Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Healthcare Inspection Report (Unannounced)

St Joseph's Independent Hospital Limited, Newport

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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 St Joseph's Independent Hospital, on 15 and 16 August 2023. The following hospital wards were reviewed during this inspection:

- St Patrick's Ward – 15 post-operative beds
- St Andrews's Ward – 8 post-operative bed
- Day Surgical Unit - 7 rooms and 4, day surgical chairs

Our team, for the inspection comprised of one HIW Senior Healthcare Inspectors, two clinical peer reviewers and one patient experience reviewer. 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 57 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:
All patients who completed a questionnaire rated the care and service provided by the hospital as very good. Patients appeared to be comfortable and cared for in a professional and dignified manner. There were good processes in place to enable patient to provide their views on the care they had received at the hospital.

Patients and their relatives or carers were treated with dignity and respect.

The 'Freedom to Speak up' initiative, which was a confidential service that offered staff an alternative way of voicing matters which they did not feel they could raise through conventional reporting lines was working well.

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
- 'Freedom to Speak Up' initiative.

Delivery of Safe and Effective Care

Overall summary:
There were suitable procedures in place for the safe management of medicines. The hospital was clean and tidy with a number of new innovative changes made recently to the set-up of the hospital.

Appropriate protocols were in place to manage risk and health and safety. Emergency resuscitation equipment was available throughout the hospital in various areas. However, some of these had not been checked daily as required. This was dealt with by our non-compliance notice process.

The facilities were fit for purpose with ample storage available. The environment was clutter free with no trip hazards noted and environmental hazards had been considered in all areas of the hospital.

Staff understanding of certain processes was mixed, this included infection prevention and control and management of a deteriorating patient. This led to a

non-compliance notice being issued, which was dealt with under HIW's non-compliance notice process.

That being said the standard of housekeeping was very good.

Immediate assurances:

- Emergency resuscitation trolleys not being checked on a daily basis
- Management of deteriorating patient.

This is what we recommend the service can improve

- Staff knowledge of various areas of infection prevention and control
- Risk assessment of patients being transferred to other hospitals.

This is what the service did well:

- The standard of housekeeping
- Overall facilities at the hospital
- The gift bag given to patients in the ward contained hand gel which encouraged patients to decontaminate their hands.

Quality of Management and Leadership

Overall summary:
Robust management and governance arrangements were in place at the hospital. This included the management and leadership for the senior management and the layers of control exercised by the various committees at the hospital.

There were sufficient numbers of appropriately trained and skilled staff at the hospital to provide safe and effective care. Staff compliance with mandatory training was high.

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 all patients agreed the service received was 'very good'. Patient comments included the following:

> *"Outpatient staff were all professional."*
>
> *"Absolutely brilliant."*

Staff Feedback -

HIW issued a questionnaire to obtain staff views on the care at St Joseph's Hospital (the hospital) for the inspection in August 2023. In total, we received 57 responses from staff at this setting. Some questions were skipped by some respondents, meaning not all questions had 57 responses.

The response to the staff survey was generally positive. All bar two staff that responded were satisfied with the quality of care and support provided to patients and would recommend the setting as a place to work.

Some comments received from the staff at St Joseph's Hospital include:

> *"Overall St Joseph's is a great hospital to work in. From my experience we provide excellent patient care and I am very proud of that. I feel very well supported by senior management. I do feel communication within the hospital could be improved as information is not often trickled down from senior management to the patient facing staff unless we are directly told face to face by senior management ourselves, often finding out about changes long after they have happened. The department I work in also does not receive patient feedback, which is unfortunate as it is vital to know where we are doing well and where we could improve. I also feel training*

should be offered to staff via email rather than going through a manager as often we are not informed of any training on offer"

"[The] Company has looked after staff effectively with salary increases in line with cost of living increase and a number of other perks"

"St Joseph's Hospital is a lovely place to work."

We asked what could be done to improve the service. Comments included the following:

"SJH staff work well as a team. Staff get complemented on how happy, helpful and professional they are and this is reflected on our feedback cards, nothing appears to be too much trouble for any of them. Personally, I feel quite privileged to be a part of such a wonderful caring team.

"On the odd occasion we do have negative feedback, it is acted upon quickly and measures are put in place to rectify this.

"Having unannounced visits from HIW is a good thing, as we all want the best nursing care when we have to use these services. Not only that there is always room for improvement wherever we go."

Health promotion, protection and improvement
Information was displayed on how patients could help their health and wellbeing. This related to protecting themselves from infection by washing their hands as well as information on sepsis. There was also information in the patient waiting areas in outpatients and on the wards. Additionally, there was health related information on the paper mats on the food trays in patients' rooms. 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.

All patients who completed questionnaires confirmed that they had been given aftercare instructions on how to prevent infection and aid healing and guidance on how to check themselves for signs and symptoms of infection. Only two patients answered the questions on whether they were given instructions and what to do and who to contact in the event of an infection or emergency, one agreed with the statement and one disagreed.

Dignity and respect
Staff were noted to be speaking to patients with dignity and respect, in a discreet, sensitive and courteous manner. Patients we spoke with said that they were treated respectfully and described staff as kind and compassionate. Patients also said that staff were considerate and respected their needs.

All staff wore name badges and appeared to have built relationships with patients through ongoing care and treatment.

Patients had individual bedrooms with ensuite facilities, therefore privacy was naturally protected. We noted that staff always closed the doors to patients' room before holding personal discussions or completing treatment with the patients. Patients confirmed this was a regular occurrence and were satisfied that they were always treated discreetly.

Staff we spoke with said that if the patients' room door was closed, then staff considered that the patient was receiving treatment, or they did not want to be disturbed and staff always approached closed doors with this in mind. There were no issues that would affect patient dignity identified. All patients appear well cared for, all were observed to be well groomed and dressed, with the majority wearing their own clothes, or hospital gowns if recently back from surgery.

All patients who completed a questionnaire agreed with our observations that staff treated them with dignity and respect and that measures were taken to protect their privacy. All patients also agreed that staff were kind and sensitive when they carried out care and that staff helped them with toilet needs in a sensitive way. Almost all patients agreed that the patients' privacy and dignity is maintained.

