and were only admitted to rooms that were large enough for a parent to stay with a child and that have been risk assessed as safe and suitable. Room 4 had been identified, equipped and decorated for children. During the inspection of Room 4 the Reviewer advised that the windows in Room 4 were situated low enough to floor level to pose a risk to small children of being able to climb through. The windows were immediately checked by the hospital maintenance staff and secured with brackets to lock them and remove the risk of children accessing or climbing through them. The environment of care in the waiting rooms, outpatient consulting rooms and phlebotomy room could be enhanced by the provision of books, artwork and distraction materials. Signage regarding hot beverages and the supervision of children were advised and actioned on the day of inspection.

Children were normally only admitted for day surgery, although some may stay overnight after surgery. Registered Children's Nurses (RSCN or RN Child) wear child friendly tabards and were responsible for planning the overall care of children and an RSCN or RN Child nurse attended theatre during a child's operation where each child was anaesthetised by a paediatric anaesthetist and operated on by a paediatric surgeon. Children were always scheduled first on the list and must have a parent or guardian present in the ward. Meetings to discuss paediatric issues were held quarterly with a record kept. Reference was made in the paediatric meeting notes to the hospital's variation on condition of registration to allow male circumcision on religious grounds but the service has not yet been implemented.

Adult and Child Protection

Adult and Child protection policies and procedures were consistent with national guidelines and local arrangements. The matron co-ordinated the protection of vulnerable adults (POVA) and child training (POVAC) and ensured that adult protection was covered in both induction and continuing professional development arrangements.

Complaints management

There was a clear policy and procedure for handling complaints and a register of these was maintained, that demonstrated complaints were dealt with in line with standards and recommended time-scales and developed action plans.

Whistle-blowing

The nursing and medical staff were aware of their duty to express any concerns about poor standards, as required in the professional codes of practise issued to each nurse and doctor. Opportunities were provided at quality meetings and at other times to discuss concerns.

Premises & Maintenance

There was a preventive planned maintenance plan that covered all areas of the establishment's buildings, and a phased refurbishment and redecoration programme was underway for the patient bedroom areas.

Pre-inspection information on maintenance and associated records had been received and these all appeared to be acceptable.

There was a passenger lift in the hospital, which was subject to a maintenance contract.

Up-to-date policies for health and safety and procedures for identifying overall responsibility were available.

Hot water temperatures within patient areas were checked weekly with random samples taken around the hospital and records retained for inspection. It was noted that the heating and water systems had been subjected to a detailed review and outstanding work had been actioned and /or was completed. This is commended.

The manager monitored Medical Device Agency (MDA) alerts and ensured that the appropriate actions were taken.

Access was available to all patient areas of the hospital for wheelchair users. A passenger lift was available to convey wheelchairs to the upper floor level. An inspection of the premises confirmed that all areas were adequately lit.

Suitable facilities were provided within the outpatient areas of the main hospital and adequate single sex toilets were provided in all areas of the hospital, including disabled facilities.

Catering

Catering facilities for patients, staff and visitors was provided between 0730hrs-19:00hrs, seven days a week. Refrigerator, freezer, and food temperatures recordings were evidenced. Copies of patient survey outcomes were viewed on this inspection and copies of menu plans were viewed. The catering manager/chef was available to meet patients and to discuss any individual requirements. Dietary advice was provided from an independent dietician.

National Vocational Qualification (NVQ) training was available to catering staff. Other staff within kitchen and ward areas had undertaken food hygiene training. This was an ongoing programme.

Risk Management

Staff induction and training programmes covered risk management. There were comprehensive policies and procedures in place to support risk management issues but some of these require review and updating.

There was evidence that internal health and safety audits were undertaken and action plans produced. Staff were provided with protective equipment and clothing to prevent risk of harm or injury to themselves. Appropriate equipment was available i.e. gloves/aprons.

Health and Safety

The hospital manager was responsible for health and safety at the hospital. A committee chaired by the matron met every two months and took action or obtained advice on any relevant issue and produced an annual health and safety report. An infection control meeting followed on from the above meeting. Policies and procedures were available, including risk management policies. All staff received training in health and safety at induction and at intervals during the year.

Clinical staff were routinely screened to include Hepatitis B and Hepatitis C. Mechanisms were in place for dealing with adverse incidents and events with regular audits of health and safety issues.

Some storage areas required reorganising and risk assessment. The spillage kit required proper labelling and storage and this was discussed with the members of the senior management team on the day of inspection.

Staff Fire Training

Fire training was part of the hospital training manual. Fire drills were held every six months, and attendance recorded.

Pharmacy Services

The manager had the responsibility for the safe and secure handling of medicines and that the management of medicines was clearly defined. In the absence of a pharmaceutical department, alternative arrangements had been made for the provision of pharmaceutical services including out of hours arrangements.

Medicines within a ward, theatre or department were the responsibility of the registered nurses designated for the purpose by the manager. Medicines brought into the hospital by individual patients which were not used, were held in a separate, safe place until discharge.

