Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Independent Mental Health Service Inspection (Unannounced)

## Regis Healthcare Limited: Brenin and Ebbw wards

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

# Our purpose

**To check that people in Wales are receiving good care.**

# Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

# Our priorities

**Through our work we aim to:**

| | |
|---|---|
| **Provide assurance:** | **Provide an independent view on the quality of care.** |
| **Promote improvement:** | **Encourage improvement through reporting and sharing of good practice.** |
| **Influence policy and standards:** | **Use what we find to influence policy, standards and practice.** |

# 1. What we did

Healthcare Inspectorate Wales (HIW) completed an urgent unannounced independent mental health inspection of Regis Healthcare on the night of 27 June and during the days on 28 and 29 June 2018.

The purpose of the visit was to assess whether the hospital was providing safe and effective care, and whether it was appropriately meeting the requirements of its registration. This was in response to the information we received from the NHS Wales Quality Assurance Improvement Team (QAIT) who recently undertook a number of visits to the hospital and as a result of these visits, suspended Regis Healthcare from their framework.

The following units were visited during this inspection:

- Brenin
- Ebbw

Our team, for the inspection comprised of one HIW clinical adviser, who led the inspection, one HIW inspector and one Mental Health Act reviewer.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with Act.

HIW explored how the service complied with the Care Standards Act 2000, requirements of the Independent Health Care (Wales) Regulations 2011 and met the National Minimum Standards (NMS) for Independent Health Care Services in Wales. Where appropriate, HIW also consider how services comply with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Further details about how we conduct independent mental health service inspections can be found in Section 5 and on our website.

# 2. Summary of our inspection

We found significant concerns regarding the governance processes, staffing numbers and timeliness of recording patient information which did not provide us with assurance that the young persons at Regis Healthcare were being cared for safely. This resulted in HIW issuing a non-compliance notice to the responsible individual and the urgent notice of decision to impose additional conditions on the registered provider on the area of staffing.

In addition to the above, we identified shortfalls with the agency staff induction process, which was being signed off, despite agency staff not being fully familiar with a number of key areas.

Because of this HIW held an internal Service of Concern meeting on 29 June 2018 where it decided that the hospital would be a service of concern. It was also decided at this meeting to impose a condition on their registration preventing them from admitting any new patients, this condition remains in place.

Despite the significant findings we saw good interactions between staff and the young persons. There were opportunities for the young persons to engage in a range of activities which included community access.

Our review of Mental Health Act records concluded they were completed to a reasonably good standard. We saw that weekly visits by a pharmacist were taking place to undertake an audit of medication as well as CO2, CO3 and Section 62 forms. This is an area we recognised as good practice.

This is what we found the service did well:

- We observed a good rapport between the young persons and staff

- The staff we spoke to and from our observations on the ward, we saw a motivated team, despite some low staff morale
- There was a good range of activities available for the young persons including community access
- The Mental Health Act documentation we reviewed was completed to a good standard

This is what we recommend the service could improve:

- Governance processes were not robust and need to be significantly improved
- Sufficient numbers of staff need to be available on both wards to ensure safe patient care can be provided at all times
- The agency staff induction process needs to be reviewed to ensure staff are competent before the process is signed off
- Patient records, information boards and restraint documentation need to be completed in a timely manner to ensure accurate and contemporaneous notes are maintained
- There needs to be improved access into the hospital, particularly at night

We identified the service was not compliant with:

- Regulation 19 (1) (a) & (b) and 20 (1) (a) of the Independent Health Care (Wales) Regulations 2011 regarding the quality of service provision
- Regulation 20 (1) (b) and 20 (2) (a) of the Independent Health Care (Wales) Regulations 2011 regarding staffing
- Regulation 19 (1) (a) and 23 (a) (i) of the Independent Health Care (Wales) Regulations 2011 regarding records and managing risks of inappropriate or unsafe care and treatment

These are serious matters and resulted in the issue of a non compliance notice to the service and an urgent notice of decision to impose additional conditions on the registration of the registered provider. Following the inspection we held a formal meeting with the registered provider to discuss the areas of non compliance. We subsequently received a level of assurance of the actions taken to address the improvements needed.