Patient information and consent
All patients who completed questionnaires told us that they were provided with enough information to understand which treatment options were available to them and the risks and benefits of each. All patients also agreed that before receiving treatment, the cost was made clear to them and that they signed a consent form.

All patients stated that staff explained what they were doing throughout, and that staff listened to them and answered their questions. Patients who completed the questionnaire all agreed that they were involved as much as they wanted in making decisions about their healthcare.

Communicating effectively
There were two Welsh speaking staff at the hospital and senior staff we spoke with said that very few patients who spoke Welsh attended the hospital. If they needed translators and the Welsh speakers were not available, they could access a

translation service. In addition, there were staff working at the hospital who spoke other languages including Spanish, Portuguese and Greek. The hospital was trying to encourage staff to learn and speak Welsh, including by publicising a word of the day and there was also a pronunciation chart of the Welsh alphabet that had been sent round to staff. Staff we spoke with said that any patients with any language requirements would be identified at the pre-admission stage.

We noted that patients were able to contact the service by telephone and that the hospital would send out information by post as well as contacting the patients by telephone or online by email.

A hearing loop was available for staff to use when patients were hard of hearing there were also braille signs, pictorial signs as well as clocks that were in a digital format and the numbers were large. There was clear information for patients and relatives to signpost relatives and carers to and from the ward or relevant area.

There was information displayed, similar to a 'who's who' board in the day surgical unit and we were told that the notice board would be installed in the ward area once the renovations to the outside of the ward were completed.

Patients we spoke with said that they were provided with treatment and care information pre-operatively and were given the opportunity to ask questions.

All the patients who answered the questionnaire said that their preferred language was English.

Care planning and provision

During the inspection we noted that staff responded promptly when a patient pressed the buzzer, requesting help. Patients we spoke with advised that staff answered the buzzer calls promptly and that staff attend to their requests, needs and care requirements promptly and without delay. All patients who completed questionnaires agreed they had access to a buzzer and that staff came to them when they had used their buzzer.

We also noted that the ward was well staffed at the time of the inspection, there was no evidence of any delayed interventions. Staff confidently stated that they had the time to care for patients. However, on speaking with patients they said there was rarely contact on a regular basis between everyone. Two patients we spoke with were delighted to have someone to speak with and stated that they were dependent on housekeeping or physiotherapist to pass the time during the day.

Staff were well versed with access to the shared drive and the content including the location of the relevant clinical policies and procedures. The healthcare assistants (HCAs) appeared to be providing the foundation of nursing care for all patients. This included phlebotomy, bladder scanning, clinical vital sign recording and providing personal hygiene. We also noted that agency nurses we spoke with were not familiar with access to policy and procedures.

There were initiatives in place to assist staff to care for patients with additional needs, sensory problems, or cognitive difficulties. Patient independence was promoted, and patients were seen sitting in chairs post-operatively.

Almost all staff who completed the questionnaire said that they would be happy with the standard of care provided by this organisation for myself or friends/ family. All staff said that they felt that patients or their relatives were involved in decisions about their care.

Equality, diversity and human rights

There were in date policies in place on harassment and dignity at work, as well as a policy on equal opportunities. The policies included a date due review and the name of the person and department responsible. We also noted a 'Freedom to Speak up' initiative, which was a confidential service that offered staff an alternative way of voicing matters they did not feel they could raise through conventional reporting lines. Management at the hospital received a summary of the concerns, outcomes and learnings. There were posters on display of the relevant staff involved in this initiative as well as being advertised on the intranet. The staff concerned wore a name badge with the green background to differentiate them from other staff badges. We were told that new staff received a welcome email about the initiative.

There were two mandatory internal training courses that staff could attend relating to equality and diversity (E&D), Managing E&D for managers 88% compliance and the importance of E&D and inclusion for all staff at 94%. The hospital had level access, or ramps where there was not level access, with lowered kerbs at various points. There was also disabled parking near the entrance to the hospital as well as wheelchairs for patients to use and a lift to the first-floor wards and theatres. Additionally, for patients undergoing cataract surgery, all instructions were in larger print. Another part of the pre-assessment would identify information such as sight or hearing difficulties as well as asking the patient their preferred name and how they wished to be addressed. We were told that during COVID-19, the Royal National Institute for Deaf People, held an awareness session for staff, including the importance of see-through masks.

All patients who completed the questionnaire 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.

Citizen engagement and feedback

There was clear information displayed in all areas of the hospital about how patients and families could provide feedback about their care. This included feedback forms, barcodes and information cards. There was also clear signage for patients encouraging them to ask for chaperones. We also saw information booklets that encouraged patients to use the offers of chaperones, as well as providing details on how to raise complaints. Additionally, the complaint leaflets were available in all outpatient areas and on table mats in the patients' rooms.

All bar one member of staff said that patient experience feedback was collected within their organisation and 88% said that they received regular updates on patient experience feedback. However, whilst 79% said that feedback from patients used to make informed decisions within your organisation, the other 21% said they did not know.

Delivery of Safe and Effective Care

Managing risk and health and safety
The hospital had a number of different buildings and areas that offered a variety of settings in a quiet and well-maintained setting. The various areas of the hospital looked fresh and bright and thought had been put into a number of the changes introduced to the hospital, including the Day Surgery Unit.

The wards and all departments at the hospital were easy to find with all areas of the hospital being fully accessible to patients or visitors with mobility difficulties. There were also drop off bays outside the main reception. The majority of the outside areas were level. Mobility aids were observed throughout the hospital, both being used by patients and in stock available, when needed.

The environment was clean and in a good state of repair, including furniture, fixtures and fittings. The facilities were fit for purpose with ample storage available and therefore all equipment and items were stored away from busy/ accessible areas. The environment was clutter free with no trip hazards noted. We noted that environmental hazards had been considered in all areas of the hospital.

There was a risk register in place, with the risks recorded. The numbers of risks were also recorded in the hospital dashboard and were presented to the quality and safety meeting.

