Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Independent Mental Health Service Inspection (Unannounced)

## Regis Healthcare Limited:

## Brenin and Ebbw

Inspection date: 16 - 18 July 2018

Publication date: 19 October 2018

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Digital ISBN 978-1-78964-016-8

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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:**

| | |
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| **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 Regis Ebbw Vale on the evening of 16 July 2018 and following days of 17 and 18 July. The following sites and wards were visited during this inspection:

- Brenin Ward - Child and Adolescent Mental Health Service
- Ebbw Ward - Child and Adolescent Mental Health Service

Our team, for the inspection comprised of two HIW inspectors, two clinical peer reviewers and one lay reviewer. The inspection was led by a HIW inspection manager.

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

Despite improvement since our recent inspections improvements are still required with regards to issues raised in the Non-Compliance Notices issued following those inspections.

Therefore we are not fully assured that Regis Healthcare is providing safe and clinically effective care.

We will continue to monitor compliance with relevant regulations and standards as part of our enforcement process. .

This is what we found the service did well:

- All employees interacted and engaged with patients respectfully
- Provided a range of suitable facilities and activities
- Care and Treatment Plans were completed in line with the Welsh Measure
- Implemented a number of changes following previous inspections.

This is what we recommend the service could improve:

- Individual care plans in regards to specific patient behaviours and risks
- Management and storage of medication
- Improve the completion and analysis of restraint records
- Management of food and/or fluid restricting behaviours.
- The stability of the hospital workforce.

We have previously identified the service was not compliant with and issued non compliance notices in regards to:

- Regulation 16(2)(b) of the Independent Health Care (Wales) Regulations 2011 regarding safeguarding patients from abuse.

- Regulation 31(1)(b) of the Independent Health Care (Wales) Regulations 2011 regarding the notification of events.
- Regulation 19 (1) (a) & (b) and 20 (1) (a) of the Independent Health Care (Wales) Regulations 2011 regarding the quality of service provision
- Regulation 20 (1) (b) and 20 (2) (a) of the Independent Health Care (Wales) Regulations 2011 regarding staffing
- Regulation 19 (1) (a) and 23 (a) (i) of the Independent Health Care (Wales) Regulations 2011 regarding records and managing risks of inappropriate or unsafe care and treatment

Despite improvement since our recent inspections there remains areas for improvement still required. Therefore we are not fully assured that Regis Healthcare is providing safe and clinically effective care. At the time of publication of this report, HIW have not received sufficient assurance of the actions taken to address the improvements needed. We will continue to monitor compliance with as part of our enforcement process.

# 3. What we found

## Background of the service

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

The service has two wards, Ebbw and Brenin, both have 12 beds and offer care to people under the age of 18 years.

The service was first registered on 15 January 2014.

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

## Quality of patient experience

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

Throughout the inspection we observed respectful interactions between staff and patients at the hospital.

However, there were staff practices which impacted upon patients' dignity that were based on blanket rules for the wards as opposed to individualised patient risks.

These must be reviewed by the hospital's multi-disciplinary teams as part of least restrictive practices.

### Health promotion, protection and improvement

Within the hospital there was a range of relevant information leaflets for patients, families and other visitors. These areas contained information on mental and physical health and well-being.

There was a school within the hospital, known as Ty Seren, which provided patients with educational input whilst being cared for at the hospital. The school had dedicated teaching and support staff to facilitate lessons.

When not attending school we observed patients taking part in a range of therapeutic and leisure activities. The hospital had a sports hall and gym which could be used by patients. There had been an increase in the number of staff who were trained to facilitate gym sessions since our March 2018 inspection.

There was a range of resources available throughout the hospital including arts and crafts, books and board-games. Staff and patients confirmed that there were regular group and individual activities within the community. Throughout the inspection we saw patients talking part in activities and accessing the community.

### Dignity and respect

We observed that staff interacted and engaged with patients appropriately, and treated patients with dignity and respect. When patients approached staff members, they were met with polite and responsive caring attitudes.

The design of the hospital assisted in maintaining patient privacy and dignity which included each patient with an en-suite bedroom. However, we noted staff practices that impacted upon patients that were based on blanket rules for the wards as opposed to individualised patient risks. This included restricting access to quiet rooms and locking of other internal ward doors.

It was positive to note that following bringing our concerns to the interim hospital manager, that these were discussed within the morning multi-disciplinary team meeting, and agreed to be reviewed on an individual patient basis or as part of the hospital's least restrictive practices.

