Focussed Review: Staffing, Governance, Patient Incidents and Risk Management Arrangements (Unannounced)

Ty-Grosvenor Independent Hospital

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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 receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

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 focussed inspection of Ty Grosvenor Independent Hospital on the 29 and 30 June and the 1 July 2020. This service was previously inspected in October 2019 and this visit prompted by an incident involving the police which resulted in significant safeguarding and whistle-blowing concerns being reported to HIW.

Ty Grosvenor – Elysium Healthcare Ltd

Ty Grosvenor is an Independent Hospital and is registered to provide rehabilitation treatment to either male or females in single gender wards to a maximum of 34 (thirty four) adults between 18 (eighteen) and 65 (sixty five) years of age who are diagnosed with a mental disorder and who may be liable to be detained under the Mental Health Act 1983.

How did we do this?

The team comprised of two members of HIW staff who visited the hospital and a further two members of HIW staff who analysed information for the visit, but did not physically visit the hospital. This arrangement was due to the Coronavirus pandemic and the need to reduce the number of people attending the hospital to minimise any risk to patients and staff at Ty Grosvenor.

The review was carried out over a night/early morning and one other full day and one other half day and focussed specifically on:

- Care plans and risk assessments
- Patient observations
- Staffing including; the use of agency
- Safeguarding/Incidents/patient concerns
- Governance and audit.

2. Summary of our inspection

Overall we were not assured that the registered provider had adequate systems and processes in place to ensure patients were receiving effective and safe care. Of particular concern was the lack of effective care planning when significant risks to the health and welfare of patients had been identified. The risks associated with bathroom access were of particular concern because it was documented that patients had no bathroom privacy but there was no care plan to guide staff in managing this risk when these patients had supervised bathroom access. In addition, care plans were not in place for wound care and for when the enhanced care facilities were being utilised.

We also identified a lack of a registered nurse by night. This meant that the registered nurses on each of the wards were unable to take their allocated break from the ward and in the event of an incident they would have no second registered nurse available for support. In addition, it was impossible on the basis of the written documentation available to determine the actual numbers of staff on the ward at a given time. This must be addressed so that the registered manager and registered provider can be assured that staffing levels are adequate and meet the needs of the patient group throughout each 24 hour period.

Many of the issues raised in this report relate to a failure of effective audit and governance. If the audit and governance process had been working effectively these issues should have been identified and acted upon before the inspection had taken place.

Our inspection found that there were some areas of noteworthy practice, these are set out below:

- There was some good evidence of multi-disciplinary input into the care planning process
- There were some examples of staff dedication to the patients.

However we also identified the service was not compliant in a number of areas detailed below;

- The service is non-compliant with Regulation 15 (1) (a) and (b) of the Independent Health Care (Wales) Regulations 2011 regarding quality of treatment and other services provided.

- The service is non-compliant with Regulation 20 (1) (a) of the Independent Health Care (Wales) Regulations 2011 regarding staffing
- The service is non-compliant with Regulation 19 (1) (a) and (b) of the Independent Health Care (Wales) Regulations 2011 regarding assessing and monitoring the quality of service provision in relation to managing risks relating to the health, welfare and safety pf patients and including annual returns

These are serious issues and resulted in the issuing of a non-compliance notice to the service in relation to the above.

In addition this report identifies further non-compliance issues as detailed below;

- The service is not complaint with Regulation 20 (2) (a) the registered person must ensure that each person employed in or for the purposes of the establishment, or for the purposes of the agency receives appropriate training, supervision and appraisal
- The service is non-compliant with Regulation 9 (2) (a) regarding how disturbed behaviour exhibited by a patient is to be managed effectively when the police are involved
- The service is not complaint with Regulation 8 (a) the registered person must keep under review and, where appropriate, revise the statement of purpose.

At the time of publication of this report HIW has received sufficient assurance that appropriate action has or will be taken to address the improvements required.