# 3. What we found

## Background of the service

Regis Healthcare Limited is registered to provide an Independent Hospital for Children and Adolescent Mental Health (CAMHS) at Ebbw Vale Hospital, Hillside, Gwent NP23 5YA.

The service has two wards Ebbw and Brenin, both have 12 beds and offer care to young persons under the age of 18 years. Both wards were single gender and accommodated females only.

The service was first registered on 15 January 2014.

The service employs a staff team which included the responsible individual who was also acting as interim manager, registered nurses and health care support workers. The multi-disciplinary team includes psychiatrists, psychologist, assistant psychologists, occupational therapists, technical assistants, teachers, teaching assistants and activities co-ordinators. There was also a large administrative team which supported the clinical teams in the daily running of the hospital.

## Quality of patient experience

*We spoke with patients,, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.*

We observed good interactions between staff and the young people which were kind and respectful.

All the young people had their own bedrooms with en-suite facilities which helped maintain their privacy and dignity.

There was a regular advocacy presence at the hospital for the young people. In addition, there were good activities available and access to the community.

We have recommended that patient information boards are covered when not in use to protect the personal and sensitive nature of the information.

### Health promotion, protection and improvement

The wards had various information displayed, including information regarding a young person's stay. This was also provided on admission in booklet format. Advocacy information was displayed and there were various boards with photos of events that had taken place in and outside of the hospital.

Each ward had its own outside space. Due to the warm weather various items had been purchased for the young people to use and we saw them making use of these during our visit to Brenin ward

Staff told us the young people had access to a gym located within the hospital and there were lots of opportunities for community access. Other facilities within the hospital, including a kitchen provided the young people with access to therapeutic spaces to gain independent living skills.

### Dignity and respect

We observed staff treating the young people with respect and kindness. All young people had their own bedroom with en suite facilities. We were told that the young people could personalise their rooms with pictures etc.

We noted that on Brenin ward, from one window, you could see the patient information board within the nurses office. While the board had a blind to cover the information when not in use, we found that during our visit the board was rarely covered. Patient information must be protected when not being used and/or updated.

Improvement needed

Patient information boards must be covered when not in use to protect the sensitive nature of the information displayed.

## Equality, diversity and human rights

There were specific and suitable places located off the wards for young people to meet with family and friends in private.

The young people had no access to mobile or pay phones, but were allowed to use the office phone to maintain contact with family and friends. Evenings were when the young people were able to use the phone for personal calls; however, there were no restrictions in place for contacting advocacy and/or solicitors.

## Citizen engagement and feedback

Staff told us they would support any young person who wanted to make a complaint. Regular advocacy visits also provided an independent means for the young people to ask for assistance in any matter.

There was no visible information displayed around the wards about how the young people and/or their families could provide feedback about their care.

Improvement needed

Information for how young people and visitors can provide feedback regarding the service needs to be clearly displayed

## Delivery of safe and effective care

*We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.*

We could not be assured that Regis Healthcare provided safe and effective care, primarily due to insufficient staffing numbers on both wards. We were significantly concerned regarding the timeliness of record keeping and the lack of support witnessed for agency healthcare support workers to complete restraint forms. Records and patient information need to be up to date and accurate to ensure care can be provided in a timely manner.

While the environment was generally satisfactory, with appropriate furniture and fixtures, there were some areas that needed attention. Some room signage on Brenin ward was unsuitably located at ceiling height. Therefore unreadable unless you looked up towards the ceiling. In addition, there were a number of locked areas on Brenin and Ebbw wards and we asked the registered provider to review this to see if a less restrictive model of care could be implemented.

Access to the hospital was an issue during our night visit. Systems need to be put in place to ensure visitors can gain timely entry. Significantly, there was not one individual responsible for the overall charge of the hospital during the nights. We have asked the provider to review this arrangement.

