Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

Regis Healthcare

Brenin Ward

Inspection date: 8, 9 and 10 April 2019

Publication date: 10 July 2019

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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**

Website: **www.hiw.org.uk**

Digital ISBN 978-1-83876-785-3

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1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced focussed inspection of Regis Healthcare's Hillview Hospital on the 8, 9, and 10 April 2019; this was HIW's seventh visit since March 2018. HIW does not routinely carry out this number of inspections in such a short timeframe, but due to the seriousness of previous findings and recent concerns reported by staff, patients and their families, HIW decided to conduct this visit to assess whether Regis Healthcare was providing safe and effective care to patients.

Regis Healthcare – Hillview Hospital

Regis Healthcare – Hillview hospital is an Independent Hospital registered to provide psychiatric treatment for up to 12 patients between the ages of 13-18 years and who may be liable to be detained under the Mental Health Act 1983 (The Act).

The hospital has one ward that is registered:

- Brenin – a 12 bed low secure unit

How did we do this?

The team comprised of two members of HIW staff, one Mental Health Act and two peer reviewers.

The review was carried out over a night/early morning and two full days and focussed specifically on:

- Admission
- Risk management
- Employment processes
- Staff Training
- Leadership, management and governance
- Mental Health Act Monitoring

2. Summary of our inspection

Overall, we were not assured that Regis Healthcare was providing safe and effective care to patients. It is also concerning to note that some of the issues that we found had been identified in previous inspections and sufficient action had not been taken to address them.

The Registered Provider was unable to provide effective risk management plans for a number of key areas. This meant we could not be assured that sufficient information was available to support staff to care for the young people effectively.

We identified that inadequate employment processes were in place that had resulted in a number of staff being employed without written references from their two most recent employers. There was also no effective system in place to confirm Nursing and Midwifery registration for Registered Nurses. We also identified that staff had not received training in a number of key areas.

This was the seventh inspection that we had undertaken of Regis Healthcare since March 2018, which is an exceptional situation and is a reflection of the concerns that we have had regarding this provider. The findings of this inspection along with previous inspection point to a distinct lack of effective governance arrangements which has the potential impact significantly on the safety of patients. On the basis of these inspection findings, and continued non-compliance following previous inspections, a Non Compliance Notice was issued. In response, the registered provider has submitted an improvement plan and evidence of how it has addressed the issues within the Non Compliance Notice.

In addition, due to the serious concerns regarding the inadequate and lack of risk management plans a decision was undertaken to issue an “Urgent Decision to Impose an Additional Condition” preventing the provider admitting any new patients to the hospital

until HIW are satisfied that any new admissions would not be exposed to the risk of harm.

Regis Healthcare remains under the highest level of scrutiny; HIW will be monitoring the service closely and is in regular contact with the commissioners of patients at the hospital.

3. What we found

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

Brenin Ward

- The "Welcome to Hillview" guide for newly admitted patients was very informative and very patient friendly
- There had been a significant reduction in the number of restraints undertaken
- The Inspection team observed a good rapport between patients and staff
- Good medicines management systems were in place

Unfortunately, we found unsafe practice in some areas, these are set out below:

Brenin Ward

A total of 6 sets of patient care documentation were examined on Brenin ward throughout the 3 day inspection on the 8, 9, and 10 April 2019.

Patient A

The care notes for patient A were examined on the evening of the 8 April. We firstly reviewed the pre-admission assessment that was carried out by a medical doctor employed by Regis Healthcare and the proposed registered manager. Within this assessment two distinct risks were identified namely; "physical harm to others/aggressiveness" and "self-harm". In addition, within the patient's care documentation, there was a comprehensive referral document from the patient's commissioning organisation. This document also identified a number of key risks including; a risk of self harm that may lead to accidental suicide and self neglect.

At 22:05hrs HIW staff requested the care plans and risk management plans for the patient. One of the Registered Nurses on duty stated that there were no risk assessments completed. The care plan provided to the inspection team was very generalised and did not put into place an effective plan of care to meet the patient's needs. The proposed registered manager and the ward manager were both asked for a risk management plan to address the identified risk areas within the pre-admission assessment. At 23:05hrs (an hour later from our initial request) HIW were given two care plans; one on "self harm" and another on "assaultive behaviour". The plans were again very generalised and did not adequately address the risks. For example the plan on "self harm" consisted of only 3 interventions and stated that the

patient “was to be nursed on 1:1 and reviewed, further staff to be allocated if required”. This failed to give sufficient detail for the observations and failed to address specific risks around bathroom and bedroom access. A HIW Inspector was also given the telephone to speak to the patient’s Responsible Clinician (RC) who informed the Inspector that the plans would be discussed at the MDT meeting to be held on the next day. The ward manager acknowledged that the care plans were inadequate and assured the Inspectors that a specific regime around 1:1 observations would be put in place that night.

In addition to these issues we identified that the “twenty-four hour observation record” for patient A was not sufficiently robust and listed only two actions for reducing risk. The risk of using the bathroom facilities was not addressed and the key risks of self harm had not been allocated a risk score. In addition, the risk of aggressiveness was not documented within the record despite being clearly identified within the pre-admission assessment.