During the first evening of our inspection the Patient Status at a Glance boards were uncovered displaying confidential information about the individual patients on the wards; these should be covered with the blind installed when not being referred to by staff. It was also noted that patient documents were viewable through one of the office windows on Brenin Ward. Staff must ensure that their practices do not enable confidential information to be seen by unauthorised persons, such as other patients.

During the first evening of our inspection, patient storage within the restricted items cupboard on Brenin Ward, and within the patient laundry on Ebbw Ward were disorganised. There was no system in place to identify which items belonged to which patient.

During our inspection in March 2018 we had concerns regarding the excessive use of restraint and how this impacted upon the dignity of the patients being cared for at the hospital; this also included the lack of detailed monitoring and poor record keeping. Since that inspection the registered provider has provided staff with further training on restraint and has developed additional documentation for recording de-escalation techniques attempts prior to restraint.

These developments demonstrate that the provider has taken actions regarding the practice and recording of managing challenging behaviours, including restraint, which can impact upon the dignity of patients. However, there were inconsistencies in the quality of incident reports being completed and improvements that could be made in the analysis of incidents and records; this is detailed later in the report.

Improvement needed

The registered provider must ensure that staff maintain patient information confidentially within the ward offices.

The registered provider must ensure that patient items within laundry rooms and restricted items cupboards are systematically stored.

### Patient information and consent

There was a range of information displayed within the hospital for patients. However, we noted that the contact telephone number for HIW was incorrect. Improvements could also be made to ensure that there is information in a suitable format for the patient group which includes:

- Information on the Mental Health Act and advocacy provision
- How to raise a complaint
- Information on Healthcare Inspectorate Wales.

There was signage throughout the hospital to assist with orientation, however, the location and quality of the signage was inconsistent. Some signage had been painted directly on to doors and walls which were easy to read, but other additional signage had been positioned above doors and high upon corridor walls, which meant it was not easy to read. We were informed that the reason for the additional signage being positioned high was that it prevented it being easily removed or damaged by patients. Whilst it is important to prevent damage to signage it needs to be positioned in a location that can be easily read. The registered provider must review the position and type of signage that is currently not easy to read so that it is in an appropriate height and can not be removed or damaged by patients.

Improvement needed

The registered provider must ensure that the wards display relevant patient information in a suitable format.

The registered provider must ensure that all signage is at an appropriate height and can not be removed or damaged.

## 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 the 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.

The wards had daily morning meetings to arrange the activities, within the hospital and the community, alongside other activities and meetings, such as care planning meetings, medical appointments and tribunals.

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 carers were also included in some meetings.

## Delivery of safe and effective care

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

Despite improvements since our previous inspections we are still not assured that the hospital is providing safe and effective care as further improvements are required.

Patients' records documented where staff had provided care in line with researched and clinically evidenced practices. However the registered provider must improve individual care plans in regards to specific patient behaviours and risks.

### Managing risk and health and safety

The hospital and car park was secured via a locked gate and access is gained via the intercom for visitors or an electronic key fob for staff. This helps to deter unauthorised persons from entering the building. It was noted that when not in use the gate was closed, this was not always the case during our March 2018 inspection.

Visitors were required to enter the hospital via a reception area and registered on arrival. The hospital was organised over two floors. There was level access to the main entrance and ground floor with a lift available to provide access to the first floor. These arrangements allowed patients and visitors, including those with mobility difficulties, safe and easy access to the unit. Access through the hospital was restricted for safety reasons.

Overall, the unit appeared well maintained with furniture, fixtures and fittings across the hospital being appropriate to the patient groups. Systems were in place to report environmental hazards that required urgent and non urgent attention and repair. We were informed that on the whole the response of the maintenance team was good.

However, there were some areas that required attention, which included one ligature point that we discussed with the registered provider during the inspection. There was also damage to some areas and items of furniture throughout the hospital which needed to be addressed; this included a ripped sofa in the quiet room on Brenin Ward.

Patients at the hospital posed risks to themselves and/or others and therefore there were restrictions in place that limited patients' movement throughout the hospital and access to certain items. Due to the potential risks posed by some patients they were under enhanced observations, which in some cases meant that the patient was observed continuously by a member (or members) of staff, sometime at no further than arms-length.

However, through conversations with various staff members at the hospital there were certain decisions about managing risk that were taken on a blanket approach, as opposed to individual patient risks and least restrictive practices. We discussed a number of examples which impacted upon the privacy and dignity of patients with senior members of staff who were open to reviewing certain practices through multi-disciplinary team discussions.