Our review of Mental Health Act records concluded they were completed to a good standard. We saw that weekly visits by a pharmacist were taking place to undertake an audit of medication as well as CO2, CO3 and Section 62 forms. This is an area we recognised as good practice.

We recommended that the Mental Health Act database used by the hospital is maintained and updated to ensure the information is

accurate.

## Managing risk and health and safety

Regis Healthcare hospital is a large building which has two wards, Ebbw and Brenin. Access to the hospital building was level entry direct from the car park which provided appropriate access for persons with mobility difficulties. The hospital décor throughout was very young person focused with colourful and brightly painted walls, with some displaying pictures and decals.

The design and layout provides an environment with appropriate fixtures, fittings and furniture to help maintain the young person's safety. We noted that there were lots of locked areas on Brenin and Ebbw wards, which restricted the young peoples' access to all the lounges and garden area without being escorted by staff. We recommended that the provider review this model of care and consider implementing a less restrictive practice that is based upon individual needs and risks and not a blanket approach. In addition, we noted on Brenin ward that whilst some doors were clearly signposted as to their function, others had signs that were located at ceiling height, making them difficult to see and read. Staff told us that this was to prevent signs being taken down by the young people, however the location of these signs was inappropriate and the provider must reconsider their position.

Access to the hospital was via an intercom system located outside the main entrance of the premises. Upon arriving at the hospital on our first night and the next day we were unable to gain timely access. This resulted in telephoning the number located on the sign outside to gain entry. This was discussed with staff at the time and we recommended that there needs to be systems in place to ensure in the absence of a receptionist, the intercom can be answered.

Once we had entered the hospital, we were told that there was no one individual assigned as the person in overall charge of the hospital. Each ward had their own teams on duty which were responsible for their own areas. There was no central coordination to help prioritise clinical need and support for patient care. An additional and dedicated person with overall responsibility for the hospital, especially at night, could support and provide a range of clinical activities essential to the care of patients out of hours. They would act as the first point of contact for ward staff seeking clinical advice/assistance. This would ensure that nurses on each ward are able to focus on patient care.

Following concerns highlighted in our previous inspection in March 2018, we fount there was still a considerable number of young people on observations and not enough staff to oversee safe care. The specifics of this issue are described in section 3 of this report.

The hospital provides a secure environment. However, we observed that there are numerous sets of locked doors that need to be navigated to reach one side of the hospital to another. All staff have keys which enable this possible, however, in the event of an emergency, a staff member going from one ward to the other would be significantly delayed by having to unlock and lock all of these doors. We recommended that this procedure is reviewed and an alternative, quicker security system installed.

Improvement needed

A review of all the locked areas on both wards is required and consideration given to implementing a less restrictive practice that would allow more access by the young people to additional areas.

The signage on Brenin ward needs to be reviewed and located appropriately

Systems need to be reviewed to ensure any visitor to the hospital can gain timely access during the day and night.

The registered provider must review the overall responsibility of the hospital, especially at night.

The registered provider must review the key operated door system to ensure this method is efficient in an emergency for staff to provide assistance elsewhere in the hospital.

## Participating in quality improvement activities

We saw that registered provider visits had been undertaken in October 2017 and January 2018, in accordance with the Regulations. However we recommended that more detailed and comprehensive reports are carried out and where applicable, updates on the actions taken to date recorded to evidence progress.

Improvement needed

The registered provider must ensure their provider reports are more comprehensive and detailed

## Records management

We reviewed a number of patient notes, restraint and incident forms, plus other documents relating to patient care. A record we reviewed showed ‘as required’ medication had been administered to a patient but had not been recorded in a timely way within the individual patient's daily entry book. Specifically, an intramuscular PRN injection had been administered to a patient but the individual notes had not been completed within a reasonable timeframe. Records for significant events need to clearly document the details in a timely manner and not left to be completed at the end of a shift. The issues identified with records are not acceptable and meant that a contemporaneous note of treatment provided to that patient was not available.

