Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Focussed Review: Governance and Risk Management Arrangements (Unannounced)

Regis Healthcare

Ebbw and Brenin Ward

Inspection date: 10, 11, 12 and 13 September 2018

Publication date: 12 December 2018

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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

In writing:

**Communications Manager**

**Healthcare Inspectorate Wales**
**Welsh Government**

**Rhydycar Business Park**

**Merthyr Tydfil**

**CF48 1UZ**

Or via

**Phone:** **0300 062 8163**

**Email:** **hiw@gov.wales**

**Fax:** **0300 062 8387**

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

Digital ISBN 978-1-78964-016-8

# Contents

# 1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced focussed inspection of Regis Healthcare on 10, 11, 12 and 13 September 2018. This was HIW's fourth visit in seven months, due to HIW's findings at its inspections and concerns raised by commissioners, members of staff, patients and their families.

HIW does not routinely carry out this number of inspections in such a short timeframe, but due to the previous findings and recent concerns, HIW decided to conduct this visit to assess whether Regis Healthcare was providing safe and effective care to patients.

**Regis Healthcare**

Regis Healthcare is an Independent Hospital registered to provide treatment or nursing (or both) to 24 persons between the ages of 13-18 years, who require treatment for the primary category of psychiatric treatment and may be liable to be detained under the Mental Health Act 1983 (The Act).

The hospital has two wards:

- Brenin – a 12 bed low secure unit
- Ebbw – a 12 bed low secure unit.

**How did we do this?**

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

The review was carried out over a night/early morning and three full days and focussed specifically on how risk was being managed and how governance processes were working.

## 2. Summary of our findings

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 apparent in other recent inspections.

The Registered Provider was unable to demonstrate that all staff, particularly agency Registered Nurses, had sufficient knowledge, competence, skill and experience to be working at the hospital. There was also no system in place for the provider to monitor the performance of agency staff.

Staffing levels had improved following our previous inspections, with appropriate levels of staff on each shift. However, we found that staffing levels were not in line with the provider's conditions of registration on the night of the 10th September, when there was only one registered nurse working on Brenin Ward. The conditions of registration for the hospital state there should be two registered nurses on each ward.

We found, from examining patient records, that whilst the registered provider had identified potential risks for the patients, and these were set out in their care plans, there were no plans in place setting out how they would minimise these risks.

This was the fourth inspection that we had undertaken of Regis Healthcare since March 2018, which is an exceptional situation and a reflection of the concerns that we have had regarding this provider. Due to the lack of significant or sustained improvements since March 2018, the absence of strong leadership and management of the hospital, inadequate governance arrangements and the potential impact of these upon the safety of patients, HIW took the decision to take further enforcement action.

On the basis of these inspection findings, and continued non-

compliance following previous inspections, HIW held a Service of Concern Review meeting and proposed to cancel the Provider's registration. A Notice of Proposal to cancel the registration of Regis Healthcare was issued on 26 September 2018. Regis Healthcare responded to this Notice and HIW is currently considering these representations.

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.

# 3. What we found

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

**Brenin Ward**

- The team found some staff to be knowledgeable and experienced.

**Ebbw Ward**

- The nurse in charge on the night shift on 10 September had good knowledge of the patients.
- The office on the ward was tidy and seemed organised
- Patients had access to education and learning activities in a well resourced education facility, and the patients that we spoke to stated that they enjoyed their time there
- The team spoke to the Responsible Clinician on the ward and noted that he was very knowledgeable concerning the Mental Health Act documentation and demonstrated considerable experience.

**Whole Hospital**

- The majority of staff at ward level engaged with the inspection process.
- The inspection team noted/observed staff treating patients with respect and dignity.

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

**Brenin Ward**

The office on the ward appeared disorganised and was generally untidy. During the night/early morning visit the inspection team had concerns about the knowledge of the agency nurse on duty. A patient had been taken to the local Accident & Emergency Department that night, but when asked the nurse could not tell the team

which Doctor had signed off the section 17 leave[1]. The nurse could also not provide the name of the patient's Responsible Clinician. The form confirming the section 17 leave for the patient to go to hospital did not contain the patient's name or the date of the leave. When our inspection team looked at looked at the patient's notes the following day the entry about the hospital visit contained just a one line update by the registered nurse.

On the morning of 11 September 2018 the inspection team observed a screwdriver and paint scraper holding open a set of double doors on the ward, these items were left here by the maintenance team who were carrying out refurbishment at the hospital. Whilst the team did not see any patients on the ward while this work was being carried out, we did not find a risk assessment in place for this work taking place.

The alarm on the ward was faulty and activated itself on a number of occasions during the inspection, indicating 'Attack' when no attack was occurring at that time. A reliable and effective alarm system is important to ensure the safety of staff and patients.

Our team found that whilst individual patient risks had been identified, and these were shown in patient records, there were no care plans in place to mitigate the risks. The following examples illustrate the issues that we found:

*Patient A*

Care documentation stated that the patient was not allowed to have bathroom privacy. However, there would clearly be occasions when the patient would need to access bathroom facilities and no plan of care had been devised to facilitate this. This plan would be crucial in establishing methods to deal with the numerous risks to the patient. There was no clear and prescriptive care plan around using the shower facilities that staff could follow. This would be essential when agency staff, who did not know the patient very well, were utilised. The patient had an x-ray taken on their arm on 2 September 2018 and fragments of metal were taken out of their arm on the same day under local anaesthetic. However, nine days after this treatment there was

[1] This is a Section of the Mental Health Act (1983) which allows the Responsible Clinician (RC) to grant a detained patient leave of absence from hospital. It is the only legal means by which a detained patient may leave the hospital site.

still no care plan in place to manage a number of key areas including infection control and pain relief.