During the first evening of our inspection we observed a large proportion of bedroom doors being propped open or ajar. Some staff we spoke with stated that this was at the request of the individual patients; other staff stated that this was due to the risk of the patient (and their associated observation level) and other staff stated that all bedroom doors had to be open. The patient records and policies we reviewed did not evidence clear decision making process around whether an individual patient's bedroom door was closed, or required to be ajar or fully open. It was evident that it had become normal staff practice to default to keeping bedroom doors open for ease of observation. Again we spoke with senior members of staff who confirmed that they would review this practice. Where there is a clinical reason or patients request that bedroom doors remain open, the registered provider must ensure that this is in line with relevant fire safety regulations.

The emergency grab bags on each ward were available and routinely checked to ensure that items were present and in date. However, when we enquired about access to ligature cutters on Brenin Ward, staff knew where they were located, but there was a delay of minutes in retrieving the key to access the ligature cutters. For patient safety, ligature cutters must be readily available to staff without delay.

The restricted patient items cupboard on Brenin Ward was disorganised and there was no method of clearly identifying which patient some items belonged to. This needs to be reviewed to ensure that patient items are clearly logged so that there is a clear record of who they belong to.

Improvement needed

The registered provider must ensure that there are environmental audits and a programme of maintenance to promptly address identified issues.

The registered providers must ensure that staff can promptly access ligature cutters in the event of an emergency.

The registered provider must ensure that practices are regularly reviewed as a multi-disciplinary team to ensure that the management of risk is undertaken on the risks of individual patients and not blanket rules for the ward and/or hospital.

## Infection prevention and control and decontamination

There were two members of staff that held overall responsibility for infection prevention and control (IPC) and decontamination at the hospital; the Head of Hotel Services and the newly appointed Clinical Lead.

Systems of regular audits in respect of infection control were in place. These were completed with the aim of identifying areas for improvement so that appropriate action could be taken where necessary. There were cleaning schedules in place to promote regular and effective cleaning of the hospital and staff we spoke to said that they were aware of their responsibilities around infection prevention and control.

However, on the first evening of our inspection the cleanliness of both ward environments was poor. The dining room on Brenin Ward had a large amount of food debris on the floor following the evening meal earlier that evening. The ward kitchen on Ebbw Ward was unkempt with food debris on many surfaces that had not been cleaned up. In addition there was a large selection of opened drinks bottles on the floor of the ward kitchen and not stored appropriately. There where no details of which patient they belonged to and when they were first opened. Other food items within the ward kitchen, such as cereal boxes, also lacked opening dates and we identified items that had passed their expiry dates or fruit which was visibly no longer fit for consumption.

The freezer within the ward kitchen on Ebbw Ward had an item that was inappropriately stored and had expanded out of its container. The freezer also appeared as though it required defrosting.

We were informed that a replacement the dishwasher had been received to replace the broken dishwasher within the ward kitchen on Ebbw Ward; the

registered provider must confirm that the replacement the dishwasher has been installed.

There were hospital laundry facilities available so that patients could undertake their own laundry with appropriate level of support from staff based on individual needs. However, the laundry on Ebbw Ward was disorganised with no system in place to identify whose clothing was in areas of the laundry.

There were hand hygiene products available in relevant areas of the hospital; these were accompanied by appropriate signage. Staff also had access to infection prevention and control and decontamination Personal Protective Equipment (PPE) when required.

Cleaning equipment was stored and organised appropriately. It was positive to note that following our inspection in March 2018 that the registered provider had installed a washing machine for cleaning mop heads and cloths.

There were suitable arrangements in place for the disposal of clinical waste. Appropriate bins were available to dispose of medical sharp items, these were not over filled.

However, one ward toilet on Brenin Ward did not have a sanitary bin; the sanitary bin in the other ward toilet was overflowing on the first evening of the inspection.

Improvement needed

The registered provider must ensure that the cleanliness of the ward is maintained throughout the day and night shifts.

The registered provider must ensure that food and drink items are stored appropriately, including opened dates and, where applicable, which patient they belong to.

The registered provider must ensure that food and drink items are disposed of on their expiry date or when visibly no longer fit for consumption.

The registered provider must confirm that the replacement dishwasher has been installed.

The registered provider must ensure that sanitary bins are in-situ and regularly emptied.

## Nutrition

Patients were provided with their meals at the hospital. The hospital had a three week rotation menu with options for lunch and evening meals. Patients also had access to snacks and refreshments.

