Independent Mental Health Service Inspection (Unannounced)

Rushcliffe Hospital

Aberavon

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

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

Email: **hiw@gov.wales**

Fax: **0300 062 8387**
Website: **www.hiw.org.uk**

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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 unannounced independent mental health inspection of Rushcliffe Independent Hospital (Aberavon). The inspection commenced during the evening of 5 November 2018 and continued on 6 and 7 November.

Our team, for the inspection comprised of three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one lay reviewer. The inspection was led by a HIW inspection manager.

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

Overall, we found evidence that the service provided safe and effective care within a pleasant environment. The service demonstrated an emphasis on patient centred care.

This is what we found the service did well:

- The hospital provided a safe and patient centred approach to rehabilitation
- Patients we spoke with were happy with their care and the services provided by the hospital and staff
- Utilised hospital range of local amenities to provide activities that aided patient recovery and rehabilitation

This is what we recommend the service could improve:

- Provide additional outside storage in order to de-clutter some patient spaces.
- The patient kitchen on the ward requires a deep clean and consideration should be given to updating the whole room.

There were no areas of non compliance identified at this inspection.

3. What we found

Background of the service

Rushcliffe Hospital, Aberavon is registered to provide an independent locked mental health rehabilitation service at:

Rushcliffe Hospital,
Scarlet Avenue
Aberavon
Port Talbot
SA12 7PH

The setting is a male only unit with 18 beds. At the time of inspection, there were 13 patients.

The service was first registered on 8th July 2009.

The service employees a staff team which includes;

- 2 Registered Managers who are both Registered Mental Health Nurses.
- 7 full time registered mental health nurses, 2 in house registered mental nurses on a bank system for resilience.
- 19 full time support workers plus 2 in house on a bank system for resilience.
- The multi-disciplinary team includes 1 Consultant Psychiatrist, 1 Psychologist with an Assistant Psychologist.
- 1 full time Occupational Therapist (OT) with 1 assistant OT.
- 1 full time activity coordinator.

The team could also access a music therapist and an art therapist who were both students in the field on a six month rotational cycle from a local university.

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 found that patients were very positive about the service and believed they were receiving a very good standard of care

The service was focused on accessing local community services as part of its rehabilitative care.

Health promotion, protection and improvement

Health promotion, protection and improvement were part of the care provided at Rushcliffe. The Physical Health and Wellbeing Strategy supported patients' physical health; this included physical health and wellbeing initiatives.

The location of the hospital lends itself to a healthy lifestyle with plenty of outside space for physical activities. The hospital had several mountain bikes for patients use, having a bike path immediately outside the hospital. Fishing equipment was also available for use which fitted with the location on Aberavon sea front.

There were also many facilities within the hospital itself. There was a communal cinema room with well stocked shelves of books and games. A pool room, music room, art room and a wood work room were also available for patients to use on request.

There was a lot of information on notice boards within the communal areas around health promotion appropriate to the patient group. There was a bowl of fruit left out for patients to eat as and when they desired. Patients were also able to access the patient kitchen until 11pm every night to prepare small meals for themselves.

Rushcliffe had a range of facilities to support the provision of therapies and activities along with regular access to the community for those patients that were authorised to leave the hospital.

Patients were engaged and supported in undertaking Activities of Daily Living[1] that promoted recovery and rehabilitation, such as preparing meals and other domestic activities. There were two laundry rooms with a washing machine and tumble drier so that patients could learn and maintain their domestic skills.

Patients were given membership to a local gym and other leisure facilities within the local community that they could access whilst on leave.

There were three designated hospital vehicles; these enabled staff to facilitate patient activities, voluntary work placements and medical appointments in the community.

There was information displayed at the hospital for patients which included details on how to raise a complaint and contact external organisations such as the local safeguarding department, police and details on the advocacy arrangements available. However, HIW contact details were not displayed in the ward area.

