Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

A review of care provided to patients with a learning difficulty or mental health issue at:

Rushcliffe (Aberavon) Ltd Independent Mental Health Hospital, Scarlet Avenue, Aberavon, Port Talbot SA12 7PH

Date of visits 16 & 30 August 2011, 11 October 2011, 8, 14 & 16 March 2012

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications and Facilities Manager
Healthcare Inspectorate Wales
Bevan House
Caerphilly Business Park
Van Road
CAERPHILLY
CF83 3ED

Or via

Phone: 029 20 928850
Email: hiw@wales.gsi.gov.uk
Fax: 029 20 928877
Website: www.hiw.org.uk

Digital ISBN 978 0 7504 8192 2

WG16914

Contents

1. Introduction and Background

1.1 Healthcare Inspectorate Wales (HIW) is the regulator of healthcare services in Wales, a role it fulfils on behalf of the Welsh Ministers who, through the authority of the Government of Wales Act 2006, are designated as the registration authority for Wales.

1.2 Independent healthcare[1] providers must be registered with HIW before they can provide services in Wales and to register, they must demonstrate compliance with the Care Standards Act 2000 and associated regulations. Further information about the Standards and related regulations can be found at www.hiw.org.uk.

1.3 In May 2011, the BBC's investigative television series *'Panorama'* broadcast a programme that highlighted abuse and ill-treatment of individuals with a learning difficulty who were residing at an independent hospital in Bristol. The programme understandably gave rise to great public concern. As a result HIW decided to bring forward our annual programme of reviews of independent hospitals providing learning difficulty and mental health services.

1.4 The focus for the reviews was to ensure that individuals accessing such services are:

- safe;
- cared for in a therapeutic, homely environment;
- in receipt of appropriate care and treatment from staff who are appropriately trained;
- encouraged to input into their care and treatment plans;
- supported to be as independent as possible;
- allowed and encouraged to make choices;
- given access to a range of activities that encourage them to reach their full potential;

[1] Independent healthcare – services not provided by the health service.

- able to access independent advocates and are supported to raise concerns and complaints; and
- supported to maintain relationships with family and friends where they wish to do so.

1.5 As part of our inspection process, we routinely hold comprehensive discussions with patients and staff, and we carefully observe the interactions between patients and staff. We may also meet with family members or patient advocates to seek their views on the care provided. In addition to reviewing the appropriateness of the physical environment we also evaluate the adequacy of a range of documentation including patient care plans, policies and procedures, staff induction and training plans and complaint, restraint and incident records. HIW uses a range of expert and lay reviewers for the inspection process including a reviewer with extensive experience of monitoring compliance with the Mental Health Act 1983.

Rushcliffe (Aberavon)

1.6 Rushcliffe (Aberavon) independent hospital *('Rushcliffe')* was first registered on 8 July 2009 by HIW and is currently registered to provide care to sixteen (16) patients on two wards. The hospital is registered to provide treatment or nursing (or both) for persons liable to be detained under provisions of the Mental Health Act 1983 but who do not require any type of acute, intensive or secure service provision. The hospital's registered provider is Rushcliffe Independent Hospitals (Aberavon) Limited.

1.7 HIW undertook unannounced visit to Rushcliffe on 16 and 30 August 2011. This was followed up by a further announced visit on 11 October 2011 and three further visits on the 8, 14 and16 March 2012.

1.8 The findings arising from those visits are set out Section 2 of this report. We have identified areas of strength as well as areas that require improvement. Section 3 of this report sets out HIW's requirements for action.

1.9 Following each of our visits detailed verbal feedback was given at the end of the day and this was followed by a letter sent to the registered provider and manager detailing regulatory breaches and areas where further action was required.

2. Our Findings

2.1 The Terms of Reference for this review are structured around a series of fundamental questions that we feel patients, their relatives and commissioners of services [2] would want us to address. For ease of reference and understanding we have set out our findings under the heading of each question. The first of these questions:

'Were those accessing services at the time of our visit safe?'

is considered in Section 3 of this report, where we present our conclusions and next steps. This question can only be answered when we have given careful consideration to the answers to the questions below.