On the morning of the 9 April HIW were given copies of risk documentation by the ward manager and were informed that these had been formulated that morning.

Overall we concluded that there was a distinct lack of planning in this patient’s care which meant that actions to manage areas of risk were not in place.

Patient B

The care notes for patient B were examined on the morning of the 9 April and the following observations were made. The patient had been admitted originally as an emergency admission and this was confirmed by the patient’s RC. However, there was no emergency admission policy in place for the hospital only a routine “admission for treatment” policy. This did not reflect the process for an emergency admission that would occur without a robust pre-admission assessment taking place by the hospital staff. In addition the “twenty-four hour observation record” for the patient was not sufficiently robust and failed to adequately address the level of supervision for bathroom access and the risks associated with using these facilities. There was also no risk management plans in place for the area of restraint that the patient had been subject too. The patient was particularly challenging and on the 10 April it was noted that this patient had become unsettled and their observations had been increased to 3:1 with a further 2 members of staff on standby to assist if the patient’s behaviour escalated.

Overall we could not be assured that the admission of this patient has been suitably assessed to ensure that Hillview Hospital was a suitable place for the patient to be cared for safely and effectively.

Patient C

The care notes for the patient were examined and the “twenty-four hour observation record” was not sufficiently robust and failed to adequately address the level of supervision for bathroom access and the risks associated with using these facilities. There was an action documented that the patient’s “toiletries are TO BE MANAGED by the supporting staff member”. However, there was no clear guidelines in place to define how the staff member would manage this. For example, could the patient have the toothpaste and the cap or was this a risk and the toothpaste had to be placed on the toothbrush to manage a risk?

Patient D

The care documentation for patient D was also examined and the following observed. The risks to the patient were assessed and identified using the Functional Assessment of the Care Environment (FACE), however, there were missing sections on protective factors and risk formulation. This is a key area that would assist for context, precipitants and perpetuating factors. The patient had “access to bathroom – remain in verbal contact” documented but there was no threshold for concern to give staff a framework to deliver safe and effective care.

Patient E

The care documentation for patient E was examined and findings were very similar to Patient D. There were missing sections within the FACE assessment on protective factors and risk formulation and again the management of risks during bathroom were not supported by explicit & stepped management plans, describing at what point specific interventions need to be carried out. For example, the patient has “partial bathroom access”. This is not clearly explained and the level of observation required is not clear.

The patient was also at risk of restricting their diet & fluids but the documentation was unclear of the threshold for an intervention and what the intervention would be to manage the risk. It was also not documented how the risk was being monitored. We also observed that some of the risks for the patient restricting their diet and fluids did not have a management plan. For example, the patient had a delusion that she will remain safe if she restricts her dietary intake.

In addition the service could not demonstrate that interventions were referenced to evidence based guideline, for example National Institute of Clinical Excellence (NICE) guidelines.

Patient F

The care documentation for patient F was examined and a number of issues were identified. The intake of nutrition was being monitoring via a nutrition chart.

However, even though these are audited it was clear that the patient was not having sufficient daily fluids to meet the European Food Safety Authority (EFSA) recommendation of 2.0litres of fluid for adolescent females per day.

There was a Nasogastric (NG) feeding care plan referred to in a restraint report which recorded that on consecutive days a seated hold was required to administer Ensure 400ml and a safe hold was required to administer the Ensure feed and water of 400mls. However, there was no action documented in the risk assessment or a management plan that would assist staff in dealing with the patient when they were refusing an adequate diet.

In one of the care plans an ECG was suggested every 6 months or as required, and a care plan review note stated that the next ECG was due in March 2019. However, there was no evidence of this being undertaken within the patient documentation.

During our visit we did not see any individual risk management plans on restraint for any of the patients whose care documentation we examined.

Employment Processes

A number of staff employment files were examined, for a range of staff disciplines, and the following issues were identified;

- Written references from the two most recent employers were not available
- There were staff members without any references on their files
- No effective system in place to confirm Nursing and Midwifery registration for Registered Nurses
- The “Recruitment, Selection and Retention Policy” had not been reviewed in line with the agreed review date of April 2016. In addition, recruitment had not been undertaken in line with this policy.

Staff Training

There was no evidence that staff had received training in a number of key areas including;

- The Mental Health Act
- The Mental Capacity Act
- Risk Management

- Patient Observations
- Eating Disorders
- Learning Difficulties including, Autism and Attention Deficit Hyperactive Disorder (ADHD)

Leadership and Governance

Again we found a distinct lack of leadership and management at the hospital in relation to governance. This is the seventh inspection since March 2018 and despite some improvement noted at our visit in February 2019, significant failings have continued to be identified. Whilst HIW have received a number of improvement plans, following the numerous inspections, the provider has not sustained regulatory compliance and has failed to demonstrate significant and sustained improvement through a robust governance process.

The deficiencies found on this inspection, particularly the lack of risk management processes in place for new and existing patients and care plans that did not adequately address identified risks, mean that HIW cannot be assured that patients are receiving safe and risk assessed care.