There was also an advocate who attended the hospital for a full day every fortnight and sat within the communal area of the hospital to be available for all patients to utilise if required. Despite there being a good amount if information displayed there was limited information displayed or readily available to patients either in Easy Read or Welsh.

The registered provider must ensure that HIW contact details are displayed within the ward area of the hospital.

[1] These activities can include everyday tasks such as dressing, self-feeding, bathing, laundry, and meal preparation.

Dignity and respect

We observed that all employees: ward staff, senior management and administration staff, interacted and engaged with patients appropriately and treated patients with dignity and respect. The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients.

We heard staff speaking with patients in calm tones throughout our inspection. We observed staff being respectful toward patients; when patients approached staff members, they were met with polite and responsive caring attitudes. On the whole patients we spoke with agreed that they were treated with dignity and respect at hospital.

Staff would regularly take their meal breaks within the ward and sit with patients to eat their meals. This created a very friendly and positive environment. Also the registered manager's office is on the ward. The registered manager employs an open door policy so patients can speak to him whenever he is there. This was witnessed several times during our inspection and again helped to create a very positive atmosphere at the hospital.

Each patient had their own bedroom with en-suite facilities which they could access throughout the day; the bedrooms provided patients with a good standard of privacy. Patients were able to lock their own bedrooms which staff could over-ride if required. We observed a number of patient bedrooms and it was evident that patients were able to personalise their rooms and had sufficient storage for their possessions.

The hospital had suitable rooms for patients to meet ward staff and other healthcare professionals in private. There were visiting arrangements in place for patients to meet visitors at the hospital. The reception area and visiting room were of a very high standard and provided a calm homely environment for patients to meet visitors.

The television room has a large window which covers the whole outside wall looking onto Aberavon sea front. At night when the lights are on members of the public who are walking along the busy footpath outside this window can look straight into the hospital, having a full view of the television and dining area where patients socialise. There is a reflective film on the window which doesn't allow patients to look out of this window at night time when the lights are on inside. This may have a detrimental effect on patients dignity and privacy

Improvement needed

The registered provider must take appropriate measures to ensure patients dignity and privacy are respected in relation to the visual access to the hospital from the public footpath outside the television room.

Patient information and consent

As detailed above patient information was readily available

Communicating effectively

Through our observations of staff-patient interactions, it was evident that staff ensured that they communicated appropriately and effectively with patients. Staff took time to undertake discussions using words and language suitable to each individual patient. Where patients remained unclear, or what they were trying to communicate was misunderstood, staff would patiently attempt to clarify what they had said.

A large proportion of the staff at the hospital were long standing employees and had very good relationships with patients. They were friendly but maintained a professional boundary.

The hospital consists of one large ward. There is a general handover between senior nurses twice a day which is documented. There is also a daily morning meeting with the registered manager and other senior clinicians and staff to discuss the specifics of the day such as treatments and patient activities including leave. The doctor performs two ward rounds every day and is available for each patient. This level of care helps ensure that all patients' needs are communicated and documented to a high standard.

A Multi Disciplinary Meeting (MDT) took place every Wednesday to discuss individual patients. For individual meetings, patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. With patients' agreement, their families and/or carers could also be present.

Patients that we spoke with confirmed that staff communicated clearly and that they understood their care. Patients also stated that they felt listened to.

We attended a number of clinical meetings and it was evident that discussions focused on what was best for the individual patient. Where the patient was present at the meeting all staff engaged respectfully and listened to the patient's views and provided the patient with clear reasons for the decisions taken.

Care planning and provision

There was a clear focus on providing safe and effective care for patients, with measured steps for appropriate discharge. Care was individualised, focused on recovery and was supported by least restrictive practices, both in care planning and ward or hospital practices.

A large proportion of the patients were from other areas of Wales and England. The hospital were very considerate of this and provided transport regularly for patients to visit family some distance away.

Each patient had their own programme of care based on their individual needs such as medication, therapy sessions and activities. These included individual and group sessions, based within the hospital and the community.