Patients we spoke with reported that the ward was regularly cleaned by housekeeping and they were satisfied with the environment. Patients stated that having an individual room made them feel comfortable and allowed them to relax and recover. A total of five of the seven patients in the questionnaire said the building was accessible (ie wheelchair friendly, facilities for visual or listening impairments) the other two were not sure.

We found inconsistent daily checks of the emergency resuscitation trolleys located on the two wards at the hospital. This included:

- St Patricks Ward – During July and August 2023 daily checks on emergency resuscitation secure tags (to show that the contents were secure) were not evidenced as having been completed.

- St Andrews Ward – Daily checks not evidenced as being completed (or the record was not marked that the ward was closed) on the following number of occasions in the months listed:

- April 2023 – Five days
- June 2023 – Five days
- August 2023 up to and including the 15 August 2023 – 12 days.

This indicated an on-going failure by the provider to robustly ensure that resuscitation trollies were checked and maintained in line with local and national guidelines. Monthly checks were signed as being carried out but there was no evidence that these monthly checks had resulted in any improvement on the daily checks. This was dealt with under HIW's non-compliance process.

There were transfers of patients to another hospital for escalated care noted which we consider could be improved. Patients were transferred with a paramedic crew (when available) only, the ward nurse did not escort the patient but provided a handover over the phone to the receiving department. In order to continue to provide the duty of care to the patient a nurse should accompany the patient to the receiving hospital. We were told that an anaesthetist and assistants would be sent when required and we were provided with copies of the hospital's deteriorating patient policy.

The registered provider is to ensure that staff are reminded that a documented risk assessment is carried out on every transfer of a deteriorating patient or a patient requiring escalated care. Where a qualified ambulance crew is not available a qualified member of staff should accompany the patient to the receiving hospital.

Complex patients would be discussed in the weekly theatre planning meeting where they carried out the scheduling. We were told that during the pre-operative assessment process, complex patients would be referred to the list anaesthetist and surgeon via email. The pre-operative assessment team would then wait for a response and take appropriate action, including referring the patient back to their general practitioner (GP) for a review. The patient would be listed for surgery whilst the background checks were ongoing. If needed the anaesthetist would see the patient personally with the outcomes recorded in the patients notes. There was a pre-operative assessment outcome part in the pathway but there was evidence in one complex case that this was not completed. This was identified to the pre-operative assessment lead, who said they would look into this.

The registered provider is to ensure that all investigations and results are recorded in the patients' medical notes.

We saw the pre-admission policy, which was under review with exclusion criteria that was being managed by the Assistant Director of Clinical Services with a

working party including consultants. We considered the content of this document to be robust.

There have been 21 occasions over the 16-month period (from 1 April 2022 to 31 July 2023) where HIW had been notified of a serious injury to patients at the hospital as required by Regulation 31 (1) (b) of the Independent Health Care (Wales) Regulations 2011. We examined the medical records of two of these notifications and noted that the root cause analysis and lessons learned of both these incidents indicated that there were issues with the scoring accuracy, frequency and escalation of the National Early Warning Score (NEWS), the system to standardise the assessment and response to acute illness. Additionally, the NEWS charts, which were being completed by HCAs, needed to be reviewed and signed as checked by a member of staff who was a Nursing and Midwifery Council (NMC) registered nurse.

During our check of patient medical records for current in-patients, we noted that for two patients, who needed close monitoring, there was incorrect NEWS scoring and gaps in the charts on these two patients from midnight to 6am and other entries were illegible. This was consistent with the root cause analysis referred to above. Additionally, the records were not signed off by an NMC registered nurse.

We also noted that two of the HCAs that we spoke with had not been trained in NEWS. Whilst training had been arranged, not all staff had attended this training.

Additionally, we noted that the Blood Bank Policy included a major haemorrhage process, but the one-page major haemorrhage process was not visible in the clinical areas which should also show the telephone number to be called. The telephone numbers in the policy refer to the Royal Gwent Hospital, whilst the blood products are now obtained from the Grange University Hospital. These issues were dealt with under HIW's non-compliance process.

These incidents and the notifiable events suggest that staff are not learning from adverse or untoward events. This would suggest a detachment between ward management and nursing staff. This was discussed with senior management and we were shown a plan which had been drawn up to address this issue which would be implemented on the return from annual leave.

The registered provider is to provide HIW with the actions taken to address the issues relating to the potential detachment between ward management and nursing staff.

We were told that a NEWS audit was completed monthly and there had been a recognition of deteriorating patient study day for staff from the ward completed at

the end of July 2023. Feedback from this study day was good and staff were asked how they were going to take one thing from the training and put into practice.

Infection prevention and control (IPC) and decontamination
Hand hygiene within the ward environment was expected to be carried out within the patient's room, with additional sinks with hands free taps installed for this purpose. All cleaning equipment used by housekeeping was kept within a locked cupboard and the keys held within a key safe. Additionally, the equipment in the sluice and cleaners' cupboards was stored and organised appropriately, with segregation of cleaning equipment. We also noted a good range of equipment and cleaning products to aid IPC.

The cleaning schedules and arrangements were discussed with the ward housekeeper. We consider the standard of housekeeping to be very good. Whilst it appeared that during their fallow, or quiet periods that wards and rooms were initially cleaned and then left empty for a period of time, sometimes several days, we were assured that there would be a damp clean within 24 hours.

As all rooms were single rooms with no patient shared areas this assisted the ability to maintain IPC and to keep any infectious patients in isolation. We were also told that patients would be screened for Methicillin-resistant Staphylococcus aureus (MRSA) before admission. The microbiologist would be contacted about any patients who were not free of MRSA, they would prescribe antibiotics as necessary and would be last on the theatre list and also, they would be barrier nursed.

We were told that infection rates were monitored with regular audits held on the shared drive. However, staff we spoke with said that they were not given regular feedback on these audits. Additionally, there was a member of staff who acted as the infection control nurse.

The registered provider is to ensure that the results of audits are both made known to staff and the results are clearly displayed in staff areas.

Staff we spoke with were aware of the importance of IPC and they knew where to find the policy on the shared drive, which they accessed when needed. Hand hygiene was described correctly by staff we spoke with, but two members of staff when asked about needle stick injuries required some prompting.