We spoke with staff regarding patients restricting food and fluid intake as part of behaviours of self-harm and/or eating disorder. Some senior registered nurses were able to demonstrate detailed knowledge; however other members of staff lacked knowledge on how to support and monitor patients before, during and after mealtimes. The records we reviewed where patients were restricting food and/or fluid intake lacked detailed care plans to manage and monitor these behaviours. We reviewed the food and fluid monitoring charts for one patient over ten days and identified that five were poorly completed or incomplete. They did not provide sufficient information to clearly document the patient's consumption over that period.

Ward staff should receive training to undertake meal time supervision to competently support patients who are restricting food and/or fluid intake before, during and after meals and snacks in an effort to increase the patient's success in completing their meal. Patients and family members should also be supported in snack and meal practice to assist patients in completing these during leave from the hospital.

Improvement needed

The registered provider must ensure that food and fluid charts are completed in full.

The registered provider should provide meal time supervision training for staff.

## Medicines management

There were clinical audits in place at the hospital which assisted with the safe and effective management of medication. There was weekly external pharmacy input and audits undertaken that assisted the management, prescribing and administration of medication. However, we identified that there were areas of improvements required in medicine management.

Medical Administration Records (MAR charts) were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. The MAR charts reviewed contained the patients name and other required personal information along with

an up to date photograph of the patient to assist identification. MAR charts also recorded the patient's legal status under the Mental Health Act (the Act).

There was evidence that there were regular temperature checks of the medication fridge and ambient room temperate of the clinic to ensure that medication was stored at the manufacturer's advised temperature.

Medication cupboards were kept locked when not being accessed by registered nurses. There were appropriate arrangements for the storage and use of controlled drugs and drugs liable to misuse; these were accurately accounted for and checked daily. The registered provider should consider storing the log books for each within a secure area in each of the clinics to ensure that they are not misplaced or amended by unauthorised persons.

The review of the clinic room on Brenin Ward identified that not all liquid medication had been dated when opened, therefore the registered provider could not be assured that it was used (or disposed) by the manufacturer's guidelines of use after opening.

The clinic room on Ebbw Ward was disorganised which inhibited staff from easily performing their duties within the room. We observed this to be the case during the inspection when a registered nurse on their second shift on the ward had difficulty in accessing cupboards and medication in a timely manner. The newly appointed ward manager confirmed that they were about to commence a review of the clinic to improve the orderliness to assist staff.

Staff had access to up-to-date British National Formulary[1] (BNF) within the clinic room and a folder containing copies of the registered provider's applicable clinic policies. However, a number of policies contained within the files had passed their review by date.

Not all registered nurses that we spoke with were able to provide us with a clear description of the reporting responsibilities and processes following a

[1] A pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about medicines. Information includes indication(s), contraindications, side effects, doses, legal classification, names and prices of available proprietary and generic formulations, and any other notable points.

medication error. This meant that we were not assured that all registered nurses would take the required action if a medication error occurred.

Improvement needed

The registered provider should consider storing the log books for each within a secure area in each of the clinics.

The registered provider must ensure that the open date is recorded on liquid medication.

The registered provider must ensure that the clinic room on Ebbw Ward is orderly.

The registered provider must ensure that all policies are up-to-date.

The registered provider must ensure that staff are fully aware of reporting responsibilities and processes following a medication error.

## 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 being made as and when required.

The safeguarding concerns that we highlighted during our inspection in March 2018 were reviewed as per protocols of the Safeguarding Team at Blaenau Gwent Local Authority.

## Safe and clinically effective care

There were significant concerns raised during our March 2018 inspection regarding the excessive use of this restraint technique for long periods of time, which was contrary to national guidance.[2] Since that inspection the registered provider has provided staff with further training on restraint and has developed

[2] https://www.nice.org.uk/guidance/ng10/chapter/1-Recommendations

additional documentation for recording de-escalation techniques attempts prior to restraint.

These developments demonstrate that the provider has taken actions regarding the practice and recording of managing challenging behaviours, including restraint. However, the inspection reports we reviewed relating to the previous two weeks of this inspection highlighted inconsistencies in the quality of incident reports being completed and further improvements that could be made in the analysis of incidents and records.

Some of the incident reports we reviewed evidenced the steps taken by staff to support the patient without or prior to a floor restraint being required. However this was not always the case which was part of our concern regarding restraint in March 2018.

Incident report forms did not document which staff member involved was leading the restraint, so it was not clear which staff member was providing the oversight and instructions for the other members of staff.