The findings of this inspection are very concerning and have resulted in the service being designated a Service of Concern as described in our enforcement procedure. This means the hospital is under the highest level of scrutiny and HIW will be monitoring the service very closely to ensure that all required improvements are made and embedded within hospital practices to ensure sustainability. We are also in regular contact with the commissioners of patients at the hospital. In addition, the registered provider has agreed to a voluntary restriction on accepting new admissions to the hospital.

3. What we found

Quality of Patient Experience

We observed a good rapport between patients and staff and the patients we spoke with commented positively on the staff interaction and approach.

Patients had a range of activities available to them and the opportunity to engage in community outings.

Some patients on Brenig ward expressed concern and stated that they were fearful for their safety because of the behaviour of a fellow patient.

We spoke with a number of patients, during the visit, to ensure that the patients' perspective is at the heart of our approach to inspection. In addition, we spoke to a range of staff including the registered manager.

Dignity and respect

During the inspection we observed positive and therapeutic staff interactions with patients. The patients we spoke with commented positively on the dedication and considerate approach by all the disciplines of staff within Ty Grosvenor. Patients were particularly complimentary in relation to the recovery workers. We observed and were told by patients about a range of social, therapeutic and recreational activities that were available.

Each patient had their own bedroom and the degree of personalisation varied depending on the behaviour and risk assessment of the individual patient.

Improvement needed

The registered provider must work with patients to ensure that they feel safe and not threatened by challenging behaviour of other patients.

Delivery of Safe and Effective Care

We were not assured that the registered provider had adequate systems and processes in place to ensure patients were receiving safe and effective care. Of particular concern was the lack of effective care planning when significant risks to the health and welfare of patients had been identified. The risks associated with bathroom access were of particular concern because it was documented that patients had no bathroom privacy but there was no care plan to address how the risks were going to be managed when these patients had supervised bathroom access. In addition, care plans had not been formulated for wound care and when the enhanced care facilities were being utilised.

There were a range of policies and procedures in place, however, the registered provider/manager needs to develop a policy and procedure on police attendance at the unit and be more proactive in developing their relationship with the local police team.

Staff supervision was not implemented consistently and some staff stated that they had not had a supervision session for a considerable length of time.

Overall this meant that we could not be assured that the registered provider was able to provide patients with safe and effective care.

Managing risks and promoting health and safety

Access to the hospital was via a locked outside door and a locked internal door and a bell was provided to enter the premises.

There were a range of policies and procedures in place covering a number of key areas. However, the registered provider/manager needs to develop a policy and procedure on police attendance at the unit and be more proactive in developing their relationship with the local police team.

Improvement needed

The registered provider needs to develop a local policy on police attendance/liaison with Ty Grosvenor.

Effective care

A total of 4 sets of patient care documentation were examined on Brenig ward throughout the 3 day inspection.

The care notes for patient A were examined on the 30 June and the following observations were made:

- The patient had a history of self-injurious/suicidal behaviour and had previously attended a general hospital for treatment following self-injurious behaviour.
- Patient A had injured themselves on occasions using various objects and had recently smashed their ipad and had used the broken glass to cut themselves. Nursing staff informed HIW staff that patient A's mental state had settled and they had once again been given access to an ipad. However, there was no risk assessment/specific care plan in place to manage this known risk.
- The care notes for patient A stated that the patient did not have bathroom privacy because of their self-injurious behaviour. However, there was no care plan/guidelines to adequately address the level of supervision for bathroom access and the risks to patient A associated with using these facilities.

The care documentation for patient B was examined and the following observations made:

- There was no care plan on wound care following a number of incidents where the patient had displayed self-injurious behaviour and had sustained a wound. Without a comprehensive care plan staff were not able to effectively monitor any progress or deterioration in the wound in a timely manner and there was no robust guidance in terms of dressings to be utilised.
- In addition, the patient B had a respiratory disease and had been subject to a number of restraints but there was no care plan in place to take account of the impact of a restraint on their ability to maintain adequate respiratory function.
- Patient B also had a well-documented history of physical and verbal aggression towards other patients and staff. However, no HCR20 (or a similar comprehensive risk assessment of violence and management of aggression) was available.