During the inspection we observed that a new agency support worker was asked by the nurse in charge to complete a restraint form when they had never completed one before. We witnessed the agency support worker struggle to complete the form and we asked the nurse in charge whether they felt support should be provided; the response was that they felt the form was self explanatory. The impact of this was that the incident had not being reported in a timely manner, potentially inaccurately, and that initially no assistance was provided to a new agency staff member to complete the form appropriately.

Risk assessments for one patient did not have any evidence of self harm tendencies present despite the fact that there had been a recent incident of this nature.

The patient at a glance board on Brenin ward had not been updated 24 hours after changes were made to a patient's observation levels.

### Improvement needed

The registered provider must ensure that all patient records are completed in a timely manner and not completed by staff at the end of a shift

The registered provider must ensure all staff are supported to complete restraint paperwork in a timely manner after an incident

The registered provider must ensure risk assessments are comprehensive for all patients

Patient information boards need to be updated in a timely manner to ensure all staff have access to current information

## Mental Health Act Monitoring

We reviewed the statutory detention documents of three patients across the two wards.

We found the patient files reviewed were in reasonably good order. We did make some recommendations to the Mental Health Act administrator about the order in which Mental Health Act (MHA) documentation and other records were retained.

There was information about the Mental Health Act administration posted in the ward areas and corridors, as well as advocate availability.

The three files reviewed related to patients from outside of Wales where the initial detention was implemented. This paperwork was reviewed and found to be in reasonably good order.

Records of Approved Mental Health Professionals (AMHP) who made applications for admission were comprehensive, with the full information of the circumstances leading to the application and consultation/discussions with the nearest relative.

Each patient had a section 17 leave card which they took with them whilst on leave. The card carried a photograph of the young person, defined risk areas as well as their date of birth. Even though this is essentially a good idea, the registered provider must consider the implications for the young person if the card were lost.

One area of good practice identified were the weekly visits by the pharmacist to undertake an audit of medication, as well as CO2, CO3 and section 62 forms. Any issues identified are then actioned initially by the nurse in charge.

We identified one file in particular where there was no apparent record made that treatment had been reviewed following the young person's transfer from another hospital in England. The issue was raised with the MHA Administrator who discussed it with the responsible clinician (RC), who initially declined to review as the document had been completed by a Second Opinion Appointed Doctor (SOAD) in England and the medication had not changed following arrival at Regis Healthcare. The Mental Health Act Administrator informed the reviewer that, after due consideration, the RC had agreed to review the treatment (and that of other patients in a similar situations) as a matter of good practice, and in this instance issued a CO2 accordingly. Assurance was given that where patients are transferred to Regis Healthcare, such reviews will take place in future.

We were provided with a list of young persons in the hospital which was extracted from the hospitals Mental Health Act database. The list had no headings and was incorrect. One young person listed as still in the hospital had been transferred out and another young person had been moved to a different ward within the hospital. The database needs to be updated in a timely manner to accurately reflect the persons at the hospital. Staff did confirm to the inspection team that the information was out of date.

Improvement needed

The registered provider must review the section 17 leave cards to risk assess the implications to a young person should they get lost

The hospital's Mental Health Act database needs to be updated to ensure the information is accurate and useable

The registered provider should ensure that the treatment of any new patient transferred to Regis hospital is reviewed by the responsible clinician and SOAD, where appropriate, and ensure that any certification is appropriate and up to date

## Quality of management and leadership

*We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Independent Health Care Regulations and National Minimum Standards.*

We found that the hospital's governance processes were not fit for purpose. The processes in place were not robust enough to monitor the actions, practices and decisions of staff within the organisation to ensure the hospital was being run efficiently, effectively and safely.

We found information was not being regularly assessed and monitored by the registered provider to ensure the quality of the service, and to identify, assess and manage risks relating to safe patient care.

Staffing was insufficient with both wards left below the required number of staff to provide safe patient care. In addition, there were no clinical ward managers in post to ensure clinical decisions were being supported.

Despite observing a motivated workforce at Regis Healthcare, staff morale was low due to the significant staffing issues. The hospital had also experienced a 50% increase in leavers in the first half of 2018 compared to 2017, which meant a major reliance upon agency staff.