There were instances where floor restraint was used in response to a patient self harming by head banging. However, the incident report did not document that a staff member was stabilising the head to prevent any further head banging, which would have been achievable whilst the patient was restrained on the floor.

Patient records did not include restraint risk management and implementation plans which would assist staff members to consider the patients physical conditions and behaviours whilst implementing restraint. Through conversations with some staff members they were aware of some patients physical health conditions which needed to be considered but these were not documented.

The registered provider must ensure that there is analysis of incident restraints to identify what worked and what didn't work. This should include why seated restraint was ineffective and floor restraint being required. This can help staff learn from incidents and restraints.

Restraint analysis statistics for the last six months showed a decline in the number of incidents that resulted in floor restraint; from 260 in January 2018 to 136 in June. Whilst this downward trend of evidences the reduction over that period further monitoring and analysis of incidents at the hospital is required to ensure that staff are using restraint as the final step of least restrictive interventions. There are other coexisting factors that can reduce statistics including the acuity of the patient group at any time and individual patient risks and behaviours.

The March 2018 inspection also identified that the hospital was under reporting incidents to Healthcare Inspectorate Wales under the requirements of Regulation 31. At the time of this inspection the registered provider was still reconciling their incidents and what had been and should be reported. Therefore the registered provider must complete this before we are assured that all applicable incidents have been reported as required by Regulation 31.

Given the areas for improvement still required with regards to the Non-Compliance Notices following previous inspections HIW we are not fully assured that Regis Healthcare is providing safe and clinically effective care. We will continue to monitor compliance with relevant regulations and standards as part of our enforcement process.

Improvement needed

The registered provider must ensure that incident reports are completed to a high professional standard.

The registered provider must ensure that patient records include restraint risk management and implementation plans.

The registered provider must ensure that incidents and restraints are reviewed to identify lessons learnt.

The registered provide must notify HIW of incidents as required by the requirements of Regulation 31.

## Records management

The care documentation and other associated records at the hospital were paper based. As identified in previous inspection the hospital had numerous files for each individual patient which made navigating information difficult. During the inspection some sections of care records were unavailable despite the efforts of staff to retrieve the relevant documentation.

The registered provider confirmed that they had commenced reviewing their recordkeeping with the intention to move towards electronic recordkeeping to centralise their documentation.

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

We reviewed the Care and Treatment Plans of a total of two patients.

The Care and Treatment Plans reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed. Care plans were developed with members of the multi-disciplinary teams. 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.

Individual Care and Treatment Plans drew on patient's strength and focused on recovery, rehabilitation and independence. There was evidence that patients were involved in developing their Care and Treatment Plans. However, there were a number of examples where the Care and Treatment Plans were written in clinical terminology and not in more straight forward language. There was also no record of patient being offered a copy of their Care and Treatment Plans and if so whether they accepted or declined.

Since our inspection in March 2018 the registered provider had commenced reviewing the physical health documentation held within patient files. Whilst there had been improvements and the patient files contained some physical health documentation, this was not comprehensive with significant sections of physical health documentation being held in separate files. This meant there was no comprehensive physical health record available to easily review.

On the whole staff entries in to patient records were of a high professional standard. Whilst patients' records documented instances where staff had provided care inline with researched and clinically evidenced practices; patients' records lacked detailed care plans for some specific aspects of care. For one patient staff were unable to provide a copy of a catheter care plan for the patient.

Gym access was also not clearly care planned to take into account the patient's current physical health and risks. For some patients this could include food and/or fluid restricting as part of self-harm or eating disorder behaviours; which as stated earlier were poorly or not documented in patient records.

The registered provider must improve individual care plans in regards to specific patient behaviours and risks and how they relate to physical wellbeing, activity and restrictive food and/or fluid intake behaviours.

Improvement needed

The registered provider must ensure that Care and Treatment Plans are written in straight forward language.

The registered provider must ensure that patients are offered a copy of their

Care and Treatment Plans and if so whether they accepted or declined.

The registered provider must continue to review recordkeeping to ensure that there is a comprehensive physical health record available to easily review.

The registered provider must ensure patients have care plans in respect to specific physical health and wellbeing needs.

## 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.*

There had been significant changes in the management and multi-disciplinary personnel at the hospital. The hospital had recruited to a number of key managerial and multi-disciplinary roles and was taking steps to stabilise ward staffing.

The hospital had updated their Corporate Clinical Governance processes and reporting, which included greater focus on areas that were identified as concerns following our recent inspections.