Throughout the inspection we observed patients participating in individual and group activities within the hospital and accessing the community. It was evident that there was mutual respect between the patients and staff.

Equality, diversity and human rights

Staff practices aligned to established hospital policies and systems which ensured that the patients' equality, diversity and rights were maintained. Statistics evidenced that well over 90% of staff were up-to-date with applicable training. All mandatory training for staff was provided on site by the registered manager.

There was a multi-faith room in the hospital that was available to any patient who wished to use it. A Kosha diet was also provided for one of the patients.

Citizen engagement and feedback

There were the opportunities for patients, relatives and carers to provide feedback on the care provided at the hospital; patients and family were invited into MDT meetings to be fully involved in the care planning. All contact details were fully maintained in the patients' care records.

Details of the complaints procedure were available on the ward. The registered provider's governance arrangements allowed for analysis of complaints and to monitor the handling of complaints in line with the registered provider's policy.

Patients we spoke with said that they felt comfortable in discussing any concerns with staff members and that they knew how to raise a complaint if required. The hospital had received thank you letters off past and present patients and their families which were very complimentary of the care provided.

As stated earlier the registered manager was stationed on the ward and patients were free to speak with him at any time and raise concerns. This was witnessed a number of times during the inspection.

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 were satisfied that the service provided a very high standard of patient centred care. There was a clear focus on recovery which was assisted by in house relapse prevention nurses with planned activities and sessions

Managing risk and health and safety

Rushcliffe had established processes in place to manage and review risks and to maintain health and safety at the hospital. This enabled staff to continue to provide safe and clinically effective care.

Access to the hospital was via an open car park to the front. In the daytime there was a small open foyer with a locked door into reception. This was accessible via key fob. At night this foyer is locked. Access to the ward was only possible through an air lock system at the rear of reception. The whole hospital is fully accessible for those with restricted mobility and wheelchairs.

Staff wore personal alarms and two-way radios which they could use to call for assistance if required. There were also nurse call points around the hospital and within patient bedrooms adjacent to their beds so that patients could summon assistance if required.

The hospital was very spacious and felt very open in all the patient areas. The ward environment looked well maintained and suitably furnished. The furniture, fixtures and fittings at the hospital were appropriate for the patient group. There were some loose television cables identified in the cinema room which were not in use. These were removed immediately by staff.

The woodwork room was a popular facility for the patients where they could be creative under supervision by staff to build items of their choice using the tools and materials provided. The room was, however, very cluttered as it was also used to store the bicycles and fishing equipment. The hospital must ensure this area is kept to a sufficient standard to provide a safe therapeutic environment for the patients.

The patient kitchen was large enough for all the patients to use, however it was in need of a deep clean and looked quite tired, clearly as a result of it being used so much. It was unclear whether the patient fridge was working correctly as there was milk that was in date but had gone off in the fridge. There was however evidence that milk was being left out of the fridge. Daily temperature readings were being recorded.

There was a ligature point risk assessment in place; this was incorporated within a specific risk assessment carried out for each area within the ward. These identified potential ligature points and what action had been taken to remove or manage these.

The training statistics provided evidenced that almost all staff were fully up to date with mandatory training which was delivered on site. There was an emphasis within the hospital of using a least restrictive practice for patients, this was evidenced with a very low number of incidents recorded on the ward. This was also confirmed by patients

The hospital was well staffed with an appropriate skill mix and number of staff to care for the patient group at the time of our inspection. There were no staffing vacancies and it was evident that all aspects of patients needs were being met.

Improvement needed

The registered provider must ensure that there is a regular deep clean of the patient kitchen

The registered provider should consider refurbishment of the patient kitchen

The registered provider must ensure there is sufficient and appropriate storage for patients' milk.

The registered provider must ensure there is appropriate storage facilities for bicycles, fishing equipment, etc. that are currently stored in the woodwork room.