The registered provider is to ensure that staff are reminded of the actions to take when there are needle stick injuries.

The HCAs we spoke with spoke confidently on decontamination of equipment. We noted that the commodes in the sluice in the ward area did not have stickers

attached to indicate that the equipment was clean. Additionally, the infusion pumps did not have cleaned stickers attached, we were told this was because clean equipment is kept in a separate area from dirty equipment.

The registered provider is to ensure that cleaned equipment, particularly commodes, are clearly marked as 'Clean'.

During our inspection we also noticed staff in the canteen wearing scrubs, masks and visors. We were told that members of staff were allowed to wear scrubs to the canteen but that the other items of clothing or equipment had to be removed.

The registered provider is to ensure that staff are reminded of the hospital dress policy.

We consider the gift bag given to patient to be an area of good practice as it contained hand gel which encourages patients to decontaminate their hands. We saw evidence that hand hygiene scores were generally 100%, where scores were lower than 95%, there needs to be an action plan and actions taken. These scores would also be reported to the hospital clinical governance meetings.

The hospital had various documented and in date policies on decontamination of medical devices and equipment. The medical and non-medical equipment policy includes decontamination, maintenance and faulty equipment. There was also a legionella policy and a number of infection control policies.

Sharps' boxes were clearly marked and kept closed. All sharps' boxes had used syringes within and some had been put together as far back as April. Ideally these would be used in a different environment to use the box and dispose of sooner for infection control purposes. Safer sharp devices were seen to be used. All sharps' bins were closed when not in use and included a date when assembled. However, some bins had been in use for some months containing soiled syringes. Good practice would suggest that sharps' bins not used for a while but have soiled products within would be used in a different area to fill and not delay any further.

The registered provider is to ensure that sharps' bins are regularly rotated when not regularly used, not overfilled and disposed of promptly.

All patients who answered the questionnaire considered that the setting was very clean and that IPC measures were being followed. The scores from staff in the questionnaires were also positive across IPC areas, most respondents stated that the organisation implements an effective infection control policy. All staff felt that appropriate PPE was supplied and used. All bar one member of staff agreed that

there was an effective cleaning schedule in place and all staff said that the environment allowed for effective infection control.

Nutrition
Patients were observed to always have a jug of water and a glass in front of them that was regularly filled by staff. Water was always within easy reach and typically on the bedside table or meal tray that could be moved closer to the patient when required. The patients we spoke with during the inspection told us that staff had encouraged them to call for more water and hot drinks whenever needed.

Patients could choose if they wanted to sit in the room chair or stay in bed for their meal, but staff always ensured that patients were sat up before their meal tray was loaded. Patients confirmed this was a regular occurrence. Patients were provided with wet wipes with their food and actively encouraged to wipe their hands before and after eating. We noted during the inspection that patients were given the help they needed to eat and drink. All meals were served to patients in a timely way once the food trolley arrived. All patients were assessed for nutrition scores and meal menu choices were given to patients. All diets were catered for, and this information was gathered at the pre-admission stage. Patients we spoke with said that they were able to make small adaptations such as requesting mash instead of chips.

The food looked appetising, appeared to be hot and portion sizes looked reasonable. Patients we spoke with stated that they were very happy with the food, drink and catering service offered at the hospital and that their needs were always met. Patients who completed the questionnaires agreed that they were given time to eat at their own pace and that staff helped them to eat and/or drink if they need assistance. All patients who answered the questionnaire said they always had access to water on the ward.

Medicines management
Overall, we noted that there were good, effective medicines management in place. Medication administration was recorded consistently and contemporaneously. Most patients were daycare and therefore there was a minimal requirement for medicine administration. Dates and signatures were seen on the charts, although due to poor handwriting it was difficult to decipher some of the drugs listed.

There was a policy in place for the self-administration of medications which was available on the shared drive, both new staff and agency staff had access to this drive. Staff were also aware of the policy for the management of adverse reactions which ensured the reporting of all adverse drug reactions to the Medicines and Healthcare products Regulatory Agency (MHRA) Yellow Card Scheme.

The drugs round was witnessed during our inspection and we noted the safe storage, prescription, administration and dispensing of drugs. We also noted a Perspex locked box in each room for patients who were self-medicating, which also meant that when a patient left the ward, any medication left could be easily seen.

Medications were stored safely, securely and continually at the required temperature behind a locked door in a locked cupboard. There was good documentation in place for the management of controlled drugs, which were recorded, checked and stored appropriately and securely.

The management of the pharmacy was also considered to be very good with a robust take home system in place for out of hours requirements. There were three monthly pharmacy audits on class two drugs in the theatre, ward and endoscopy.

The medication fridge temperatures recorded were noted as being below the required range of two to eight degrees. This may be due to the thermometer needing recalibration which needs to be addressed.

The registered provider is to ensure that the temperature of the fridge remains within the required range and that the thermometer is recalibrated regularly.

We also noted that the eye wash available was out of date on the ward on the first day of the inspection and despite informing staff of this, it was still out of date on day two.

The registered provider is to ensure that all out of date, drugs, equipment and ancillary items are removed from use and replaced.

Safeguarding children and safeguarding vulnerable adults
All patients we spoke with reported feeling safe and comfortable within the hospital. Patients advised us that they were encouraged to raise concerns and felt that staff would address any issues they might have.

Staff we spoke with understood the requirements of the Deprivation of Liberty Safeguards (DoLS), mental capacity and safeguarding. Staff also had access to the All-Wales Safeguarding application for up-to-date information on safeguarding. There were no patients on the ward who were subject to DoLS at the time of the inspection and staff we spoke with said that they did not routinely admit patients subject to DoLS. One member of staff in particular who we spoke with was very knowledgeable on DoLS, dementia and areas of safeguarding.

We were told that there had been two instances recently where staff had identified two potential issues relating to safeguarding that had been reported. Support was received from the local authority social services. Senior staff said that they were in the process of arranging a talk from the local authority on safeguarding.

From a check of the training records there was 90% compliance with safeguarding training to the required level, with four members of staff being trained to level three. These four members of staff were the hospital safeguarding leads.