The care notes for patient C were examined and it was observed that there was no care plan in place for the patient being accommodated in an "enhanced care" area of the ward. When a decision is made to accommodate a patient in an "enhanced care" area there must be a care plan in place clearly describing the rational for this and a plan to ensure that a patient does not spend an excessive time in such a facility.

The care documentation for patient D was examined and it was noted that the patient did not have bathroom privacy because of their self-injurious behaviour but

there was no care plan/guidelines to adequately address the level of supervision for bathroom access and the risks to the patient associated with using these facilities.

The absence of the care plans and risk assessments outlined above meant that staff did not have a framework to guide them and enable them to deliver safe and effective care.

Improvement needed

The registered provider must ensure that there are comprehensive risk assessments and care plans in place for all patients.

The registered provider must review their governance processes to ensure that any patients without appropriate risk assessments and care plans are identified promptly.

Quality of Management and Leadership

It was evident during the inspection process that there was a lack of effective audit and governance processes. This observation is relevant to the findings outlined earlier in this report in relation to care planning and risk assessment but also in relation to staffing by night and the inadequate level of recording the actual staff numbers on the ward at a given time.

It is essential that a range of governance processes are available and implemented to ensure that they are self-diagnosing improvements required and initiating change for the service.

Governance and accountability framework

There were a range of systems and processes in place in relation to governance and audit. However, the systems were not working in relation to improving all aspects of the service and addressing the areas identified earlier in this report.

Throughout the visit the Inspectors were not provided any care plan audit documentation that confirmed an audit system/process was in place. During the feedback session the registered manager confirmed that these had not been undertaken.

HIW were not assured that there are robust governance processes in place given the seriousness and frequency of the issues identified within this report.

Improvement needed

The registered provider must review the governance arrangements across the hospital to ensure that they are effective at identifying issues of concern and tracking the completion of corrective action.

Workforce recruitment and employment practices

During the late evening and night time of the 29 June there were only 2 Registered Nurses on duty, 1 for each of the wards. There was no supernumerary night co-ordinator available and the inspectors were informed that this person was not currently working. This was not an isolated occasion and the duty rotas confirmed the lack of a night co-ordinator on many occasions during the previous weeks. For example; 15, 16, 17, 18, 19, 20, 21, 24, 25, and 26 June. The reality of this situation was that the Registered Nurses were working in excess of 12 hours without a break. This situation is not safe and is completely unsatisfactory.

In relation to the numbers of staff working at any given time, the documentation presented to the inspectors did not provide a sufficient level of assurance that appropriate staffing levels were always maintained. The level of assurance required could have been achieved by the inspectors being given the completed “day allocation” sheets for both wards. However, these were not available and the Inspectors were informed that these were not being completed. A range of other documentation was requested but not available. Inspectors were informed that the information was available at ward level and would be written onto a white board, but this information would be removed on a daily basis. This left the registered manager, ward manager and the inspectors with no reassurance in terms of actual numbers of staff available throughout the current or past 24 hour periods.

In addition the registered manager could not provide the inspectors with the necessary level of assurance in terms of the adequacy of the numbers of staff in meeting individual patient needs.

Improvement needed

The registered provider must put an action plan in place to address the deficits in staffing numbers and a system that easily identifies the actual number of staff working on the wards at any given time.

Workforce planning, training and organisational development

In terms of staff supervision there was evidence that some staff had not had a supervision session for a considerable period of time and in addition some staff had not had an appraisal in line with Elysium’s policy. Generally, staff had received a range of training and during the visit we noted that training was taking place.

Improvement needed

The registered provider must ensure that all staff receive appropriate supervision and appraisal.