We found that the agency induction process to be inadequate and despite being signed off by staff and the agency member, the knowledge of Regis processes, policies and procedures for some areas had not been completed.

### Governance and accountability framework

The hospital has a clinical governance framework which aims to ensure that the hospital focussed on continuously improving its services. However, we found that the governance processes were not fit for purpose and did not allow for robust monitoring of the actions, practices and decisions of staff within the organisation to ensure that the hospital was being run efficiently, effectively and safely.

Our review of documentation further identified that the hospital governance arrangements were not effective. Information was not being regularly assessed and monitored by the registered provider to ensure the quality of the service and to identify, assess and manage risks relating to safe patient care.

Questions were asked regarding the input and involvement of key staff at the hospital, including the hospital manager, ward managers and responsible individual as to why these systemic issues regarding inadequate staffing numbers had not been identified, considering the involvement and responsibilities that each role had. It was evident that the two systems (staff rotas and staff allocation) in place were not compatible and despite requests and frustrations given by ward staff regarding insufficient numbers, nothing appeared to be identified by the hospitals governance processes.

We were told that staffing was not discussed at governance meetings, however due to HIW's concerns and findings regarding inadequate staffing numbers at the hospital we were informed that a new corporate governance process to be implemented to review all aspects of staffing, retention and recruitment.

As a result of our concerns, a non compliance notice was issued to the service and a notice of decision to impose additional conditions added to the hospital's registration relating to staffing levels. It is important to note that we do not routinely take the step of issuing conditions relating to staffing upon a hospital's registration, however the action we took reflected our level of concern. The safety and wellbeing of the young people are our priority and our processes legally guide the redress to ensure the safe provision of care.

Improvement needed

The registered provider must ensure that governance processes are robust for monitoring the actions, practices and decisions of staff within the organisation to ensure the hospital is being run efficiently, effectively and safely, with a particular emphasis upon the adequate number of staff being available on each ward.

## Workforce planning, training and organisational development

Major concerns regarding staffing at the hospital were identified. Whilst at the time of our visit, staffing numbers were satisfactory, it was clear from our investigations and discussions with staff at ward level that staffing had been a significant concern. The numbers of staff per shift were not always sufficient for ensuring safe care. Despite ward staff requesting additional support, it was confirmed that requests were not always granted. The process described to us for obtaining additional staff involved three different levels of management, with signoff being made only by the responsible individual. This was not conducive to providing timely and sufficient numbers of staff for patient care.

We reviewed staffing rotas and work allocation sheets from a selection of records from a three month period. Whilst ward managers and senior staff worked from staff rotas, all ward based staff were adhering to the staff allocation sheets. These two systems were not compatible and hence the staffing issues we identified.

Our review of a number of staff allocation sheets between April and June 2018 found there were numerous occasions when staffing fell below safe levels. We saw that on multiple occasions only one registered nurse was on duty on each unit. This meant they were unable to take breaks and take appropriate clinical observations as appropriate. Given the complexity of the service and the challenges presented by the patient group this is not considered safe.

The allocation charts also highlighted that staff who had been allocated to care for patients, who required close observation, were taken away from their planned duties to assist colleagues with patients in other parts of the unit. This meant that patients who should be constantly supervised were not.

We were told that a restraint would sometimes require four members of staff to ensure the safety of the young person and three staff were used as a minimum. However, from the records we reviewed, this number of staff was clearly unavailable without taking them from other key duties, such as patient observations. We frequently found staff allocation sheets whereby units were frequently left understaffed. This meant that in an emergency no staff were available to provide support, leaving the young people and staff vulnerable and unsafe.

In addition, the recording of patient observations had to be completed retrospectively. Sufficient staff must be available to support the young people requiring additional help without the need for staff to be taken away from observations as this leaves the units and all individuals vulnerable.

The staff allocation sheets clearly showed that staff were spending considerable continuous periods of time on patient observations. The hospital policy states that no period of observation by a member of staff should be longer than 2 hours. However we identified staff completing continuous periods of observations of three and five hours with the same patient. Extended periods of observations can cause a lapse in vigilance and with units being understaffed this practice must be reviewed to ensure the hospital is adhering to their policy. The policy should be reviewed and updated in line with NICE guidelines.