All medicines were administered to a patient with a written prescription or drug administration chart, signed by a legally authorised prescriber. Controlled drugs were administered by a medical practitioner or senior nurse and witnessed.

There was a consultant led Medicines Advisory Committee to oversee the formulation, agreement and implementation of policies concerning medicine use.

Management of Pathology Services

The hospital had a service level agreement (SLA) with all specimens going to the neighbouring NHS trust.

Infection Control

The hospital had good links to the local NHS trust for advice and support and the local trust manual for Infection Control was available for reference but the hospital has their own policies, which required review and updating. Microbiology was not done on site but advice on results was available from the trust infection control nurses and microbiologist.

An ’e-learning’ package was available to cover areas of health and safety and infection control as an induction package. All hospital staff must complete the package. There was a functioning infection control committee within the hospital that has clear aims and objectives and met two monthly to discuss all issues in connection with controlling and preventing infection. Infection control audits were undertaken quarterly, viewed on inspection. However, please see entry under premises and maintenance with regard to water and heating systems.

Outpatients

The areas were well maintained and the treatment rooms and consultation rooms appeared clean.

Ward Area

The rooms looked clean and tidy but some sink areas required replacement seals. Multi-point room checks were undertaken daily to ensure a clean environment for the patient and rooms were found to be clean on inspection. However, it was noted that a bottle of cleaning agent had been left in a cupboard in a bathroom. This was removed during the visit.

Theatre Department

There was one theatre with a small recovery area that was satisfactory.

Resuscitation

Resuscitation policies and procedures were evident. The resuscitation equipment on the ward was available and checked daily by a registered nurse. Written records were kept of these checks with signatures were provided by the nurse responsible for checking the equipment. The equipment was prominently sited in the ward. All staff were aware of the location of the resuscitation equipment.

Records management.

The policies and procedures viewed on records/documentation were comprehensive and robust. Details of mechanism to maintain and retain records for the period specified in the Regulations were included. The hospital had policy and procedures for completion, storage, security and transfer of health records. Sancta Maria hospital undertook audit for record process and well-established and regularly reviewed care pathways were in place for the majority of procedures. Sancta Maria Hospital had a confidentiality policy in place. This complied with Medical Confidentiality Guidelines and Data Protection legislation. The staff induction programme included training on data protection and confidentiality. There were no patient records available for patients attending outpatients and this must be rectified immediately.

The Inspection team would like to thank the patients, relatives, senior management team and all members of the staff for their time, assistance and co-operation throughout the inspection process.

Achievements and compliance

Post inspection feedback was undertaken throughout the inspection. It must be noted that the senior management staff team responded positively and were proactive in actioning and undertaking requirements.

There were no outstanding from the 2008-2009 visits.

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 medical treatment under general anaesthesia or intravenous sedation.

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.	No more than thirty- three (33) patients may be accommodated overnight.	Compliant
2.	The registered person must give the Healthcare Inspectorate Wales at least 28 days prior written notice of the provision of any new or different treatment or service.	Compliant
3.	Inpatient treatment for children is restricted to those aged three (3) years of age and upwards, with the following exceptions: ▪ Male patients aged six (6) months and above undergoing circumcision. ▪ Male patients aged six (6) months and above undergoing revision of circumcision surgery	Compliant This specific service provision has not yet commenced.

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 almost met
C8	Patients are assured that the establishment or agency is run by a fit person/organisation and that there is a clears line of accountability for the delivery of services	Standard met
C9	Patients receive care from appropriately recruited, trained and qualified staff	Standard met

Number	Standard Topic	Assessment
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 almost 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
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 almost met

Number	Standard Topic	Assessment
C32	Patients are assured of appropriately competed health records	Standard almost 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	Acute Hospital Standards	Assessment
A1	Patients receive clear information about their treatment	Standard met
A2	Patients are not mislead by adverts about the hospital and the treatments it provides	Standard met
A3	Patients receive treatment from appropriately trained, qualified and insured medical practitioners	Standard almost met
A4	Medical practitioners who work independently in private practice are competent in the procedures they undertake and the treatment and services they provide	Standard almost met
A5	Patients receive treatment from medical consultants who have the appropriate expertise	Standard almost met
A6	Patients have an appropriately skilled and trained doctor available to them at all times within the hospital	Standard met
A7	Patients receive treatment from appropriately skilled and qualified members of the allied health professionals	Standard met
A8	Patients receive treatment from appropriately qualified and trained staff	Standard met
A9	Health and safety	Standard almost met
A10	Infection control	Standard almost met
A11	Decontamination	Standard almost met
A12	Resuscitation	Standard almost met
A13	Resuscitation equipment	Standard met
A14	Meeting the psychological and social needs of children	Standard met
A15	Staff qualifications, training and availability to meet the needs of children	Standard met
A16	Facilities and equipment to meet the needs of children	Standard almost met
A17	Valid consent of children	Standard met
A18	Meeting children's needs during surgery	Standard met
A19	Pain management for children	Standard met
A20	Transfer of children	Standard met