Infection prevention and control (IPC) and decontamination

Throughout the inspection we observed the hospital to be visibly clean and free from clutter other than the area identified elsewhere in this report. Cleaning equipment was stored and organised appropriately. There were records of cleaning schedules being maintained which evidenced regular cleaning.

Staff also had access to infection prevention and control and decontamination personal protective equipment (PPE) when required.

Training statistics evidenced all staff within the clinical area of the hospital were trained to appropriate levels of infection prevention and control

Nutrition

Patients were provided with meals at the hospital which included breakfast, lunch and evening meal. Patients choose their meals from the hospital menu that was on a four week cycle. This was displayed in the main communal area of the ward. There is also a facility to adjust meals to suit certain dietary requirements. Patients also had access to snacks along with hot and cold drinks that they could make themselves in the patient kitchen up until 11pm.

Patients gave generally positive views on the meals provided at the hospital. Some patients complained that food was repetitive and the menu wasn't changed very often. One patient suggested that the amount of food previously wasn't enough but this situation has improved recently.

Patients were however able to cook their own food if and when required. Patients could access the community to purchase food items and ingredients. We also noted that ward staff and kitchen staff would purchase specific food items and ingredients on a patient's behalf if they did not have leave.

During the inspection left over food from the evening meal was left uncovered and not stored appropriately in the main hospital kitchen. This hadn't been cleared away and disposed of as it should have. There was some disagreement around whose responsibility it was to perform this duty. The hospital management should ensure there is a clear policy in place to deal with this issue to avoid a reoccurrence.

Improvement needed

The registered provider must ensure that there is a clear policy for the disposal and storage of food after each meal time.

Medicines management

Overall medicines management at the hospital was safe and effective. There were some drugs stored on the open shelf of the drug trolley, due to limited storage. Otherwise medication was stored securely within cupboards and medication fridges that were locked. Medication trolleys were locked and

secured when not in use. There was evidence that there were regular temperature checks of the medication fridge and clinic room temperature to ensure that medication was stored at the manufacturer's advised temperature.

However, there was limited medication storage space remaining. At the time of the inspection the hospital was not fully occupied with vacancies for up to an additional five patients, therefore with additional patients there may be insufficient medication storage within the clinic room.

We reviewed samples of Medication Admission Record (MAR) charts. All the MAR Charts reviewed contained the patient's name and their mental health act legal status. MAR charts were consistently signed and dated when medication was prescribed and administered. However, there were a small number of incomplete MAR charts with omissions when medication had been refused by the patient.

The controlled drugs records were in good order. There were regular stock checks of the controlled drugs against the log book at each handover.

There was a regular external pharmacy audit undertaken that assisted the management, prescribing and administration of medication at the hospital. However, it was evident that errors were repeatedly being identified by the audit and not always improving the practice of staff.

Staff had access to all relevant medicine management policies at the hospital, although this was dated 2016. This should be revisited and brought up to date to take account of any changes in this time. Staff also had access to the current British National Formulary (BNF)[2].

Improvement needed

The registered provider must ensure that there is sufficient medication storage at the hospital

The registered provider must ensure that staff complete MAR charts when

[2] British National Formulary is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about individual medicines.

medication is refused by patients.

The registered provider must ensure that errors identified by the pharmacy audit are addressed and that sustainable improvements to staff practice are made.

Safeguarding children and safeguarding vulnerable adults

There were established processes in place to ensure that the hospital safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

The training statistics provided by the registered provider evidenced that 100% of staff were up to date with their safeguarding training. This training is carried out on site by the registered manager.

The safeguarding documents were in order at the hospital and the referrals were of a good standard. The hospital has a good working relationship with the local safeguarding department and public protection unit.

Medical devices, equipment and diagnostic systems

There were regular audits of resuscitation equipment undertaken on the ward. These documented that all resuscitation equipment was present and in date. However the equipment was not kept all together so could not be carried at the same time. The hospital should consider keeping this equipment in a 'Go' bag so it will be far easier to convey in an emergency.