'Were those accessing services at the time of our visit cared for in a therapeutic, homely environment?'

2.2 At the time of our visits patients were being cared for on two wards available at Rushcliffe. Two female patients were being cared for on one ward (this ward can accommodate eight patients) and eight male patients were being cared for on the second ward (the maximum for this ward).

Male ward

2.3 All bedrooms on the ward had en-suite facilities and bedrooms were personalised with posters, pictures and other personal items. The ward was decorated to a satisfactory standard, however there was some parts of the male ward corridor that were dark and there did not appear to be sufficient lighting. There were a small number of pictures on the walls. Overall the ward did not provide a cheerful and homily environment.

[2] Commissioners of services - the organisation that is purchasing services and treatment from the registered provider.

2.4 There was insufficient seating in the lounge to accommodate all eight patients and almost all seating was placed around the wall areas making the environment look and feel institutional. There were no pictures or photographs displayed in the lounge area

2.5 There were no information boards or staff picture orientation boards available on the ward.

Female ward

2.6 The bedrooms on the female ward had en-suite facilities and the ward was clean and decorated with pictures and soft furnishings.

2.7 Similar to the male ward no patient information boards or staff picture orientation boards were displayed.

Security and access systems and process

2.8 When we visited on the 16 and 30 of August 2011 it was noted that there was no system for logging in and logging out of staff key fobs, which are used to access all areas of the hospital. Therefore there was no record of who had access to key fobs and it was difficult to identify whether a fob had gone missing. Similarly there was no record of fobs that required maintenance. These issues clearly need to be addressed as a matter of urgency.

2.9 There was no alarm or call bell system within the hospital and we considered the environmental security to be poor, with faults not being properly logged.

2.10 On-call arrangements were unclear and required clarification as there was confusion and a lack of awareness amongst staff with regard to the hospitals procedure for contacting management personnel in the event of an accident/incident. Management telephone contact numbers were not available on the wards.

'Were those accessing services at the time of our visit in receipt of appropriate care and treatment from staff who are appropriately trained?'

Staff numbers

2.11 Our visits highlighted a number of fundamental issues in relation to staffing both in terms of capacity and capability. While without exception all the staff we spoke to were personable and spoke of their commitment to patients, there were very clear shortfalls in permanent and bank staffing numbers. We were unable to fully establish which members of staff were where on which day and the numbers of hours worked because staff names and designated times and hours of work did not correspond to the staff signing-in and signing-out book. Our review of staff rotas did not clarify the situation as there were so many changes and amendments to the rotas.

2.12 There was a lack of clarity and confusion in relation to the roles and responsibilities of staff and there was evidence of housekeeping and reception staff working as support workers when staff numbers were low.

2.13 In order to build up successful therapeutic relationships and trust it is important that patients have consistency in the staff providing care to them. It is equally just as important that staff members have the training and capability to implement and establish a person-centred relationship with individual patients.

2.14 Staff told us of high staff turnover rates[3], low staffing numbers and staff becoming tired because of the shortage of staff and long working hours. Rushcliffe needs to ensure that there are appropriate levels of staff on duty and contingency plans should be in place to ensure that it can appropriately manage and deal with staff leave and sickness. Feedback from staff indicated that supervision and appraisal was very limited or non-existent and a formal structure and programme

[3] Turnover rates - refers to the number of staff that have terminated and commenced employment with the registered provider.

needs to be put in place urgently. In addition, it is imperative that staff receive an appropriate level of supervision and support. We have been advised that following our visit a structured induction, supervisory and appraisal programme had been formulated and implemented so that the care provided to patients is not compromised.

2.15 Following our visits in August 2011 the registered provider submitted an action plan to HIW setting out how our concerns would be addressed.

2.16 We followed up staffing issues when we revisited on 16 March 2012 and will continue to seek updates and reassurance from the registered provider.

Staff training

2.17 We interviewed ten members of staff during our visits including permanent and bank[4] staff. We found that staff mandatory training had not been undertaken during the previous twelve months. This included training in the Protection of Vulnerable Adults (POVA), Mental Capacity, consent etc. This was a matter of concern.