4. What next?

Following the visit HIW held a service of concern review meeting where it decided, due to the findings of the visit, that a non-compliance notice should be issued and that Ty Grosvenor would be designated a Service of Concern. In addition, due to the serious concerns identified within this report, a decision was made to request the registered provider to agree to a voluntary restriction on accepting new admissions until HIW are satisfied that any new admissions would not be exposed to the risk of harm.

The areas for improvement identified in this report and the non-compliance notice are presented in the improvement plan that can be found at Appendix A. This includes details of action being taken by the provider to address the issues raised. At the time of publishing this report HIW is sufficiently assured that that appropriate action is being taken but we will be monitoring the service closely to ensure improvements are embedded within hospital practices and are sustained permanently.

Appendix A – Improvement plan

Service: Ty Grosvenor Independent Hospital

Date of inspection: 29 and 30 June and the 1 July 2020.

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
Patient Experience				
The registered provider must ensure that patients on Brenig ward feel safe and not threatened.	Regulation 19 (1) (a) and (b)	Following the Focused Unannounced Inspection on 29, 30 June and 1 July 2020, feedback from HIW Inspectors indicated that some of the female patients on Brenig Ward felt unsafe due to the presence of one particular female patient, this particular patient is detained under the Mental Health Act. At the time of Inspection the patient had been presenting with behaviours that could be interpreted as intimidating towards other patients and staff due to her mental ill health and psychotic ideation in regards to serial killers and in particular the coast-to-coast murderer Ted Bundy. HIW questioned whether this patient was suitably placed. Liaison took place between the Multi-Disciplinary	Hospital Director, Edward Rowlands Hospital Director, Edward Rowlands	Completed To Continue Monitoring via ICR & MDT Meeting

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Team, as the Stakeholders in the patients care, regarding the individuals continued suitability for service provision at Ty Grosvenor. The clinical decision taken was to liaise with the patients Commissioners and identify the patients presenting challenges and symptoms of mental ill health. A Gatekeeping Assessment was commissioned to determine if a more secure setting was required, however as this process was implemented the patients mental health improved with a significant reduction in the number of incidents being reported and an evident response to prescribed treatment. Following discussions with the individual patient, their Commissioner and the Multi-Disciplinary Team it was felt appropriate to continue her care and treatment at Ty Grosvenor (Least Restrictive Option) as there had been a significant improvement in her Mental Health, with the patient openly agreeing to comply with all treatments and to engage more appropriately with the other patients. Community Meetings continue to be facilitated, as a component of this meeting the patients are asked if they feel safe and secure, members of the Senior Management Team are present and can escalate concerns immediately to the Hospital Director.	Hospital Director, Edward Rowlands	Completed & Ongoing

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Signage has also been put up on the ward stating that bullying/threatening or intimidating behaviour will not be tolerated.		
		The Advocate has resumed visits to site on a weekly basis and is able to offer the patients an additional voice should they feel unable to speak out for themselves should they feel threatened. The hospital Advocate has direct access to the Hospital Director on each and every visit, should it be required	Hospital Director, Edward Rowlands	Completed
		Suggestion/Concern/Compliment boxes are also in-situ on the ward giving an opportunity to raise a suggestion, concern or compliment anonymously. Reviewed weekly by the Complaints Officer and Hospital Director.	Hospital Director, Edward Rowlands	Completed
		The contact numbers for HIW are also clearly displayed on the notice boards should a patient wish to escalate anything to the regulatory body. The boards are checked weekly to make sure the information has not been removed by any of the patients.	Hospital Director, Edward Rowlands	Completed
Delivery of safe and effective care				
The registered provider must ensure that there are comprehensive risk	Regulation 15 (1) (a) and (b)	Following the Focused Unannounced Inspection on 29, 30 June and 1 July 2020, full and	Hospital Director,	Completed & Ongoing as a