Improvement needed

The registered provider should consider an alternative method of storing the emergency medical equipment.

Safe and clinically effective care

Overall, we found governance arrangements in place that helped ensure that staff provided safe and clinically effective care for patients to a very good standard. The arrangements for the hospital fed through to the Rushcliffe Group’s governance arrangements which facilitated a two way process of monitoring and learning.

There were areas of very good practice that were highlighted, such as:

- 72 hour admission assessment and admission checklists
- One to one therapeutic sessions
- The use of several evidence based tools in facilitating treatment
- Care and Treatment Plan (CTP) and Multi Disciplinary Team (MDT) reviews were found to be of an excellent standard.
- It was noted that the hospital employed a very positive approach to least restrictive interventions, there was very little use of restraint.

Improvement needed

The registered provider must ensure admission checklists are completed in full or evidence why there are gaps.

Participating in quality improvement activities

The registered manager provided evidence of research carried out by clinical staff at the hospital on the subject of the Prescription of medicines for side effects of psychotropics in a psychiatric rehabilitation unit. This was presented at the Royal College of Psychiatrists International Congress 2017 in Edinburgh.

Records management

Patient records were held in a paper format. These were found to be of an excellent standard; very well indexed and clear to the reader. MDT notes are electronic but a paper copy is held on the patient's care notes file.

We witnessed a patient being provided money by staff at reception to use on leave. There was no evidence that this was signed for by the patient at the time of receiving the money. he hospital should consider tightening this process so that there is an audit trail of patients receiving their money. This will assist with any future queries and discrepancies.

Improvement needed

The registered provider must ensure that there is a clear auditable record of the distribution of patient monies

Mental Health Act Monitoring

We reviewed the statutory detention documents of three patients. We also reviewed the governance and audit processes that were in place for monitoring the use of the Mental Health Act at the hospital.

Medication was provided to patients in line with Section 58 of the Act, Consent to Treatment; with consent to treatment certificates always kept with the corresponding Medication Administration Record (MAR Chart). This meant staff administering medication could refer to the certificate to ensure that medication was prescribed under the consent to treatment provisions of section 58 of the Act.

All patient leave had been authorised by the responsible clinician on Section 17 Leave authorisation forms. Section 17 Leave clearly stated the conditions of leave, i.e. escorted or unescorted, location and duration. It was clear that this leave was facilitated as much as possible to suit the patient's needs.

In some cases it was not documented within patient records whether the patient had been offered or received a copy of their Section 17 Leave form which is required to evidence compliance with the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 (the Code), paragraph 27.18. The hospital must ensure that this is complied with in every instance.

Staff had access to a range of patient information leaflets to help assist discussions with patients regarding their care and treatment in hospital. It was documented within patient records that they had been informed of their rights (Section132 of the Act), both verbally and with written explanations.

All patient detentions were found to be legal according to the legislation and well documented. There were two members of staff who carried out the Mental Health Act Administrators role alongside other duties. All the required documentation was held on site and of a high standard. Issues were highlighted around the format in which the documentation was filed; the way the files were presented was very confusing to the reader. The files require consolidating and streamlining with only original documents being retained instead of copies as these are, at the moment, duplicated in different files. Copies were not identified or stamped as copies before being sent to the ward which could cause confusion.

The registered provider is required to ensure that there are sufficient staff, time and resources with appropriate knowledge to fulfil the registered provider’s statutory responsibility of the Act and that practice follows the guidance set out in the Code.

Improvement needed

The registered provider must ensure that there are sufficient staff, time and resources with appropriate knowledge to fulfil the registered provider's statutory responsibility of the Act and that practice follows the guidance set out in the Code.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

We reviewed the care plans of a total of six patients.

They were generally of a very high standard.

There was evidence that care co-ordinators had been identified for the patients. The Care and Treatment Plans reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed.