2.18 We had concerns regarding the use of terminology used by staff, both in written records and in conversation with the HIW team. For example the terms *'Restraint,' 'Sanction,' 'Calm time'* etc with regard to patient incidents were commonly used, despite us being advised that restraint is never used within the hospital. It was noted that no staff had received training in the use of restraint or de-escalation models. We discussed this with members of the senior management team and asked that an explanation be given of in what context and in relation to what circumstances these terms were used. HIW have concerns that use of such terms could impact negatively on the dignity and care of patients.

[4] Bank staff - staff employed by an organisation on a session basis when required not necessarily full or part time but some bank staff may be contracted on a regular basis.

2.19 We had concerns with regard to the use of medication i.e. *'medication restraint.'* Medication was noted to being administered on a frequent basis, although it was prescribed to be given as required. For example, medication prescribed on a p.r.n basis: abbreviation meaning *'when necessary'* (from the Latin *'pro re nata,'* for an occasion that has arisen, as circumstances require, as needed) was given on a daily basis. Such regular administration should have been noted by staff and the responsible clinician and should have led to a review of the patients' medication regime so that any necessary changes could be made to meet the patients' needs. This review should include participation of the individual patient.

2.20 Very limited child protection training had been received by some members of the staff, while other members had received none. Such training is necessary to ensure staff have sufficient knowledge to enable child protection procedures to be effectively implemented when necessary.

2.21 Our visit undertaken on the 16 March 2012 highlighted that a patient was developing a high level of complex medical needs. It was clear that staff did not have the knowledge and skills to meet all of his anticipated needs. We highlighted the need for staff to contact and engage with the appropriate professionals to ensure that an appropriate care plan was available to meet specific care needs of the individual.

Policies and procedures

2.22 For an organisation to operate safely and consistently, all staff should know how to access policies and procedures and should be able to demonstrate knowledge of them. Examples of key policies that staff must have knowledge and access to include, medicines management, Section 17 leave when detained under the Mental Health Act 1983, community escorting of patients and complaints. At the time of our visits Rushcliffe had a range of polices and procedures in place, however, we found evidence of non-compliance with these policies and procedures. For example, some medication sheets were unsigned and the reason for medication not being given was not documented.

2.23 Some staff were able to demonstrate a limited knowledge of the various policies and procedures in place. However, inadequate staff induction, lack of staff supervision and poor communications systems between management and staff did not help ensure that staff members were fully aware of the hospital's policies and procedures. There was no evidence of systems being in place to assess staff awareness and understanding of policies and procedures on an on-going basis.

2.24 A lack of organisational and managerial structures resulted in poor communication and accountability arrangements.

2.25 Overall, there was little evidence of clinical governance arrangements and processes being in placed and embedded.

> ***'Were those accessing services at the time of our visit encouraged to input into their care and treatment plans, supported to be as independent as possible and allowed and encouraged to make choices?'***

Review of care plan documentation

2.26 We reviewed care planning documentation and found limited evidence of patients being involved in the care planning process. Some care plans had no patient signatures evidencing patient choice and involvement. The preferences and needs of patients were poorly documented and it was unclear as to what changes to plans were discussed with patients. We found that patient care plan goals were non specific and that there was a lack of person centred care. There was little evidence of relatives being involved in care planning and no documentation was provided to provide reasons for their lack of involvement. In addition there were some difficulties in relation to ward based staff accessing historical notes that were essential when formulating reports and care plans. A number of files were disorganised and there was no evidence of a system of monitoring, review and audit in place.

2.27 A range of different types of individual patient risk assessments were in place. However, we noted that these had not been regularly monitored and updated with regard to patient care and outcomes. It is imperative that these risk assessments form the basis of decisions making regarding the care and treatment of individual patients, and blanket decisions that apply to all patients on a ward should be kept to an absolute minimum. All decisions must be based on a sound and reasonable rationale which should be explained to patients and clearly documented.

2.28 There was evidence of the Care Programme Approach[5] (CPA) being in place and of patients being seen by their community care co-ordinator[6] and to families being invited to CPA meetings. However, record keeping was poor and disjointed and some aspects of the CPA documentation was difficult to access as they were not held on the appropriate files. There was also a lack of evidence of a systematic approach to discharge planning. In one case, there was no documentation on file confirming the discharge arrangements for a patient who had already been discharged from the hospital.