### Governance and accountability framework

Since our inspection in March 2018 there had been significant changes in the management and multi-disciplinary personnel at the hospital. The Hospital Manager had departed their post with the Responsible Individual acting as Interim Hospital Manager until a new Hospital Manager takes up their role on 30 July. A new Clinical Lead had joined the hospital in June and two new ward managers had been appointed in July. The hospital had also appointed two new consultants, one who had commenced employment in June and the second to take up their role on 30 July.

The hospital had established a new Senior Management Team to facilitate governance and management arrangement at the hospital. At the time of the inspection this included the Responsible Individual, Clinical Psychologist, Head of Human Resources, Finance Director. The Responsible Individual also expressed a desire for the Senior Management Team to in future include a staff representative and a patient representative.

The hospital had updated their Corporate Clinical Governance processes and reporting, which included greater focus on areas that were identified as concerns following our March 2018 inspection, including incidents, restraint use, regulation notifications, staff recruitment, retention and agency use.

It was positive that during the inspection staff at the hospital appeared co-operative with the inspection process and receptive to our views and recommendations; this was an improvement on previous inspections at the hospital. Through conversations with staff members there were generally positive comments regarding the transition of the hospital due to recent changes. However, due to the these being implemented in a short period prior to our inspection, with additional changes to come, further time is required to evaluate the impact these changes will have on the management, leadership and governance of the hospital.

### Workforce planning, training and organisational development

As identified in March 2018 the staffing establishment at the hospital was not sufficient to fulfil the staffing rotas.

Due to concerns identified with staffing during a focused inspection in June 2018, Healthcare Inspectorate Wales imposed additional conditions on the registered provider. One condition was an increase in the number of registered nurses on each ward from one to two during the night shift.

There was a high reliance upon agency staff but there was an attempt to source regular agency workers from an organisation that specialised in Child and Adolescent Mental Health Services (CAMHS).

With regards to registered nurse vacancies the registered provider had seven agency nurses on long term contracts with an additional two registered nurses due to start at the hospital in the following weeks of this inspection. Staff rotas evidenced that the hospital were repeat booking the majority of healthcare support workers. Therefore, although not permanently employed by registered provider there was a consistent workforce which gave some measure of reliability to the provision of the service.

The registered provider had recruited an additional 22 healthcare support workers following our June 2018 inspection. These new members of staff were completing the registered provider induction process prior to commencing shifts on the wards.

Our focused inspection in June 2018 identified shortfalls in the induction process for agency staff. Subsequently the registered provider had amended the process and paperwork which had only been implemented. Therefore there was not a significant quantity of inductions completed to demonstrate that the revised process addressed the concerns of our June inspection; this will need to be monitored over a longer period.

Improvement needed

The registered provider must provide an update on the recruitment process and vacancy position.

# 4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

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

The improvement plans should:

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

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

# 5. How we inspect independent mental health services

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

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

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

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

We also consider other professional standards and guidance as applicable.

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

Further detail about how HIW inspects mental health and independent services can be found on our website.

## Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

| Immediate concerns identified | Impact/potential impact on patient care and treatment | How HIW escalated the concern | How the concern was resolved |
|---|---|---|---|
| No immediate concerns were identified on this inspection | Not applicable | Not applicable | Not applicable |