Individual Care and Treatment Plans drew on the patient's strengths and focused on recovery, rehabilitation and independence. These were developed with members of the multi-disciplinary team and utilised evidence based practice. Care and Treatment Plans also included good physical health monitoring and health promotion.

To support patient care plans, there were a range of patient assessments to identify and monitor the provision of patient care, along with risk assessments that set out the identified risks and how to mitigate and manage them.

Patients confirmed that they were encouraged to be involved in developing their care with a focus on discharge to a less restrictive environment. There was evidence of discharge planning where appropriate for patients on that pathway.

With the permission of the individual patients we attended a number of care reviews and observed staff conducting an inclusive patient focused meeting. When a patient decided to be involved in the meeting we observed that the patient's views and wishes were listened to and staff provided clear reasons for decisions taken. It was also the case that family members and advocates could attend these meetings if the patients so wished.

There was little evidence found within the care plans of where unmet needs were identified and also evidence of whether patients had capacity to agree to treatment plans. The provider must ensure both these matters are documented within the care plans of the individual patients

Improvement needed

The registered provider must ensure that unmet needs are evidenced within patient care plans.

The registered provider must ensure that it is documented whether the patient has capacity to consent to the treatment plan.

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 evidence of a very good management structure with strong structured leadership and a positive relationship with staff and patients.

Governance and accountability framework

We found that there were well defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit and its established governance structure which enabled key/nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

Identified senior managers had specific responsibilities for ensuring that the programme of governance remained at the forefront of service delivery. Those arrangements were recorded so that they could be reviewed both within the hospital and the wider organisational structure.

There was a clear organisational structure for the hospital, which provided clear lines of management and accountability. These arrangements were clearly defined during the day with senior management on-call arrangements in place for the night shift. There was a registered nurse in overall charge of the hospital on a night shift.

There was strong multi-disciplinary team-working with staff commenting favourably on each other and stating that they felt that their views were listened to and respected by other members of staff.

Staff spoke positively about the support from colleagues across the disciplines and they stated that morale was high. There were no vacancies at the hospital and many staff members had been there for some time evidencing a strong

team bond. We found that staff were committed to providing patient care to high standards.

It was positive that, throughout the inspection, the staff at Rushcliffe were receptive to our views, findings and recommendations and acted on them immediately after discussions.

Dealing with concerns and managing incidents

There was a complaints policy and procedure in place at the hospital. The policy provides a structure for dealing with all patient complaints for services within Rushcliffe.

Complaints were categorised as informal or formal complaints. All complaints were dealt with by the registered manager who was responsible for the final sign off. Formal complaints were monitored and reviewed through clinical governance arrangements which ensured that the complaints process was followed and completed.

There was system in place for recording, reviewing and monitoring incidents. These were entered in to the paper system that included the names of patient(s) and staff involved, a description, location, time and length of the incident. Any use of restraint was documented. These were also documented on the care notes.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and reviewed at hospital and organisation level so that the occurrence of incidents could be reviewed and analysed.

Arrangements were in place to disseminate information and lessons learnt from complaints and incidents to staff both at the hospital and the wider organisation.

Workforce planning, training and organisational development

We reviewed the staffing establishment at Rushcliffe and it was evident that the registered provider had undertaken recruitment to fill any vacancies at the hospital. At the time of the inspection all vacancies had been appointed to;

There was no reliance on the use of agency staff to fulfil rotas. There were a number of former employees who worked as bank staff and were available at short notice if required. Both registered managers were registered nurses which offered resilience also.

We reviewed the mandatory training statistics for staff and found that completion rates were on the whole very high with all mandatory training being completed in house by one of the registered managers. All other training compliance was also very high. There is a training matrix in existence which allows the management team to identify training needs and keep on top of compliance in this area.