Number	Acute Hospital Standards	Assessment
A21	Documented procedures for surgery - general	Standard met
A22	Anaesthesia and Recovery	Standard met
A23	Operating Theatres	Standard met
A24	Procedures and Facilities Specific to Dental Treatment under General Anaesthesia Facilities	Standard not inspected
A25	Cardiac Surgery	Standard not inspected
A26	Cosmetic Surgery	Standard met
A27	Day Surgery	Standard met
A28	Transplantation	Standard not inspected
A29	Arrangements for Immediate Critical Care	Standard met
A30	Level 2 or Level 3 Critical Care within the Hospital	Standard not inspected
A31	Published Guidance for the Conduct of Radiology	Standard met
A32	Training and Qualifications of Staff Providing Radiology Services	Standard met
A33	Published guidance for the conduct of radiology	Standard met
A34	Training and qualifications of staff providing radiology services	Standard met
A35	Responsibility for pharmaceutical services	Standard met
A36	Ordering, storage, use and disposal of medicines	Standard met
A37	Administration of medicines	Standard met
A38	Self administration of medicines	Standard met
A39	Medicines management	Standard almost met
A40	Management of Pathology Services	Standard met
A41	Pathology Services Process	Standard met
A42	Quality Control of Pathology services	Standard met
A43	Facilities and Equipment for Pathology Services	Standard not inspected
A44	Chemotherapy	Standard not inspected
A45	Radiotherapy	Standard not inspected

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 met
3 (Part I)	Period for which medical records must be retained	Standard almost 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	Standard not inspected
4 (Part II)	Details to be recorded in respect of a child born at an independent hospital	Standard not inspected

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
C7(2)(4)(5) C 23 (2) A 41 (1)(3)(4) A (33) A 44 (1) (3)(4) C 24 (3) C 25 (2) A36 (3) (7) C17 (1) C16 (1) (3)(4) C 2 1 C 29 (2) A 12(2) (3) C 22 (1) (3) C23(1)(5) A 11 (5) C 19 (4) C23 (3) A 7 (3) C 27(1) A 10 (1) C 4 (1)	Regulation 8 (1)(3)(4)	**Findings:** Many policies require review and updating as outlined **Action Required** The registered person is required to review and update policies for all operational areas and ensure that these are placed in an accessible position.	To make available interim guidance that clarifies the fact that Sancta Maria Hospital will use their un-reviewed policies and procedures until reviewed and that the policies as will be updated by the 25 February 2010 (Completed)

Standard	Regulation	Requirement	Time scale
C 24 (5)) C 24 (4) C34 (1) A 15 (1) A19 (1) A20 (1) A 21 (1) C 14 (2)			
C3(1)(2)	Regulation 14(b)	**Findings:** File of consultant clinical preferences with no clear evidence base. **Action Required:** The registered person is required to The Consultants preferences for care will be matched against evidence, typed and signed and kept in a central folder accessible to clinical staff.	15 January 2010
C22	Regulation 14(2)(a)(b)	**Findings:** Spillage kit insufficiently stored, labelled and maintained. **Action Required:** The registered person is required to ensure that the Spillage kit is boxed, clearly labelled and easily accessible	19 December 2009 (Completed)
C23 & A9	Regulation 24(2)(a)(b)	**Findings:** Some storage areas a health and safety risk. **Action required:** Storage areas need review to ensure that they comply with protecting the health and safety of staff in particular the cupboard fro mattresses and physiotherapy equipment storage space.	24 December 2009 (Completed)

Standard	Regulation	Requirement	Time scale
C31 (5) (6) C 32 (1)(2) (3) (4)(5)	Regulation 20(1)(a)(i)(ii)	**Findings:** No record of patient visit to outpatient and treatment plan available. **Action required**: There needs to be a copy of the patient's record of outpatient treatment kept in the patient's notes and accessible to Sancta Maria staff.	Immediate and Ongoing (Completed March 2010)
C9 (6)(7) C11 (2) A3, 4 & 5	Regulation 17(20(a)	**Findings:** Consultant appraisal and CPD unavailable. **Action required:** Consultants will be contacted to clarify and obtain signatures that they are not prohibited from any areas of practice and that they are up to date with their continuing professional development.	15 January 2010.

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
C1	It was recommended that the information leaflets required the statement of 'This information is available in other languages and formats on request' to be added. **HIW informed by responsible individual that signage has been posted informing patients and visitors of availability of information.**
A1	Add statement to children's information leaflets that information will be provided in other languages and formats on request. **HIW informed by responsible individual that signage has been posted informing patients and visitors of availability of information.**
A16	Improvement of environment of care in waiting areas, consulting rooms and phlebotomy room by providing books, artwork and distraction materials. **HIW informed by responsible individual that this has now been actioned and completed.**
C22	Provide signage in relation to hot beverages and supervision of children. Secure low level windows in Inpatient Ward Room 4. **Actioned by staff on the day of inspection.**