## Appendix B – Improvement plan

**Service:** Regis Healthcare Ltd

**Wards:** Brenin and Ebbw

**Date of inspection:** 16 – 18 July 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 staff maintain patient information confidentially within the ward offices. | 10. Dignity and respect | A blind was in place at the time of inspection however not all staff utilised this. All staff have been reminded of the need to use it and random spot checks are now undertaken by the ward manager | All staff | Completed<br><br>30/9/2018 |
| The registered provider must ensure that patient items within laundry rooms and restricted items cupboards are systematically stored. | 10. Dignity and respect | The system of storage has been changed to ensure better storage of belongings. The laundry rooms have been reorganised. | Team Leaders | Completed |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | Laundry Management Procedure is being developed as part Infection Control Manual | Clinical lead | 30/9/2018 |
| The registered provider must ensure that the wards display relevant patient information in a suitable format. | 9. Patient information and consent | HIW details have been updated on all displayed posters | Responsible Individual | Completed |
| The registered provider must ensure that all signage is at an appropriate height and can not be removed or damaged. | 9. Patient information and consent | Signs were placed up high as young people were removing signs that were placed lower – however, the names of each room will now be stencilled above the doorways so that the rooms can be identified more easily. | Head of maintenance | 30.09.18 |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| **Delivery of safe and effective care** | | | | |
| The registered provider must ensure that there are environmental audits and a programme of maintenance to promptly address identified issues. | 22. Managing risk and health and safety<br>12. Environment | There is a maintenance book on each ward which is checked daily in order to prioritise jobs required. | Security Leads | Completed |
| The registered providers must ensure that staff can promptly access ligature cutters in the event of an emergency. | 22. Managing risk and health and safety<br>12. Environment | A ligature policy and procedure was developed and will be ratified at Clinical Governance meeting on 05.09.19<br>Ligature cutters are be stored securely in appropriate locations offering quick access for staff. Ty Seren office, upstairs each located on locked cupboard and Nurses station<br>Ligature Cutter, their storage and locations will be checked at each staff handover and incoming staff will familiarise themselves as to their location.<br>This will be logged in the Daily Log book and signed off by outgoing and incoming staff. | Security Manager<br>Security Leads<br>Heads of Departments<br>Security Leads | Completed |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| The registered provider must ensure that practices are regularly reviewed as a multi-disciplinary team to ensure that the management of risk is undertaken on the risks of individual patients and not blanket rules for the ward and/or hospital. | 22. Managing risk and health and safety<br>12. Environment | The MDT now discuss this at morning meeting and at ward rounds to make sure that decisions are done on a case by case basis. In addition, areas of the hospital/service would be discussed at clinical governance. | Head of Psychology<br>Clinical Lead<br>Responsible Clinician | Completed |
| The registered provider must ensure that the cleanliness of the ward is maintained throughout the day and night shifts. | 13. Infection prevention and control (IPC) and decontamination | All Staff in Regis Healthcare have a responsibility to promote and safeguard the cleanliness of the environment. This will be monitored through Security Leads in their daily responsibility on the ward. A record of daily checks will be maintained.<br>A review of the infection control Policy will include Environmental Cleaning Procedure.<br>Regular audit will be reported through Clinical Governance and Quality improvement Plans. | Head of House Keeping<br>Security leads on each shift<br>Clinical Lead<br>Head of House Keeping | Completed<br>30 September 2018<br>Quarterly |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| The registered provider must ensure that food and drink items are stored appropriately, including opened dates and, where applicable, which patient they belong to. | 13. Infection prevention and control (IPC) and decontaminati on | Fridge checks Occurs, to ensure that the service remains compliant. The Daily checks will record food labelling with opened dates compliance and disposal of food not labelled | Security Leads in Ward Serveries<br>Kitchen Staff in Staff areas and cross checking in ward Serveries | Completed |
| The registered provider must ensure that food and drink items are disposed of on their expiry date or when visibly no longer fit for consumption. | 13. Infection prevention and control (IPC) and decontaminati on | Fridge checks Occurs, to ensure that the service remains compliant. The Daily checks will record food labelling with opened dates compliance and disposal of food not labelled | Security Leads in Ward Serveries<br>Kitchen Staff in Staff areas and cross checking in ward Serveries | Completed |
| The registered provider must confirm that the replacement dishwasher has been installed. | 13. Infection prevention and control (IPC) and decontaminati on | The broken dishwasher within the ward kitchen on Ebbw Ward has been replacement and installed | Domestic staff Lead | Completed |
| The registered provider must ensure that sanitary bins are in-situ and regularly emptied. | 13. Infection prevention and control (IPC) and decontaminati on | Sanitary Waste is collected disposed by designated waste management company PHS. All toilets and bathrooms have access to sanitary bins easily accessible to staff patients and visitors | Head of Housekeeping | Completed |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| The registered provider must ensure that food and fluid charts are completed in full. | 14. Nutrition | Food and fluid Charts are checked and audited through records audits to check for completeness | Security Leads | End of September (due to new roles) |
| The registered provider should provide meal time supervision training for staff. | 14. Nutrition | Scheduled for 7th and 12th September | Nursing team | End of September 2018 |