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
assessments and care plans in place for all patients.		comprehensive audits of Care Plans, Risk Assessments and Risk Management Plans were undertaken. The Ty Grosvenor team were supported in this process by the Quality Assurance Lead for Wales.	Edward Rowlands	regular response to Care & Treatment
		The process included reviewing each and every Care Plan for all patients on Brenig Ward, using a care plan audit tool. The findings of this audit then formulated an action plan and it is those actions that were then implemented to create SMART Care Plans.	Hospital Director, Edward Rowlands	Completed & Ongoing as a regular response to Care & Treatment
		The Risk Assessment tools HCR20 and START were reviewed and accurately scored in order to reflect the actual risk of each and every female patient on Brenig.	Hospital Director, Edward Rowlands	Completed
		Similarly a HCR20 risk assessment was formulated for one particular person identified by HIW Inspectors as potentially requiring this due to an escalation in her identified risk behaviours. This is now in-situ.	Hospital Director, Edward Rowlands	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		The Risk Management Plans were also reviewed in order to ensure they adequately and effectively identified the risk and the interventions required to mitigate that risk, so they were informative to all personnel delivering care, treatment and safeguarding the individuals from harm also ensuring that all three triangulated in a seamless reflection of risk and risk mitigation.	Hospital Director, Edward Rowlands	Ongoing Review to Maintain Dynamic Risk Management Plans
		A review of the Governance process for care packages was undertaken.	Hospital Director, Edward Rowlands	Completed
		Ty Grosvenor are implementing an audit programme for risk management plans and care plans. The audit results will be considered by the SMT at the monthly site Governance meetings. The Morning MDT meeting has now become a Quality Assurance Meeting where the events of the past 24 hours are reviewed and any changes to observation levels, risk behaviours, physical health, safeguarding and treatment are discussed and documented and any actions required are allocated to an appropriate clinician.	Hospital Director, Edward Rowlands	Ongoing, Reviewed Monthly