Senior staff we spoke with said that they were notified of any changes to safeguarding legislation and the implications for staff. These would be passed onto staff. There was a safeguarding people policy which was in date and which staff had access to. Staff were also aware of the actions to take regarding mental capacity and the advocacy arrangements in place. We were told that anything identified at the pre-operative assessment would be highlighted and there would be a multi-disciplinary team best interest meeting held.

Medical devices, equipment and diagnostic systems
There appeared to be sufficient equipment for the needs of the service at the hospital which was appropriate for its intended use and the environment in which it was used. All staff were responsible for cleaning equipment after use and an external contract was in place for equipment maintenance. Staff were aware that the ward clerk had responsibility for reporting the device to the company for repair. All equipment checked was marked with the date of the testing with additional documentation held by the ward clerk and ward manager.

Safe and clinically effective care
There was evidence of audit activity being regularly undertaken and the results published on the hospital dashboard and to the health and safety committee.

Staff we spoke with said that the results were made known to them by a variety of means. We reviewed the results of these audits including the June environment audit and cataract audit. We were told that as a result of this audit work, a new dual profile (booklet) was introduced. This included relevant information such as covering pre-assessment, screening, consultant and admission documents, take home medications and consent as well as checklists and post operative plans in one document. Previously this information was in a single pathway booklet but was now in a dual pathway document to cover both visits.

In order to reduce the amount of time spent in the outpatient clinic for patients rather than bring a large cohort of patients in at one time, patients were now brought in, in pairs, every 30 minutes from 7am.

Whilst staff we spoke with were aware of the clinical guidelines associated with their area of practice, in particular relating to patient deterioration, the number and detail of adverse incidents suggests that practice and lessons learned were quite different.

Patient status at a glance boards were seen on the wards and in the day surgical unit (DSU) as well as the use of handover sheets to communicate information.

There were Temperature, Infection, Mental decline, Extremely Ill (T.I.M.E.) charts seen on the wall in each department to raise awareness of sepsis. To aid staff in identifying possible cases of sepsis, NEWS scores and news charts were used. Staff we spoke with were not able to confirm there were sepsis processes and policies in place. They stated there had been a hospital training day, but there were no flow charts or sepsis bundles used. Staff were able to recall the sepsis six. Staff training records showed 96% compliance with sepsis training.

The registered provider is to ensure that information relating to Sepsis Six is clearly displayed in all staff areas on the wards and theatres.

The Resident Medical Officer was always available for cases involving escalation in care. We considered that staff did not seem confident in answering emergency situations and had a lack of knowledge on the sepsis process. Staff reported that there had been a hospital training day with mock events. Some staff we spoke with were also unsure if there was a sepsis policy and documentation. However, they stated there was information on the shared drive. Additionally, regarding the major haemorrhage process, staff were unsure whether there was a policy or flow chart. We were told that there had been a gynaecological major haemorrhage and that the patient was packed and transferred out and since then there has been a major haemorrhage pack for gynaecology. Any transfers out to the NHS follow the flow centre information, which is to call the local health board number and then the patient is transferred to the NHS.

The registered provider is to ensure that further training is carried out for relevant staff on sepsis and major haemorrhage protocols.

Staff we spoke with said that they knew how to access the NMC Record Keeping Guidance for Nurses and Midwives and were aware of patient safety notices.

We established that arrangements were in place to ensure Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) discussions had taken place. During pre-admission patients were asked about whether they had a DNACPR, although staff we spoke to were unsure of the process. Patients would be asked to bring in their

documentation. This would be discussed at the theatre weekly meeting and consultants would be aware of whether the arrangements were in place. The DNACPR would not be completed on site, patients would bring their own documentation with them.

We noted the audits of Venous thromboembolism (VTE) on surgical notes, where the hospital had previously identified that they were not doing as well with regard to audit compliance. As a result, during May an audit of 259 sets of notes for 50 consultants was reviewed. Each consultant was sent a letter with the results and agreed a set of actions that would form part of their revalidation.

We found the DSU to be very clean, well-organised and welcoming. All hard areas had stickers indicating when cleaned fully. The emergency trolley was noted as being checked daily and there were clear indicators of when the unit was closed. The seating area for patients was pleasant with the metal pipe work well hidden by innovative shade umbrellas which also protect patients from the bright sunshine through the glass roof. The chairs were also numbered so staff could identify the patients. There was a good selection of information sheets and advice on what to do about any conditions, but available in English only. There was good signage on doors in Welsh and English including braille. The day care theatres were adjacent to the unit and were easily accessed on foot or trolley by patients. There were locked doors to the theatre suite. We noted a good checklist being used for debriefs being used in theatres and there was a good safety system if surgical cases overran.

Patients we spoke with were very satisfied with their care and treatment at the hospital. Patients typically used the words "Excellent" and "Very good" when speaking about their overall care and treatment. Patients advised that they feel safe and well cared for whilst at the hospital.

All patients who completed questionnaires told us that they had completed a medical history form, or had their medical history checked, and signed a consent form before receiving treatment.

Almost all staff who completed the questionnaire said they felt that the care of patients and service users was the organisation's top priority and that overall, they were content with the efforts of the organisation to keep themselves and patients safe.

Participating in quality improvement activities
We were shown the localised, optimally filtered, ultra clean surgical environment piece of equipment which was used to carry out microsurgical procedures and minor surgeries, which the hospital benefitted from being able to use.

One of the rooms on the ward also had overnight facilities for a relative or carer to stay with the patient overnight. An example of the use of this room resulted in a consultant writing a letter of thanks to the hospital for the way the hospital accommodated this patient.

Bloods
We were told that no blood products were held on site, the hospital had to request one unit at a time from the local health board hospital, when required. Patients were cross matched as part of the pre-operative assessment. This poses a risk in the event of a major haemorrhage at the hospital, with no blood products on site. Staff had been trained in blood transfusion, but they were not aware of the major haemorrhage process, or the pathway and they did not know if there was a policy, but if there was one it would be on the shared drive. When we spoke to senior staff, we were told that blood products used to be held on site, but this process was removed by the local health board due to wastage and not using the emergency blood on site. They said they would be given priority when requesting blood in an emergency.