In addition, the lack of robust employment processes and lack of training on a number of key areas did not demonstrate that the provider had effective recruitment processes and that staff had the necessary skills, training and knowledge for the needs of this complex and challenging group of patients.

Mental Health Act Monitoring findings

Two Mental Health Act files were examined and the following observations are made. The Responsible Clinician had undertaken a thorough evaluation of the patients' capacity to understand the nature, purpose and likely effects of prescribed medication. The patient's ability to understand, retain and weigh up the positive impact of the medication and the possible negative side effects was well documented. The Capacity assessments were regularly reviewed.

A CO2 form had not been completed for one of the patients following their transfer to the hospital. This meant that there was no evidence to confirm that the patient had consented to the transfer and their treatment more broadly. In addition, the Mental Health Act documentation was not filed in chronological order and this needs to be undertaken to facilitate an effective check and audit process.

There was evidence that detained patients received information upon their rights under section 132 of the Mental Health Act and this was repeated on a regular basis.

The Mental Health Act administrator must be supported in the role and receive relevant training in Mental Health Law and attendance at the Mental health Administrators forums.

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 Regis Healthcare would remain a service of concern. In addition, due to the serious concerns regarding the inadequate and lack of risk management plans a decision was made to issue an “Urgent Decision to Impose an Additional Condition”; the effect of which was to stop the provider admitting any new patients to the hospital 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.

Following this inspection, HIW conducted a further visit to Hillview Hospital on 15 May 2019 to examine Regis Healthcare’s internal governance arrangements. This was a much more positive visit and provided assurance that these processes have been improved. We were also able to review updated care plans and risk assessments which were much improved and demonstrated that the provider had responded effectively to the findings detailed in this report. Furthermore, as a result of these positive actions the condition limiting patient admissions was lifted.

Despite the improvements made since this visit Regis Healthcare remains under the highest level of scrutiny and HIW will be monitoring the service closely and is in regular contact with the commissioners of patients at the hospital.

Appendix A – Improvement plan

Service: Regis Healthcare Limited (Hillview Hospital)

Date of inspection: 8, 9 and 10 April 2019

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
Delivery of safe and effective care				
The registered provider must ensure that all employed staff have the two most recent employers listed as reference where possible and that a robust recruitment policy is in place and up to date in line with regulations.	21 (2) (d) Schedule 2 (4)	Regis Healthcare Ltd – Hillview Hospital's governance structure around obtaining of staff references were reviewed in line with Reg. 21 (2) (d) Schedule 2 (4). (attached is a copy of the new improved excel spreadsheet electronic system designed for HR to maintain electronic records which will enable HR to track for references). This will be an on-going process moving forward. Outstanding references for the 2 doctors and a nurse (EM).	Human Resources	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		EM was placed on two weeks annual leave (due back 18-05-19) subject to obtaining successful references from his previous employers - **update: -** - 2 Doctors - One doctor had all references on file; however they were missed by the HR Assistant (see attached evidence) **Completed** - Junior doctor – the agency attested that he was employed by them and the employers were not willing to offer references as they argued that he was a locum doctor. We had obtained a character reference for the doctor. (see attached evidence) **Completed**		
The registered provider must ensure that there is an effective system in place to confirm and monitor the registration status of all qualified staff. E.g. Doctors, Nurse	21 (2) (b)	A new electronic system for monitoring Nurses, Doctors and Allied Health professional's registration status is now live. The system is designed to show amber when a pin is approaching renewal date (within 30 days), red when	Human Resources	Complete

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		its due for renewal and green when in date. NMC employer's registration to access nurse's status was obtained on 3 March 2019 – **Completed**		
The registered provider must ensure that all staff are adequately trained to carry out their role and that training is provided in areas specific to the needs of the patient groups.	21 (2) (b)	Attached is a new training matrix covering identified key areas (Mental Health Act, Mental Capacity Act, Observations, etc.)	Human Resources	Completed
The Registered Provider must ensure that risk management processes are in place for all patients, particularly around bathroom use and observations.	15 (1) (a) & (b)	The Hospital Operations & Clinical Lead (HOCL) has implemented the Roper, Logan and Tierney nursing model for activities of daily living and there is a risk management plan in place for this. The WARRN will also address this (evidence submitted on 16th April 2019)	HOCL and Ward Manager	Corrective action is complete but ongoing review required to ensure improvement is sustained
The Registered Provider must ensure that all patient care plans adequately address any identified risk areas for self-harm and aggression.	15 (1) (a) & (b)	The HOCL identified for each young person, the specific risks for self-harm and aggression, and individualised, prescriptive care plans where required, have been formulated collaboratively with the young people	HOCL and Ward Manager	Corrective action is complete but ongoing review

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
				required to ensure improvement is sustained
The Registered Provider must ensure that care plans for all patients that had been subject to restraint, identify the effective use of restraint.	15 (1) (a) & (b)	The HOCL identified for each young person, the specific risks for self-harm and aggression, and individualised, prescriptive care plans where required, have been formulated collaboratively with the young people	HOCL and Ward Manager	Corrective action is complete but ongoing review required to ensure improvement is sustained