At the time of our visit, the two ward manager positions were held by non-clinical staff. For some tasks this was not an issue, however where clinical input and decisions were required then they were not qualified to fulfil these, for example, adherence to NMC guidelines and some of the duties described within the job description of Regis ward managers. This was raised with the responsible individual during the visit and we were informed that a clinical appointment for ward manager on Brenin unit had been made.

Following our visit in March 2018, we noted that an induction process was in place for agency staff. When we arrived on Brenin ward, an agency member of staff was starting their first shift. We noted that a full induction had been signed as being completed by the nurse in charge and the new member of agency staff. The process had taken approximately two hours and covered many areas. When we spoke to the new staff member it became clear that not all aspects of the induction had been fully covered. The impact of this is that the agency member of staff was not fully aware of the key guidance, policies and procedures with regards to their role and responsibilities. There were no separate sections within the induction form to show which areas had been fully completed and which areas required further shadowing to evidence competence. Therefore HIW could not be assured that staff were competent to provide safe and effective care.

Improvement needed

The registered provider must review the two systems in place used by staff (rotas and allocation sheets) to ensure they are compatible and provide the organisation with an accurate picture of staffing levels and needs to both wards.

The registered provider must review the agency induction process to ensure each agency staff member has appropriate training and knowledge before being signed off as competent

The registered provider must ensure ward managers have sufficient clinical skills and knowledge to ensure safe and effective patient care

The registered provider must review the time staff are spending on continuous patient observations and ensure it is in line with relevant guidelines. Hospital policies to be updated and communicated to all staff.

The registered provider needs to ensure sufficient staff are available on each shift to provide safe and effective care

The registered provider needs to ensure observation records are not completed retrospectively and are a contemporaneous document

### Workforce recruitment and employment practices

We identified that in March 2018 that there was a high reliance on agency staff; this was the same situation in June 2018; however there was an attempt to source regular agency workers, therefore, although not permanently employed by Regis Healthcare there was a consistent workforce which gave some measure of reliability to the provision of the service.

Our review of staffing highlighted a very small number of permanent nursing staff at the hospital. Whilst we recognise that CAMHS is a specialist area, there is a need for more permanent staff that the young people respond to much more positively. Recruitment was something the organisation is trying to address.

A review of leaver statistics showed that there had been a 50% rise in leavers in 2018 compared with 2017. Data showed that five nurses left in 2017 and 10 in the first half of 2018. The number of healthcare workers that had left had risen from 18 leavers in 2017 to 33 in in the first half of 2018. We were concerned by this high turnover of staff. The information provided showed that not all leavers had received an exit interview. It is essential that leaver information is collected and analysed to gain feedback from employees in order to improve aspects of the service, better retain employees, and reduce turnover. The information should also be used as part of the hospitals governance process and to ensure better recruitment.

Improvement needed

The registered provider needs to review leaver information and use the data to ensure robust recruitment takes place so the hospital has the necessary permanent staffing levels required.

Given the areas for improvement identified during this inspection, consideration should be given to ensuring that there are more effective and proactive

arrangements in place at the service to monitor compliance with relevant regulations and standards. Whilst no specific recommendation has been made in this regard, the expectation is that there will be evidence of a notable improvement in this respect at the time of the next inspection.

# 4. What next?

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 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.

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a non-compliance notice. The issuing of a non compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

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.

# 5. How we inspect independent mental health services

Our inspections of independent mental health services are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of independent mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards
- Comply with the Care Standards Act 2000
- Comply with the Independent Health Care (Wales) Regulations 2011
- Meet the National Minimum Standards for Independent Health Care Services in Wales.

We also consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within independent mental health services.