| The registered provider should consider storing the log books for each within a secure area in each of the clinics. | 15. Medicines management | The Controlled and Drugs Liable to misuse log books for Brenin and Ebbw Ward are now stored in secure area to prevent being misplaced or amended by unauthorised persons. | Ward Managers | Completed |
| The registered provider must ensure that the open date is recorded on liquid medication. | 15. Medicines management | Limited Life Medications are audited weekly by Ashton pharmacy. This report is available for all Nurses and medical Teams. Notices have placed in all the Clinic Rooms to remind nurses to Label and check that Limited Life Medications are labelled | Ward Managers | Completed |
| The registered provider must ensure that the clinic room on Ebbw Ward is orderly. | 15. Medicines management | The Clinic room was reorganised with labelling of medications and keys. Photos have been displayed in each Clinic room to assist with easy access | Ward Managers | Completed |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | and identification of medications and items | | |
| The registered provider must ensure that all policies are up-to-date. | 15. Medicines management | All policies are reviewed throughout clinical governance and will now be passed through Corporate clinical governance | Senior Management Team | September 2018 |
| The registered provider must ensure that staff are fully aware of reporting responsibilities and processes following a medication error. | 15. Medicines management | Medication errors must be reported to the senior person on shift/ doctor as soon as is possible. The staff noticing the error is required to raise an incident form | Nurse in-Charge on each shift | Ongoing |
| The registered provider must ensure that incident reports are completed to a high professional standard. | 7. Safe and clinically effective care | Patient safety and ward managers trained in Checking the accuracy of incidents. This was completed on 30.06.18<br><br>Incident checklist guidance developed for Patient safety and ward managers<br><br>During each shift MDT led by Psychology check that incident forms are adequately completed by staff, including completing de-briefs with staff and young people after incidents.<br><br>This then countersigned by the nurses | Nurses on duty<br><br>Safety Leads<br><br>Psychology | Completed |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | on duty. MDT monitors this on daily meetings for completeness | | |
| The registered provider must ensure that patient records include restraint risk management and implementation plans. | 7. Safe and clinically effective care | No hands first boards have been placed on both wards and the young people have written advanced wishes outlining how they wish to be supported should they become distressed, this gives several options of what to do prior to physical intervention but then includes details of what the team can do to make things better for them should it escalate to physical intervention | Safety leads<br>MDT | Completed and ongoing |
| The registered provider must ensure that incidents and restraints are reviewed to identify lessons learnt. | 7. Safe and clinically effective care | Daily handover meetings reviews incidents.<br>Report and Action plans each by Ward Managers to allow lessons learnt will form part of Clinical governance.<br>The service will develop a newsletter with themes of Lessons learnt for all staff | MDT<br>Ward manager<br>Clinical Lead | On-going<br>Monthly<br>November 2018 |
| The registered provide must notify HIW of incidents as required by the requirements of Regulation 31. | 7. Safe and clinically effective care | The Responsible individual has completed the Retrospective reporting of incident under regulation 31 | Responsible individual | Completed 31.07.18 |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | The service has implemented a system at present with Clinical lead supporting in Notification | Clinical lead | When incidents occur |
| The registered provider must ensure that Care and Treatment Plans are written in straight forward language. | Mental Health (Wales) Measure 2010 | Care planning process will be reviewed to evidence that they are collaborative using language that is easy to understand, empowering, meaningful and hopeful to the young people using the service. There is evidence in the records that care plans are:<br>• Up to date<br>• Reflect the person's own assessment of their situation and priorities<br>• Are written in simple personally meaningful language<br>• Are created in partnership with the young person using the service and when appropriate with their carer<br>• Have clearly identified SMART goals and actions (including a review date) | Clinical Lead and MDT | completed |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| The registered provider must ensure that patients are offered a copy of their Care and Treatment Plans and if so whether they accepted or declined. | Mental Health (Wales) Measure 2010 | Copies of care are made available to young people. Where this is not met, it is clearly indicated on the care plan stating the reasons why. | MDT | Monthly and Ongoing |
| The registered provider must continue to review recordkeeping to ensure that there is a comprehensive physical health record available to easily review. | Mental Health (Wales) Measure 2010 | All patients have a Physical health care Plan | RGN | Monthly - completed |
| The registered provider must ensure patients have care plans in respect to specific physical health and wellbeing needs. | Mental Health (Wales) Measure 2010 | All patients have a Physical health care Plan | RGN | Monthly - completed |
| **Quality of management and leadership** | | | | |
| The registered provider must provide an update on the recruitment process and vacancy position. | 25. Workforce planning, training and organisational development | Recruitment process to keep track of vacancies and staff turnover in line with Regis healthcare Needs.<br><br>Ward managers communicating their needs with HR<br><br>Use of bank to cover gaps and vacancies | Human resources | Ongoing |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | Use of selected Agency RMNs who can build in elements of consistency<br><br>Workforce plan completed with an HR strategy for workforce | | |

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): Danmore Padare**

**Job role: Clinical Lead**

**Date: 30 August 2018**