'Were those accessing services at the time of our visit given access to a range of activities that encourage them to reach their full potential?'

Patient activities

2.29 We discussed a range of issues with patients focusing on whether they felt safe and properly supported. Generally patients felt able to make some decisions regarding their daily routine but a recurring theme was that patients felt *'bored.'* Particularly, few activities were available on weekends and in the evenings. A number of the male patients raised with us the fact that activities, leave and even access to the garden could be curtailed or cancelled at short notice if there was not enough staff on duty.

[5] Care Programme Approach - This is a co-ordinated system of care management, based on a person centred approach determined by the needs of the individual. There are four elements within CPA; a systematic assessment, the development of a care plan, the appointment of a care co-ordinator and regular reviews of the plan.
[6] Community Care Co-ordinator - A qualified health or social care professional who designs and oversees a care plan as part of the CPA.

2.31 Patients were only allowed access to the smoking area, within the garden for 15 minutes on every hour. On occasions, due to staff shortage, access to the area was late or curtailed. As a result patients understandably had on occasions become upset and challenged this decision.

2.32 While care plans made reference to group therapy activities, a programme setting out the range of activities on offer to patients was not displayed on wards. This programme was displayed in the atrium, a general communal area for all patients. Access to this area was very limited, as both ward doors were always locked and a key fob was required to access the atrium. The hospital has a *'cinema'* room next to the atrium, however, this was often in use by staff, which limited patient access. At the time of our visits there were no group activities taking place on the wards, although on one of our visits a number of patients were involved in a group activity in the communal area. Individual therapy did take place within the ward areas.

Nutrition

2.33 In terms of diet and nutrition, we found that patients' preferences were catered for. Patients had opportunities to shop for and cook their own food under supervision. There was variety and choice in the food provided

2.34 Patients could make their own drinks as required and could also purchase and store beverages of their choice.

'Were those accessing services at the time of our visit able to access independent advocates and were they supported to raise concerns and complaints?'

Access to services

2.35 There was a good level of understanding amongst the patients of how to raise any concerns and complaints; in addition patients knew how to access advocacy

services. However, on both of the wards we found that there was a lack of information on display for patients or their relatives about advocacy services or how to make a complaint.

2.36 We noted that the complaints process and procedure was not comprehensive in recording actions, outcomes and 'lessons learnt.' Overall, we found that complaints were not well documented, very difficult to follow, poorly managed and did not contain the required level of details. There was limited evidence of feedback being given to the complainant.

'Were those accessing services at the time of our visit supported to maintain relationships with family and friends where they wish to do so?'

Support for patients to maintain contact with friends and family

2.37 A number of patients had their own mobile phones. There was also a payphone available in the visiting room in the reception area of the hospital. However, access to the payphone was dependent on there being a staff member free to accompany the patient to the visitor's room.

2.38 A number of patients were receiving Section 17 leave [7] and this was having a positive impact upon maintaining family relationships. However, we were concerned that there were occasions when patients, were unable to go on escorted leave due to staff shortages.

[7] Section 17 leave - Formal permission for a patient who is detained in hospital to be absent for a period of time. Patient remains under the powers of the Act when they are on leave and can be recalled to hospital at anytime.

3. Conclusion

'Were those accessing services at the time of our visit safe?'

3.1 HIW's visit undertaken on 16 and 30 August 2011 identified a number of significant regulatory breaches. One of the most concerning aspects of the visits was the low staff levels within the hospital. Some staff members were working excessive hours. HIW have been informed that staff working hours are now being monitored and that staff recruitment has been commenced.

3.2 On the 16 August 2011 when HIW inspectors arrived at the establishment the registered manager was not available at the hospital. There was evidence to indicate that the registered manager was only present in the hospital for short periods of time and was not present on some days of the week. Our discussions with the registered manager gave raise to concerns in relation to the understanding of the role and responsibilities of a registered manager. The registered provider subsequently responded to this issue by confirming to HIW that a new manager (designate) is now in charge of the hospital.