The registered provider is to further negotiate with the local health board for blood products to be kept on site, with an agreement to ensure that there is adequate rotation of these products to minimise wastage.

Records management
Overall, there was evidence of how decisions relating to patient care were made and generally there was good quality in terms of accuracy, being up to date, complete, understandable and contemporaneous. The records were stored securely in compliance with the Data Protection Act 2018 and there was an effective records management system. From the sample of four patient medical records checked, we noted the following:

- No post operative Waterlow score – two instances
- Medications not given but no reason listed – two instances
- Risk assessment not fully completed – one instance
- No NEWS score – two instances
- Compression socks prescribed but not signed by the physician – one instance.

The registered provider is to ensure that patient medical records are completed in full, including all the relevant examinations, risk assessment and narrative to support decisions made duly signed.

Quality of Management and Leadership

Governance and accountability framework
There was a statement of purpose available and this contained all the relevant information in accordance with the Independent Health Care (Wales) Regulations 2011. We discussed the services provided with senior staff and these were in accordance with the statement of purpose. Additionally, the service was compliant with the conditions of registration.

We spoke with senior management about the reported notifiable incidents that had been received by HIW, in relation to serious injury as required by the above regulations. We were told that staff were encouraged to report errors and that the hospital erred on the side of caution in reporting these.

There were clear governance, management and leadership in place. There was a board of directors that oversaw the management and business of the hospital as well as a quality and safety committee with independent members sitting on this committee, in addition to the directors at the hospital. The committee met monthly. There was a clinical governance meeting with all clinical heads of department, which was chaired by the Director of Clinical Services. Senior Management team meetings were held weekly, with the items on the agenda including items on DATIX from the previous week. The hospital also held daily 'nine at nine' meetings, where they discussed any serious incidents, staffing issues and building work. We were provided with minutes for the above meetings which evidenced they were held regularly, with discussions and action points.

These meetings also formed part of the flow of information from management to staff and vice versa. We were told that any patient safety or medication alerts would be sent to the relevant personnel.

In response to questions on the questionnaire regarding their immediate management, staff responses were:

- They asked for their opinion before making decisions that affected their work – 82%
- They could be counted on to help with a difficult task at work – 95%
- Gave clear feedback on their work – 96%.

Regarding senior management responses were

- Senior managers were visible - 96%
- Senior managers were committed to patient care - 95%
- Communication between senior management and staff was effective - 82%.

Staff comments included:

> *"Overall, I'm very happy here and feel supported. Our managers organise regular staff meetings to give us updates and ask for our input on how things are going. Managers also admit they are not perfect and are open to feedback. I'd feel comfortable talking to my manager about anything, but if I didn't there are clear routes via the Freedom to Speak Up service that are always promoted. As a relatively new staff member from the NHS, I'm happy with what I see here."*

Regarding patient care, all bar two respondents felt that they could meet the conflicting demands of their work and most respondents felt there were enough staff to do their job properly (49/57). Comments included:

> *"I think that changes made over the last year have been mostly positive and the patient experience is almost always very good. I disagree with the earlier discharge time of 9.30 and sometimes feel that we are rushing patients out as we have others booked in sometimes for 11.00. Often patients are not ready to discharge at that time for one reason or another and this puts pressure on nurses if patients' lifts have arrived as they were expecting to leave at 9.30 as discussed in preadmission."*

> *"[The] Company has looked after staff effectively with salary increases in line with cost-of-living increase and a number of other perks"*

Dealing with concerns and managing incidents

An in-date copy of the complaints policy was seen, 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 Sector Complaints Adjudication process.

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 staff appeared comfortable using this system. This included the reporting of the incident, identifying the root cause analysis and any lessons learned, discussed at the various meetings above and the lessons learned cascaded to staff.

We were shown the records kept of the complaints made, both closed and current complaints. The record of these was kept on a spreadsheet with the dates that replies were sent and a brief outcome. We were told that the Head of Governance oversaw all complaints and would contact patients and collate the responses. In

addition, all complaints should be logged onto DATIX. There were currently seven open complaints with two over the 20-day resolution limit, but we were given valid reasons for this.

The common themes appeared to be perceived delay in receiving results following investigations and the patient's clinical treatment assessment. We were told that staff were kept up to date with the outcomes of the complaints. Regarding incidents, concerns and safeguarding, staff commented as follows:

- The organisation encouraged them to report errors, near misses or incidents – 98%
- Staff involved were treated fairly – 96%
- The organisation takes action to ensure that errors, near misses or incidents did not reoccur – 100%
- Feedback was given in response to reported errors, near misses or incidents - 93%
- They knew how to report a concern – 100%
- They felt secure raising concerns about unsafe clinical practice 91%
- They felt confident that the organisation would address the concern – 88%.

Comments included:

> *"Reporting of any worries or concern are a strong Priority for St Joseph's as well as feedback on changes implemented as a result of the report"*

Workforce planning, training and organisational development
Staff we spoke with said that the number and skill mix at the of staff was appropriate to meet the needs of the patients. They felt that the staffing was adequate. Staffing rosters also supported this. However, during our inspection we noted an agency nurse on their first shift on a ward with one patient and no permanent member of staff accompanying them.

The registered provider is to ensure that all staff including permanent, locums, bank and agency staff are given a full induction before they work in their specific area.

A total of 86% of staff said there were enough staff working at the hospital to allow them to do their job properly and all staff said they were able to access ICT systems provide good care and support for patients.

We were told that the hospital had recently completed a recruitment drive for ward staff and they had reviewed the establishment based on the forecast of the predicted workload. They had successfully recruited to those numbers.

We were told that there were regular appraisals at the hospital, the percentage compliance currently was an overall total of 71%, of which there was 86% compliance in clinical staff. The heads of department knew that they had to do 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%.

Mandatory training compliance to the hospital was generally good with over 90% compliance in the majority of areas. This included Fire safety 99%, manual handling 90%, First Aid at Work 95% and Immediate Life Support at 95%.