Further detail about how HIW inspects mental health and independent services can be found on our 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 |
|---|---|---|---|
| We issued the service a non compliance notice to address the concerns we identified | | | |

## Appendix B – Improvement plan

**Service:** Regis Healthcare

**Ward/unit(s):** Brenin & Ebbw

**Date of inspection:** 27 - 29 June 2018

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 | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| **Quality of the patient experience** | | | | |
| Patient information boards must be covered when not in use to protect the sensitive nature of the information displayed. | Regulation 15 (1) (b) | A blind was in place at the time of inspection however not all staff utilised this. All staff have been reminded of the need to use it and random spot checks are now undertaken by the ward manager. | Ward Managers | End July 2018 |
| Information for how young people and visitors can provide feedback regarding the service needs to be clearly displayed | Regulation 9 (1) (g) & 19 (2) (b) (i) 24 (3) (a) | A feedback box has been placed in the reception area for family and visitors to leave comments – this information will be collated by senior management and | Hospital Manager | End July 2018 |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | (b) (c) | shared at both clinical governance and corporate clinical governance meetings | | |
| **Delivery of safe and effective care** | | | | |
| A review of all the locked areas on both wards is required and consideration given to implementing a less restrictive practice that would allow more access by the young people to additional areas. | Regulation 15 (1) (a) (b) & (c) | Both brenin and ebbw ward have had a change in the operational philosophy to enable both wards to have different identities. Ebbw ward is now a transition ward and young people on the ward have access to all areas within the ward. Brenin has a small area of restricted rooms due to it becoming the admission and stabilisation ward. However, the majority of rooms can now be accessed by young people. | Clinical MDT | End of August 2018 |
| The signage on Brenin ward needs to be reviewed and located appropriately | Regulation 26 (2) (c) | Signs were placed up high as young people were removing signs that were placed lower – however, the names of each room will now be stencilled above the doorways so that the rooms can be identified more easily. | Hospital Manager | End September 2018 |
| Systems need to be reviewed to ensure any | Regulation 15 | A proposal has been made via the | Responsible | End |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| visitor to the hospital can gain timely access during the day and night. | (2) | statement of purpose for the responsibility of the hospital by night which we feel would also address the issue of access. | Individual | September 2018 |
| The registered provider must review the overall responsibility of the hospital, especially at night. | Regulation 9 (e) & Regulation 19 (1) (b) | A statement of purpose update has been forwarded to HIW which outlines a proposal for staffing by night and includes the role of a night coordinator who will have responsibility for the service by night | Responsible individual/registe ed manager | End September 2018 |
| The registered provider must review the key operated door system to ensure this method is efficient in an emergency for staff to provide assistance elsewhere in the hospital. | Regulation 26 (2) (a) | The service is reviewing a number of the doors with a view to identifying an alternative system to ensure there is speedy access to the ward but that the safety required for a low secure unit is maintained. The provider has meetings scheduled with providers of alternative on the week of the 13th August 2018 | Responsible Individual/Registe red Manager | End October 2018 |
| The registered provider must ensure their provider reports are more comprehensive and detailed | Regulation 28 (4) (a) (b) (c) | The provider reports will be more comprehensive and actions will be reported on during clinical and corporate governance meetings for review by the | Responsible Individual | End of October 2018 |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | whole team. | | |
| The registered provider must ensure that all patient records are completed in a timely manner and not completed by staff at the end of a shift | Regulation 23 (1) (a) (i) | Observation sheets are now completed by staff during the course of their observations not when they have completed their allocated times. Observations are randomly spot checked by a number of team members during a shift to ensure that this continues. | Ward Manager | End of August 2018 |
| The registered provider must ensure all staff are supported to complete restraint paperwork in a timely manner after an incident | Regulation 20 (2) (a) & 23 (1) (a) (i) | Patient safety leads have been introduced to the hospital, part of their role will be to review paperwork and support the staff team | Patient safety leads | End of August 2018 |
| The registered provider must ensure risk assessments are comprehensive for all patients | Regulation 23 (1) (a) (i) | All risk assessments are reviewed following significant incidents or a change in behaviour as soon after they have occurred. | Head of Psychology | End of August 2018 |