3.3 Immediately following our visits of 16 and 30 August 2011, HIW sent a letter to the registered provider outlining the issues that required urgent action. In response to our letter, an action plan was submitted to HIW and regular progress updates received.

3.4 At the time of writing the registered provider had to take action to ensure:

- All staff receive supervision as per hospital policies and procedures.
- Clarity regarding roles and responsibilities.
- Effective communication systems
- Staff receive mandatory training.
- Clarify in use of terminology.
- Effective environmental security
- Effective and appropriate administration of medication.
- Effective organisational and managerial structures are placed.

- The appropriate management of complaints
- Effective clinical governance arrangements.
- Consent to Treatment documentation is available for all patients.
- Appropriate staff are aware of and knowledgeable in the relation to the documentation required regarding Consent to Treatment.

3.5 Whilst a number of significant issues were highlighted in our visits, the registered provider acted quickly to put in place actions and there has been considerable dialogue with HIW in relation to these. A number of improvements were noted when we revisited in March 2012 and there has been a change in senior management at the hospital. These changes should assist in promoting and embedding the required changes and on-going development needed.

4. Requirements

4.1 The requirements set out below address any non-compliance with the Independent Health Care (Wales) Regulations 2011 that we identified either as a result of the inspection or from other information which we received from and about the provider. These requirements are the responsibility of the *'registered person'* who, as set out in the legislation, includes both the registered provider and/ or the registered manager for the establishment or agency to take forward. The registered person must provide an action plan confirming how they intend to address the required actions. HIW will, if necessary, take enforcement action to ensure compliance with the regulations.

National Minimum Standard	Regulation	Findings (paragraph number)	Requirement	Time scale
Standard 24	20(2)(a)	2.24	The registered provider is required to ensure that there is an appropriate system of staff supervision and that staff are aware of and comply with the hospitals own policies and procedure.	Immediate and on-going.
Standard 18	9(1)(h) & 20(2)(c)	2.11	The registered provider is required to ensure that staff members are aware of, and know their roles and responsibilities.	Immediate and on-going.
Standard 18	18(2)(a)(b)	2.25	The registered provider is required to ensure that there are adequate and appropriate arrangements in relation to communication systems between management and staff and staff and patients.	Immediate and on-going.

Standard 25	20(2)(a)	2.17	The registered provider is required to ensure at all times suitably qualified, skilled and experienced persons are working in the establishment. This should include appropriate levels of training in Protection of Vulnerable Adults (POVA), Mental Capacity, Consent, Protection of Vulnerable Children (POVC), etc.	Confirmation that a staff training programme has been organised and implemented is required by 30 June 2012.
Standard 18	9(2)(a)(b)(c)(d) & 16(2)(a)(b)	2.18	The registered person is required to ensure at all times suitably qualified, skilled and experience persons are working in the establishment. This should include training in documentation and report writing, continued professional development and mandatory training for all staff, these terms were used.	By 20 September 2011.
Standard 12	9(1)(c)	2.8	The registered person is required to ensure that the premises provide environmental security and that an appropriate system for recording faults and repairs is established.	By 30 September 2011.
Standard 15	9(1)(m) & 15(5)(a)	2.19	The registered person is required to ensure that the hospital's medication policies and procedures are followed. Patient medication regime reviews must be undertaken as appropriate i.e. medication was noted to being administered on a frequent basis, although it was prescribed to be given as when required.	By 20 September 2011.

Standard 22	19(1)(a)(b)	2.25	The registered person is required to ensure that there is appropriate and effective organisational and managerial structures, with clear lines of communication and accountability.	By 30 September 2011.
Standard 23	24(5)	2.36	The registered person is required to ensure that complaints are effectively managed. This should include details of complaints, outcomes and analysis of complaints to inform the learning process.	By 30 September 2011.
Standard 1	19(1)(a)(b)	2.26	The registered person is required to ensure that the hospital has an effective system of clinical governance arrangements and processes established.	By 30 September 2011.

5. Next Steps

5.1 Further visits will be undertaken by HIW to Rushcliffe and compliance against the regulations and action plan will be further assessed.

5.2 The registered provider will be required to send an updated action plan to HIW that addresses all the regulatory issues identified within this report within two weeks.