Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
Sancta Maria Hospital
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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Sancta Maria Hospital as part of its programme of assurance work.

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

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

We spoke to the Hospital Manager (Registered Manager) on 17 August 2020 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

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

COVID-19 arrangements

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

The following positive evidence was received:

We were told that at the peak of the pandemic, beds were reduced from 20 to 14 beds. Two bedrooms were decommissioned and were used as IPC Stations. Additionally, the hospital

ensured that there were adequate hand washing facilities for staff and areas where staff could don and doff PPE.

Access to the building was controlled and the doors were locked, any admissions to the premises were controlled by staff. When the patient arrived at the hospital a risk assessment was undertaken, including a temperature check and confirmation of being asymptomatic of signs and symptoms of COVID.

Management stated that all staff and visitors were signposted to hand sanitising points on entry/exit to the hospital. There were posters, visual displays and government videos which were used for staff training.

We were advised that the waiting area was redesigned to enable 50% less occupancy and to enable the maintenance of the two metre social distance. Additional hand sanitiser points and staff changing facilities were provided. A dedicated room was also identified for use should a patient become unwell with COVID symptoms.

Staff stated that cleaning schedules had increased. This was not considered as challenging, once the flow of patients was managed.

We were told that there were screens placed in reception and where staff meet to limit the spread of COVID. There were limits placed on internal meetings and the manager believed that staff were disciplined about that and what worked for the hospital. In addition to developing the new ways of working, management also said there was also a need to retrain staff, when they returned from furlough, to these practices.

The registered manager stated that the hospital established a virtual COVID Hub, which included a shared folder to ensure quick and prompt access to a range of resources, data, actions and decisions. The Hub displayed and/or signposted the team to any information they might need. This included details regarding staff on site, or self-isolating, shielding and details of key contacts. Patient pathways were developed and these were also available on the hospital information technology system.

The types of surgery carried out at the hospital were limited to below the clavicle and there was no joint surgery carried out in July, we were told this was to reduce the possibility of infection. Additionally, the hospital attempted to limit the surgeries carried out, to patients who would not require an overnight stay.

The arrangements that were in place to support the wellbeing of staff during the pandemic were described by the registered manager. These included:

- Human Resources called all staff who were shielding, furloughed or working from home on a weekly basis

- Emails were sent to all staff to keep them updated on the hospital
- Daily team meetings were held at 9am, these took place in the hospital grounds when conditions allowed
- The register manager regularly walked around the hospital to talk and listen to staff and patients, any issues were then followed up, as necessary.

No areas for improvement were identified.

Environment

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

The following positive evidence was received:

We were told that risk assessments were undertaken to identify specific equipment needs. Additionally the hospital stores team monitored all consumable stock and were alerted to any shortfalls promptly. Standalone oxygen was also placed in all bedrooms.

Management stated that the hospital design made it difficult for one access and a separate egress point. Therefore, patients and visitors were asked to arrive on time, tested and then escorted to the waiting room, which was limited to four people. The registered manager stated that he visited the waiting room and talked to patients, to explain that in addition to patients being tested, all staff were also being tested and that there was increased cleaning throughout the hospital.

Due to the inability to have a one way system between the theatres and ward, we were told that when patients were to be transferred, outpatients were informed and the relevant doors closed to eliminate the risk of passing other members of staff.

We were told that whilst there was the opportunity for patients to exercise outside in the gardens, the use of this facility was discouraged and also the patient stay was generally short. Each room had en-suite facilities, to give the patients privacy. The manager believed that the ethos and culture was good in the hospital and this was shown in the patient feedback received.

Evidence supplied on patient feedback, showed that the “Friends and Family test”, that asks patients if they would recommend the service and offers a range of responses, was used and 95% of patients would recommend the service. (The last full patient feedback was December 2019). We were told that during August 2020, there has been some reinstatement of services

and further feedback will be obtained. All feedback is monitored for trends and themes. All positive and negative feedback was shared with the staff for reflection and learning.

No areas for improvement were identified.