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. Almost all of the respondents said they had an appraisal, annual review or development review in the past 12 months. Comments from respondents on further training they would find useful included Mental Health First Aid, ECG training, Project Management and IT. Specific comments included:

> *"I find that our organisation is extremely proactive in all its practices"*

> *"I am new to the role so still undergoing some training. But so far, all training has been very good, helpful and informative of my role"*

Workforce recruitment and employment practices

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 disclosure barring services (DBS) check and professional indemnity. These were all agreed and signed off by the Chief Executive and Director of Clinical Services. 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.

In relation to permanent members of staff, the process in place to ensure staff were not employed until the relevant documentation and process were followed was described. We checked a sample of five members of staff and found that they

all had the appropriate pre-employment checks, such as reference checks, registration and DBS requirements. In addition, there were relevant up-to-date job descriptions and contracts of employment. We also noted that the terms and conditions of employment stated that the employee had to inform their line manager if anything occurred that would affect their DBS status.

Regarding NMC and allied health professional's revalidation, the records were checked at the start of the month that the registration expired, reminders were sent the next week and then copied to the line manager in the third week to chase the member of staff.

When asked about the organisation, 95% of staff said that they were supportive, 93% said the organisation supported staff to identify and solve problems and 88% said that they took swift action to improve when needed. A total of 79% of staff agreed that they were involved in deciding on changes introduced that affect their work area.

We were told that support and access to occupational health for staff was through a contract with a local independent clinic, who also did the sickness reviews and managed the hepatitis B compliance. Staff were asked a series of questions regarding health and wellbeing at work. Most staff respondents 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. Additionally, 52 out of 57 members of staff agreed that their job was not detrimental to their health and 46 out of 57 were aware of the occupational health support available.

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 resolved during the inspection.			

Appendix B – Immediate improvement plan

Service: St Joseph's Hospital

Date of inspection: 15 and 16 August 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
Resuscitation Trolley Checks The registered provider must ensure that daily and monthly checks of the emergency resuscitation trolley are completed and evidenced in full on the relevant documentation at all times. The registered provider must ensure that compliance audits take place which are reported to the corporate governance quality and safety meetings as applicable.	Regulation 15	The following actions have been undertaken: The resuscitation lead has demonstrated to ward and physiotherapy staff how to undertake the daily and monthly checks The qualified staff within the ward have been allocated the responsibility of completing these checks on the ward. A daily review is being undertaken to ensure compliance. A hospital wide trolley audit tool has been developed and introduced monthly.	Theatre Manager Ward Manager Associate Director of Clinical Services ALS trained member of staff.	Completed Completed Ongoing Ongoing

		With exception reporting to the Director of Clinical Services. The audit results have been added to the corporate quality and safety committee dashboard and discussed in the clinical governance committee as a standing agenda item. As part of our annual practical resuscitation training and scenario exercise updates, both will now include resuscitation trolley checks.	Head of Governance and Quality Theatre Manager	Ongoing Ongoing
Deteriorating Patients The registered provider must ensure that: • All staff involved in NEWS are appropriately trained • Nursing and Midwifery Council (NMC) registered nurse staff countersign the entries	Regulation 31(1)(b)	The following actions have been undertaken: Ward staff have had either 1:1 training and/or e-learning during the last 7 days. A further 2 Detection of the Deteriorating Patient Study days for 2023 have been arranged. Individuals have demonstrated and signed to say they are confident and competent in the completion of the NEWs 2 assessment tool.	Theatre manager and Ward Manager Head Governance and Quality/Ward Manager/ Theatre Manger	Completed Completed 14th October and Date to be confirmed in December 2023

• Regular compliance audits are carried out to ensure the NEWS scores are accurate and the relevant action is carried out as a result of the scores. The results to be reported to the relevant management and action taken as a result of any issues identified • The Blood Bank Policy is updated to reflect the correct supplier of blood products • The major haemorrhage protocol is appropriately displayed on the wards with the relevant telephone number included on the protocol.		Staff who are either on leave or off sick will have updates provided on their return. The NEWs2 assessment tool paper work has been adapted to include a registered nurse signature confirming review. (Attached) The form has been produced in A3 format to aid completion and legibility introduced 24/8/2023. Daily audit of NEWs2 documentation is being undertaken by the Associate Directors of Clinical services and training needs addressed. Spot audits are also being undertaken by the ward management team. The health care assistant's competency workbooks have been enhanced to reinforce NEWs2 documentation and escalation criteria. (Attached) An independent review to confirm learning has been totally embedded into practice is to be undertaken in October 2023.	Associate Director of Clinical Services Associate Director of Clinical Services Associate Director of Clinical Services Independent Reviewer Confirmed.	Completed Completed On- going On-going Completed October 2023

		The results of the audits and review to be reported and discussed at the corporate Quality and Safety Committee, Clinical Governance committee and the ward staff meetings. The Blood Bank policy has been updated to reflect the current supply arrangements which includes appendix 4 the major haemorrhage protocol and appendix 5 important phone numbers these are displayed in the wards, theatres and the resident medical officer's office for quick reference. The revised document has been uploaded onto the hospital shared policy drive for all staff to access. (Attached)	Head of Governance and Quality Theatre Manager	On-going Completed

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): **Jan Green**

Job role: **Director of Clinical Services (Registered Manager)**

Date: **25/8/2023**

Appendix C - Improvement plan

Service: St Joseph's Hospital

Date of inspection: 15 and 16 August 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 signage and the selection of information available, taking into consideration the communication needs and wishes of patients using the service.	Standard 3 – Health promotion, protection and improvement	Eido healthcare leaflets available in both Welsh and other languages as required. T.V. slide show now includes Welsh language request slide. Patient information letters request that individuals who may use our service confirm if any language, visual and/or hearing considerations are required to meet individual patient needs.	Director Of Clinical Services	Completed
The registered provider is to ensure that a risk assessment is carried out on every transfer of	Standard 22 Managing Risk and Health and Safety	Policy has been reviewed and amended to contain information about escorts if required.	Director Of Clinical Services	Completed

a deteriorating patient or a patient requiring escalated care. Where a qualified ambulance crew is not available a qualified member of staff should accompany the patient to the receiving hospital.		This risk assessment is now included in the Transfer Checklist documentation. If indicated by the risk assessment an appropriate qualified member of staff will accompany the patient to the receiving hospital		
The registered provider is to ensure that all investigations and results are recorded in the patients' medical notes.	Standard 20 Records Management	A multi-disciplinary standard operating procedure has been developed. All staff have been made aware via staff meetings and email of their responsibilities and via the audit cycle review and monitoring will assist in highlighting areas that require strengthening.	Director Of Clinical Services	Completed
The registered provider is to provide HIW with the actions taken to address the issues relating to the potential detachment between ward management and nursing staff.	Standard 1 Governance and accountability framework	Evaluation, monitoring and review of system to highlight and/or identify where potential areas of weakness, may require and/or need underpinning and strengthening to support and establish full team cohesion.	Chief Executive / Director of Clinical Services	On-going December 2023