Workforce recruitment and employment practices

Staff explained the recruitment processes that were in place at Rushcliffe and we reviewed a sample of four staff files. It was evident that there were systems in place to ensure that recruitment followed an open and fair process; with records of application, interviews and communication held on each file. Prior to employment staff references were received, professional qualifications checked and Disclosure and Baring Service (DBS) checks were undertaken, and then renewed every three years.

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, measurable, 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.

IF NO IMMEDIATE CONCERNS WERE IDENTIFIED STATE - "No immediate concerns were identified on this inspection" in the table below

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
Spare television cables were left in the TV room	These could be used to self harm and created a ligature risk	Registered manager informed	Cables were removed immediately

Appendix B – Improvement plan

Service: Rushcliffe Hospital, Aberavon

Ward/unit(s): whole unit

Date of inspection: 5 6 7 / 11 / 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				
The registered provider must ensure that HIW contact details are displayed within the ward area of the hospital.	3. Health promotion, protection and improvement	Action achieved- contact details displayed in the atrium area and patient's notice board.		
The registered provider must take appropriate measures to ensure patients dignity and privacy are respected in relation to the visual access to the hospital from the public footpath outside the	10. Dignity and respect	All Patients bedrooms have curtains for every window panel and have been encouraged and reminded to close their curtains when going to bed. However patients have refused to have a curtains		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
television room		or blinds put in place in the television room as they are always fully dressed and appropriate in that area and would like to have the full sea view from this room.		
	9. Patient information and consent			
	18. Communicating effectively			
	8. Care planning and provision			
	2. Equality, diversity and human rights			
	5. Citizen engagement and feedback			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The registered provider must ensure that there is a regular deep clean of the patient kitchen The registered provider should consider refurbishment of the patient kitchen The registered provider must ensure there is sufficient and appropriate storage for patients milk. The registered provider must ensure there is appropriate storage facilities for bicycles, fishing equipment, etc. that are currently stored in the woodwork room	22. Managing risk and health and safety 12. Environment 4. Emergency Planning Arrangements	Deep clean rota has been put in place and has been achieved as per plan. The kitchen was recently painted, and new cupboards ordered. A small fridge for milk was also purchased. Outside 20ft container has been ordered and therefore all bikes and other equipment can be kept safe appropriately.		
	13. Infection prevention and control (IPC) and			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	decontaminati on			
The registered provider must ensure that there is a clear policy for the disposal and storage of food after each meal time	14. Nutrition	Rushcliffe hospitals food policy 2.18 states that food will be disposed within 90 minutes after food is served and not consumed.		
The registered provider must ensure that there is sufficient medication storage at the hospital The registered provider must ensure that staff complete MAR charts when medication is refused by patients. The registered provider must ensure that errors identified by the pharmacy audit are addressed and that sustainable improvements to staff practice are made.	15. Medicines management	New double cupboards have been installed in the clinic room. A new procedure for medication checks has been put in place. During handovers medication charts are reviewed by the outgoing nurse and the incoming nurse on shift and this have ensured 100% compliance in respect to signatures.		
	11. Safeguarding children and safeguarding vulnerable adults			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	17. Blood management			
The registered provider should consider an alternative method of storing the emergency medical equipment	16. Medical devices, equipment and diagnostic systems	Emergency medical equipment storage bag has been ordered.		
The registered provider must ensure admission checklists are completed in full or evidenced why there are gaps.	7. Safe and clinically effective care	This is part of the audit process and is done monthly by Registered Hospital Manager		
	6. Participating in quality improvement activities 21. Research, Development and Innovation			
	19. Information management and communications technology			
The registered provider must ensure that there	20. Records	A new document is in place which		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
is a clear auditable record of the distribution of patient monies	management	requires both staff and patient to sign out their money when accessing community leave..		
Quality of management and leadership				
	1 Governance and accountability framework			
	23 Dealing with concerns and managing incidents			
	25. Workforce planning, training and organisational development			
	24. Workforce recruitment and			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	employment practices			

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): Robert Tamirepi

Job role: Registered manager

Date: 24/01/19