| Patient information boards need to be updated in a timely manner to ensure all staff have access to current information | Regulation 23 (1) (a) (i) | There has been an introduction of a security lead per shift who will work with the ward manager to ensure this data is maintained | Security lead/Ward Manager | End of August 2018 |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| The registered provider must review the section 17 leave cards to risk assess the implications to a young person should they get lost | Regulation 19 (1) (b) | All cards have been reviewed and dates of birth have been removed | Mental Health act administrator | End of July 2018 |
| The hospital's Mental Health Act database needs to be updated to ensure the information is accurate and useable | Regulation 23 (1) (a) (i) | The database is maintained by the mental health act administrator and held centrally so that staff only have access to the one which is the most current | Mental health act administrator | End of July 2018 |
| The registered provider should ensure that the treatment of any new patient transferred to Regis hospital is reviewed by the responsible clinician or SOAD, where appropriate, and ensure that any certification is appropriate and up to date | Mental Health Act 1983 Code of Practice for Wales (2016) 25.80 | Regis will initiate this good practice following any new admissions to the service. | Mental Health act administrator | Following next admission to the service |
| **Quality of management and leadership** | | | | |
| The registered provider must ensure that governance processes are robust for monitoring the actions, practices and decisions of staff within the organisation to ensure the hospital is being run efficiently, effectively and safely. | Regulation (19) (a) (b) | A whole new governance structure has been implemented in July which includes a number of fail safes to ensure that information reaches all parties concerned in a timely manner. It also does not rely solely on an individual but has measures in place for checking with | Responsible individual/registered manager | End of July 2018 |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | external agencies involved. Governance now takes two forms with clinical governance including senior members of the MDT and management with a further layer of governance at corporate level which reviews the practices in place as well as receiving information from clinical governance. This is attending by members of the hospital board | | |
| The registered provider must review the two systems in place used by staff (rotas and allocation sheets) to ensure they are compatible and provide the organisation with an accurate picture of staffing levels and needs to both wards. | Regulation (19) (a) & 20 (1) (a) | Rotas are provided daily to the wards as part of a pack that is presented to the wards at the start of each shift this will have the most up to date information. At the end of the shifts the information for the actual rota is taken from the allocation sheets provided by the ward and compared to the fire logs that are also completed each shift. | Registered manager | End of July 2018 |
| The registered provider must review the agency induction process to ensure each agency staff member has appropriate training and knowledge before being signed off as competent | Regulation 20 (2) (a) | Agency nurses have now worked either a shadow shift before or have been supernumerary on their first shift so that they can understand the wards and the | Registered Manager | End of July 2018 |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | day to day running of the ward. The induction form has also been amended | | |
| The registered provider must ensure ward managers have sufficient clinical skills and knowledge to ensure safe and effective patient care | Regulation 20 (1) (a) | Ward managers have been replaced with Clinical ward managers who are qualified nurses | Registered manager | End of July 2018 |
| The registered provider must review the time staff are spending on continuous patient observations and ensure it is in line with relevant guidelines. Hospital policies to be updated and communicated to all staff. | Regulation 19 (1) (a) (b) | The observation policy has been updated | Clinical manager | End of August 2018 |
| The registered provider needs to ensure sufficient staff are available on each shift to provide safe and effective care | Regulation 20 (1) (a) | A new staffing matrix has been introduced to determine staffing levels for each shift. This is monitored by the ward manager and patient safety leads | Registered manager | End of July 2018 |
| The registered provider needs to ensure observation records are not completed retrospectively and are a contemporaneous document | Regulation 23 (1) (i) | Observation records are now completed during the course of the observation period, not once it has been completed. | Ward Manager | End of July 2018 |
| The registered provider needs to review leaver information and use the data to ensure robust | Regulation 20 (1) (a) | Exit interviews are now carried out by | HR Manager | End of July |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| recruitment takes place so the hospital has the necessary permanent staffing levels required. | | the HR team, not individual managers. | | 2018 |
| | | | | |

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): Stephanie Haywood**

**Job role: Responsible Individual**

**Date: 14th August 2018**