*Patient B*

The patient had issues with staff asking too many questions about their life, which made them angry. However, the inspector could not find a plan of care that took account of this issue in order to assist staff undertaking one to one levels of observations.

On 10 September 2018, it was recorded that the patient had inserted three foreign objects in their body, with a further update on 11 September. No care plans had been devised for this issue. From the notes examined, it is clear that there were numerous previous occasions when this behaviour had occurred and this risk had been identified within the care documentation. However, there was no care plan(s) devised to mitigate this risk.

*Patient C*

The patient had previously been fed via a nasal gastric tube and no specific care plan was in place in relation to this area. There was also no care plan in place for inserting the tube and feeding whilst under restraint.

**Ebbw Ward**

Care plans (both electronic and paper) could not initially be located by the ward manager who informed the inspection team that the primary nurse would be able to locate these and provide up to date copies. However, electronic and paper copies of these plans must be available on the individual patient records to ensure that all staff are aware of the issues and strategies for dealing with them. This is of particular relevance to agency nurses who may have little or no knowledge of the patient group. The inspector was also informed that agency Registered Nurses, who were booked at short notice, would not have access to the electronic patient records making it even more vital that up to date paper records are on the individual patient files.

There were no restraint care plans located on the ward. The inspection team was informed that these were removed and responsibility for their completion was now with the newly created patient safety lead's team.

The team examined care notes on this ward and found the following issues:

*Patient D*

The patient's care plan did not cover a number of key areas that had been previously identified within the 'observation and engagement decision form'. These areas included bathroom privacy: restricted to one hour after meals, and a pat down before entering this area. The care plan dated 1 August 2018 actually stated 'I currently do not have bathroom privacy', which is in direct conflict to the 'observation and engagement decision form'. Other risks, where no specific care plans had been developed, were observation levels, sexualised behaviour and violence and bullying towards others.

*Patient E*

The patient's care plan did not cover a number of key areas that had been previously identified as areas of risk. This included the patient's head banging behaviour which had previously resulted in the patient sustaining a number of injuries. In addition, the patient had issues with going outside the hospital ward and open spaces; again no plan of care was in place in relation to this area.

**Whole Hospital**

At the point of inspection the hospital had 14 agency registered nurses and only 7 permanent registered nurses, which included the ward managers and the Clinical Lead. There was no system in place to monitor and audit the work of agency staff, meaning that the hospital was unable to identify any poor performing members of staff

There has been no Registered Manager in place at the hospital since 29 June 2018, the provider had nominated two individuals who were not suitable and who subsequently withdrew their applications.

**Leadership and Governance**

We found that there was a distinct lack of leadership and management at the hospital. This is the fourth inspection since March 2018 and despite some improvement noted at our inspection in June 2018, significant failings have continued to be identified. Whilst HIW received improvement plans following inspections in March and June 2018, the provider has not achieved regulatory compliance and failed to demonstrate significant and sustained improvement

The deficiencies found on this inspection, particularly the lack of care plans for identified risks, demonstrate a significant failing and we cannot be assured that patients receive safe care consequently

There was insufficient evidence to demonstrate that there were adequate leadership, systems, processes and governance in place to ensure that safe and effective care was being provided.

**Mental Health Act Monitoring findings**

The policies and procedures available were limited and there was no clear differentiation between what the policy was and what needed to be translated into a procedure. The Policies did not come with an overriding 'policy statement' specifying their purpose and the organisation's commitment to compliance with the Act and ensuring their implementation. The policies did not include a date of implementation and date to be reviewed; also missing was the name of the author and their position within the organisation.

The language used within the policies was not consistent with that used in the Act and code of practice for Wales e.g. 'acceptance of section papers' should be 'receipt and scrutiny of admission documents'.

There was no policy on file regarding how they administer section 2 admissions.

One patient's MHA file did not contain a record of a Hospital Managers' hearing that was held on 5 March 2018, which had been adjourned twice. As a result our reviewer had concerns that the patient continued to be detained after the section expiry date; further investigation evidenced that the 'meeting control form' for the hospital managers' review had not been filed, leading the reviewer to consider the possibility that the patients detention could be invalid. Following discussion with the MHA administrator, the form was located and filed appropriately.

One Hospital Managers' Review form was completed with incorrect renewal data. Having checked with the Mental Health Act administrator, there was agreement that the document was indeed incorrectly dated. A change to the form was suggested by the reviewer to ensure that such information would be recorded by the MHA administrator in future.

Hard copies of the code of practice for Wales were not available on either ward for patients, visitors and others to access. They are available only to staff electronically; hardcopies need to be obtained and made available.

Social circumstances reports are currently sent directly from the local authority to the Mental Health Review Tribunal (MHRT) – not via the MHA office. Good practice requires that all reports are collated by MHA administrators for timely dispatch to the MHRT.

There are times when reports are not available until the day of a manager hearing which is unacceptable because it does not provide enough time to assess all information available. The advocate stated that reports for manager hearings/tribunals are often very long and patients struggle to take in the information which can prove very stressful to them.

The organisation is urged to consider implementation of an electronic Mental Health Act system to help ensure the safeguarding patients rights.

# 4. What next?

Following the visit HIW held a service of concern review meeting where it decided, due to escalating concerns following four separate inspections over a seven month period, to propose cancelling the registration of Regis Healthcare.

A Notice of Proposal to cancel the registration of Regis Healthcare was issued on 26 September 2018. In line with the legal process, Regis Healthcare sent written representations to HIW on 23 October 2018. HIW is now considering those representations, and will then make a decision on whether it upholds the Notice of Proposal to cancel and issues a Notice of Decision to cancel, or it accepts the representations submitted by Regis Healthcare.

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.