Infection prevention and control

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

The following positive evidence was received:

The registered manager stated that obtaining PPE was a challenge at the start of the pandemic. Failure rates were significant, but stocks were quickly obtained to an acceptable level. A FIT testing system was hired that test checks whether a respirator properly fits the face of someone who wears it. The fitting characteristic of a respirator is the ability of the mask to separate a worker's respiratory system from ambient air. Inventory was checked weekly and daily calls were initially made (now twice weekly) with other hospitals and nursing homes in the group to ensure an equitable supply between the various locations.

We were told that in anticipation of admitting and caring for COVID patients in Sancta Maria Hospital, a week of relevant training was organised in-house. The topics included: basic life support, end of life care, airway management, IPC and PPE. Any updates to guidance from Public Health Wales and NICE was made known to staff through regular meetings and the COVID Hub.

We saw evidence of the IPC Policy and Principles that had been recently updated. The hospital were also in the process of drafting “A Clinical Guide for Preparedness for a Second Peak of Coronavirus 19 Infection”.

We also saw evidence of current infection rates being at 0%. This included urinary tract infections following catheterisations (a procedure used to drain the bladder and collect urine), healthcare associated infections and reported incidents. Evidence of the IPC audits, including hand hygiene, were also seen, with 100% compliance reported.

No areas for improvement were identified.

Governance

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

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

The following positive evidence was received:

We were told that staffing levels were planned in advance based on patient acuity, to maintain the quality of the service and professional judgement. This was done in addition to the minimum staff numbers required, based on patients on the ward. Also, there was a resident medical officer on site 24 hours a day and the ward manager had supernumerary status, meaning that they were not included in the staff numbers but were available for patient care if required.

Unplanned absence was risk assessed and covered by bank staff or by moving staff as required throughout the hospital. Should there be insufficient staff on the ward to manage any future patients following surgery, then the procedure would be cancelled. There were also weekly meetings to discuss patient volume, bed occupancy and staffing.

We saw evidence that staff compliance with mandatory training, throughout the hospital, was at 94%, the ward staff compliance was 100%. We were told that in addition to mandatory training, professional development was supported through ward based skill drills training, eLearning and external training programmes. Also, as described above, a training programme was developed in anticipation of receiving COVID patients, which had 100% attendance.

Performance and development annual review levels for the ward were 100%. The registered manager believed that staff support supervision was good and had improved over the last couple of years. The registered manager also said that there is now a culture where staff can raise concerns and there is access available to senior management. An external organisation was sub-contracted for staff to have access to mental health, legal, stress, anxiety and other concerns.

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

We saw evidence of the quarterly reports of all incidents that were presented to the hospital senior management and organisational management meetings. Any trends and themes were discussed at these meetings. The most recent theme was late COVID test result. As a result, we were told that the hospital was in the process of obtaining a one hour point of care testing system, to ensure that results are obtained almost instantly.

The evidence supplied showed that the organisations' Chief Executive Officer (also nominated responsible individual) visited the hospital, prior to COVID, at least every two months, and

issued a report to the Board of Trustees as required. Since the pandemic there have been regular virtual meetings and phone calls with management and staff.

We were told and saw evidence of the process in place to provide a medical practitioner with practising privileges. This included the evidence that the hospital requires, and the checks undertaken, before an individual is given practising privileges. These included medical checks, professional registration checks and proof of indemnity insurance. There was on-going monitoring of the medical practitioner by means of appraisals and reviews. During the COVID period, we were told that several new medical practitioners used the surgical facilities at the premises for specific procedures, such as biopsies (a sample of tissue taken from the body in order to examine it more closely) on behalf of the NHS who contracted them to work. We were told that the hospital used a shortened version of the normal requirements to practice at the hospital. The consultants concerned were all employed by the local NHS health board

We were also told that there had been no loss of time, by staff, due to COVID related illness.

The hospital is due to move from its current premises to a new purpose built facility at the beginning of 2021.

No areas for improvement were identified.

What next?

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

Where an improvement plan is required, it should:

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

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

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

Improvement plan

Setting: Sancta Maria Hospital

Ward/Department/Service (delete as appropriate): Sancta Maria Hospital

Date of activity: 17 August 2020

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

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

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	No improvements identified.				

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

Name: Geoff Bailey, Registered Manager

Date: 26 August 2020