		This has included the following mechanisms: • Detailed SWOT analysis, outcomes identified and feed-back. • Renewing, enhancing and promoting current staff team members linkages at an individual and team member level. • Staff working patterns reviewed, to assist and promote understanding and increased awareness of knowledge and understanding between all staff team members. • This includes visibility and access to the Heads of Department (HOD) formally i.e. staff meetings, audit and information reviews, updates and outcomes. • Informally, participating in different work streams, encouraging and promoting individual and team bonds. • To undertake a staff survey to establish if the changes have		

		been effective and embedded into practice.		
The registered provider is to ensure that the results of audits are both made known to staff and the results are clearly displayed in staff areas.	Standard 6 Participating in Quality Improvement Activities	Designated audit information notice boards have been allocated to all departments. An agenda item on all staff meetings, clinical governance and quality and safety to encourage sharing of knowledge and feedback to all parties. Audit data available to all staff in a shared drive.	Head of Governance and Quality	Completed
The registered provider is to ensure that staff are reminded of the actions to take when there are needle stick injuries.	Standard 13 Infection Prevention and Control (IPC) and Decontamination	Flow chart recirculated to all departments for ease of reference if a needlestick injury should occur. Full policy available on the shared drive.	Head of Governance and Quality	Completed
The registered provider is to ensure that cleaned equipment, particularly commodes, are clearly marked as 'Clean'.	Standard 13 Infection Prevention and Control (IPC) and Decontamination	Reintroduced and reaffirmed the application of green "I am clean stickers".	Head of Governance and Quality	Completed

		Daily audits of compliance.		
The registered provider is to ensure that staff are reminded of the hospital dress policy.	Standard 13 Infection Prevention and Control (IPC) and Decontamination	Uniform policy recirculated and reaffirmed. Spot checks in place. Café notice in place reminding all staff.	Head of Governance and Quality	Completed
The registered provider is to ensure that sharps' bins are regularly rotated when not regularly used, not overfilled and disposed of promptly.	Standard 13 Infection Prevention and Control (IPC) and Decontamination	Monthly sharps bins audits in place. Assessment of the requirement for sharps bins in certain departments has resulted in some areas having bins withdrawn. Rotation of sharps bins to ensure compliance with policy.	Head of Governance and Quality	Completed
The registered provider is to ensure that the temperature of the fridge remains within the required range and that the thermometer is recalibrated regularly.	Standard 15 Medicines Management	Introduction of monthly audit to ensure daily monitoring. All fridges' thermometers have been recalibrated and additional new	Head of Governance and Quality	Completed

		portable temperature thermometers have been purchased and utilised. A service contract with an external provided has been introduced to ensure on-going compliance.		
The registered provider is to ensure that all out of date, drugs, equipment and ancillary items are removed from use and replaced.	Standard 15 Medicines Management	All out of date eye wash equipment has been removed.	Head of Governance and Quality	Completed
The registered provider is to ensure that information relating to Sepsis Six is clearly displayed in all staff areas on the wards and theatres.	Standard 13 Infection Prevention and Control (IPC) and Decontamination	All clinical departments have relevant information now on display within their areas.	Head of Governance and Quality, ward manager and theatre manager	Completed
The registered provider is to ensure that further training is carried out for relevant staff on sepsis and major haemorrhage protocols.	Standard 13 Infection Prevention and Control (IPC) and Decontamination	New Sepsis 6 tool and check list introduced. Introduction of a new policy to support the introduction of the new tool for all staff.	Head of Governance and Quality, ward manager and theatre manager	Completed

		2nd Specific training day delivered to clinical staff. Major haemorrhage flow chart circulated to relevant clinical areas and Resident medical doctor (RMO). Discussed in the weekly RMO update meeting.		
The registered provider is to further negotiate with the local health board for blood products to be kept on site, with an agreement to ensure that there is adequate rotation of these products to minimise wastage.	Standard 17 Blood Management	We have met with our local Health Board who have currently declined to support the reintroduction of blood products on site. In line with the current national guidance re blood shortages Further national discussion is required. They support the hospitals major haemorrhage policy and protocols. Transport arrangements have been reviewed and the SOP amended.	Chief Executive / Director of Clinical Services	Completed, Pending any national guidance / legislation changes.

The registered provider is to ensure that patient medical records are completed in full, including all the relevant examinations, risk assessment and narrative to support decisions made duly signed.	Standard 20 Records Management	Monthly audits in place. Amended the daily spot checklist. Redesigned the multi- disciplinary signature sheet to make it easier to establish responsible clinician.	Director of Clinical Services	Completed
The registered provider is to ensure that all staff including permanent, locums, bank and agency staff are given a full induction before they work in their specific area.	Standard 24 Workforce Recruitment and Employment Practices	The current RMO(Locum) induction documentation has been amended to provide a framework for induction for all locum, bank and agency staff.	Director of Clinical Services	Completed
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%.	Standard 25 Workforce Planning, Training and Organisational Development	Currently as of 17/10/2023 overall compliance is 93% Clinical staff compliance is 100% Non-Clinical staff compliance is 82%. All staff are being managed to achieve 100% compliance across all staff groups by the end of the year.	Chief Executive / Director of Clinical Services	On- going, Jan 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): Jan Green

Job role: Director of Clinical services, Registered Manager

Date: 18/10/2023