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		These actions are then reviewed the following morning to ensure compliance, for example physical health, wound care has a care plan in-situ, safeguarding that an appropriate referral has been submitted etc. Ty Grosvenor are also rolling out START Risk Assessment training to all Registered Nurses to ensure that the nurses have a clear understanding of the scoring outcomes of the Risk Assessment Tools and an understanding of the formulation. All care plans are now prescriptive giving clear indication the arrangements regarding bathroom access, privacy, dignity and a mitigation of risk.	Hospital Director, Edward Rowlands Hospital Director, Edward Rowlands	Completed November 2020
The registered provider must review their governance processes to ensure that any patients without appropriate risk assessments and care plans are identified promptly.	19 (1) (a) and (b)	The Hospital Director has reviewed the Clinical Governance process and in doing so has ensured that there is a reporting line to support the Governance and continued improvement of Care Planning, Risk Management, Training, Supervision and Appraisals. Designated Leads have been tasked with the formulation of reports to feed into the Clinical Governance process at Ty Grosvenor to give a full and comprehensive overview of our effectiveness in the care and treatment of our patients, our	Hospital Director, Edward Rowlands Hospital Director, Edward Rowlands	Completed Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		responsiveness to the needs of the patient with regard to complaints and patient surveys etc. and to ensure effective leadership in regards to Supervision, Appraisals, Training and continuous CPD for all team members. Care Plan Audit, Risk Management Audit, Safeguarding, Complaints, Compliments, Mandatory Training, Supervision and Appraisals are just some of the statistics that would be reviewed at Local Governance. Since the Inspection on 29, 30 June and 1 July 2020 Supervision and Appraisal schedules have been devised by the various Heads of Department and these statistics are being fed into a central recording tracker, so that the Hospital Director has a clear overview of any deficiencies in staff support. Debriefs following incidents are now being more effective monitored and supported by the Quality Assurance Meetings and the Senior Management Team are able to follow up on each individual, to include patients, who may need a debrief.		
The registered provider needs to develop a local policy on police attendance/liaison with Ty Grosvenor.	Regulation 9 (2) (a)	A document has been drafted in conjunction with the police and will be discussed at the September site Governance meeting so that all stakeholders can	Hospital Director,	October 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		review and comment on the document, it is envisaged that this document can be finalised by October 2020.	Edward Rowlands	
Quality of Management and Leadership				
The registered provider must review the governance arrangements across the hospital to ensure that they are effective at identifying issues of concern and tracking the completion of corrective action.	Regulation 19 (1)	Following the Focused Unannounced Inspection on 29, 30 June and 1 July 2020, the Hospital Director has reviewed the Governance processes and the Governance Agenda has been broken up into areas of responsibility allocated to key personnel. Those stakeholders now have accountability to submit reports on a monthly basis which will inform the Senior Management Team of information appertaining to the care and treatment of patients, the safe and effective care, any human resources issues with regard to supervision, training, appraisals, recruitment and retention, incidents, lessons learnt and wellbeing. The Hospital Director is also in the process of developing an electronic Dashboard specifically for the purpose of Governance, this will have information readily available appertaining to the compliance of Ty Grosvenor simply at the touch of a button. The Governance Action Plan and the Morning	Hospital Director, Edward Rowlands Hospital Director, Edward Rowlands	Completed, Monthly Monitoring October 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Quality Assurance Meeting will incorporate any regulatory/inspection action plan to ensure that no action remains outstanding.	Hospital Director, Edward Rowlands	Completed, Monthly Monitoring
The registered provider must put an action plan in place to address the deficits in staffing numbers and put in place an effective system to enable effective audit on the staffing numbers.	Regulation 20 (1) (a)	All clinical posts have been filled, we currently have 3 RN vacancies and we are over recruiting our Recovery Worker positions so that any current or future requirement of enhanced observations can be absorbed by substantive staff directly employed by Elysium Healthcare, mitigating the need to have a reliance on agency staff. The Human Resource of the Nursing department will be continuously reviewed in order that the Hospital Director remains proactive in recruitment and no vacancy remains unfilled. Regular liaison is maintained with our recruiters at Head Office and the On-Boarder for Wales. Daily discussion with on-site HR Administrators takes place to maintain an overview of new starters, leavers and on-boarders.	Hospital Director, Edward Rowlands Hospital Director, Edward Rowlands Hospital Director, Edward Rowlands	Daily Weekly Weekly Daily

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Since the Focused Unannounced Inspection on 29, 30 June and 1 July 2020, the Hospital Director has instructed the Lead Nurse and Ward Managers to ensure they assume accountability for ensuring the Register Nurses managing the shift on a daily basis, night and day, complete the shift allocation sheets comprehensively to evidence the staff on duty, duties undertaken and breaks facilitated. The process is further supported by ensuring there is a second registered nurse to cover breaks and support with any incidents that may occur. The off duties/rotas will also reflect the staff on duty and discussion with the Ward Managers has requested that all changes to the off-duties are visible so that any future Inspectors are presented with a working version. All names of staff to remain legible and any crossing out to be one-line only. There is currently an on-call mobile phone that permits absence notifications from our absence management system, this notifies the senior nurse on call of any unplanned absences out of hours and this allows them to take corrective action and notify	Hospital Director, Edward Rowlands Hospital Director, Edward Rowlands	Ongoing, Evidenced via Clinical Governance Ongoing, Evidenced via Clinical Governance

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		the Hospital Director.		
The registered provider must ensure that all staff receive appropriate supervision and appraisal.	Regulation 20 (2) (a)	Following the Focused Unannounced Inspection on 29, 30 June and 1 July 2020, the Hospital Director has ensured all Heads of Department have scheduled 12 months supervision with all team members, along with an annual appraisal. This data has been recorded centrally by the Hospital Directors PA.	Hospital Director, Edward Rowlands	Completed