Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Rushcliffe Mental Health Hospital
Aberdare

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at Rushcliffe Independent Hospital, on 25, 26 and 27 September 2023. Rushcliffe provides care for up to ten patients and at the time of our inspection there were seven patients being cared for in the hospital.

Our team for the inspection comprised of three HIW Healthcare Inspectors, two clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and a patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. A total of one patient questionnaire was completed. We also spoke to staff working at the service during our inspection. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Staff interacted and engaged with patients appropriately and treated patients with dignity and respect. Patients were provided with a range of therapeutic activities to support and maintain their health and wellbeing. However, the hospital's Occupational Therapist post was vacant and being recruited to at the time of our inspection. We found strong evidence that patients could engage and provide feedback about their care in a number of ways. Patients had access to a mental health advocate who provided information and support with any issues they may have regarding their care.

This is what we recommend the service can improve:

- Individual patient food cupboards should be labelled to display patient names for general awareness
- The registered provider's Statement of Purpose must be reviewed to ensure it contains relevant and up to date information
- The service should install information boards which inform patients, family and carers of changes made as a result of their feedback.

Delivery of Safe and Effective Care

Overall summary:
Staff appeared committed to providing safe and effective care. Suitable protocols, policies and processes were in place to manage risk, health and safety and infection control. However, we identified several safeguarding risks which were appropriately resolved during the inspection. Some examples included staff leaving the hospital's pool table and equipment unattended, insufficient pagers available to staff and the inclusion of restricted contact details within a care plan which was accessible to the patient concerned.

Patient Care and Treatment Plans were being maintained to a good standard but improvements were required to ensure the voice and involvement of patients is reflected in patient records. Robust procedures were in place for the safe management of medicines and we observed sensitive and appropriate prescribing of medication in accordance with patient needs. The statutory documentation we saw verified that the patients were appropriately legally detained. However, improvements were necessary to ensure patient detention was reviewed in a timely manner by Hospital Managers' review panels. Additional Mental Health Act

(MHA) monitoring improvements were required in respect of MHA record keeping, mental capacity assessments and the provision of additional training for staff.

This is what we recommend the service can improve:

- Patient food and drinks must be appropriately labelled to display the opening date and use-by dates. Any outdated items must be discarded
- Patient therapeutic observation records must be reviewed by a qualified nurse on a four-hourly basis and the relevant documentation must be completed at the time
- An assessment of capacity must be conducted and documented before carrying out the care and treatment of patients
- The views of statutory consultees must be recorded to support medical treatment authorised by the Second Opinion Appointed Doctor
- Consent to Treatment forms must be completed and stored with corresponding patient medication records for staff awareness
- The service must implement additional Mental Health Act training and governance oversight for staff which includes Consent to Treatment provisions
- The service must ensure Hospital Managers' hearings are undertaken in a timely manner.

This is what the service did well:

- We saw examples of good practice including the use of easy read and pictorial information to support patient understanding
- Patient rights were updated on a monthly basis as standard practice.

Quality of Management and Leadership

Overall summary:
We found established governance arrangements in place to provide oversight of clinical and operational issues. Staff told us that they felt supported in their roles and satisfied with their organisational management. Processes were in place to ensure staffing levels met the hospital's staffing templates but it was clear that the service required a high use of agency staff to fill vacant shifts, which placed additional pressure on staff. At the time of our inspection we noted a high number of permanent staffing vacancies and some staff told us they felt there were not enough staff to meet increased patient demand on the ward.

Processes were in place for senior staff to monitor compliance with mandatory training via the hospital's electronic training matrix. However, staff had difficulty in navigating and filtering the system to obtain accurate training data and the

compliance statistics provided during the inspection were later found to be incorrect. Following the inspection we were provided with current training compliance data for staff which evidenced that overall staff mandatory training compliance was generally high. We were provided with assurances that there was a robust programme of governance oversight in place which ensured mandatory training was completed and regularly monitored.

This is what we recommend the service can improve:

- The service must ensure the hospital's staff meeting process is actively promoted and attended in order to capture staff feedback and act upon any issues raised
- The service must review the hospital's current staffing template to consider whether it continues to support effective patient care and staff welfare requirements
- The service must continue to actively focus on the recruitment of staff to outstanding permanent vacancies
- The service must review the hospital's training matrix to improve ease of navigation and ensure accurate retrieval of training compliance data
- The service provider must ensure staff are supported to complete outstanding mandatory training courses and update HIW upon completion.

3. What we found

Quality of Patient Experience

Health promotion, protection and improvement
We looked at a sample of three patient records and saw evidence that patients had received appropriate physical assessments upon their admission in addition to their mental healthcare. Patients had physical health care plans which documented regular health screening and referrals to other primary care health professionals when required.

The hospital had a dedicated Activities Coordinator to assist with the provision of therapeutic patient activities. We found patients had access to a range of appropriate ward and community-based activities. However, the hospital's Occupational Therapist post (OT) was vacant and being recruited to at the time of our inspection. There were no gym facilities on site but we were told that patients could undertake external gym visits as required.

Throughout the inspection we saw appropriate therapeutic activities were being offered to patients but staff told us there was little patient uptake for the activities on offer. The service may wish to conduct further discussions with patients to gain their feedback and review whether the current provision of activities and sessions is suitable for patient needs.

Dignity and respect
The registered provider's Statement of Purpose outlined how hospital staff supported patients to maintain their privacy and dignity. Each patient had their own en-suite bedroom which provided a good standard of privacy. We were told that patients could lock their rooms if they wished, but staff could override the locks if necessary. We saw staff knocking before entering patient bedrooms, which evidenced their respect for patient privacy. Patients were able to store possessions and personalise their rooms as desired.

All bedroom doors had observation panels which allowed staff to undertake patient observations without opening the door. This minimised the risk of disturbing the patient and helped to maintain patient privacy and dignity. Staff also had access to a night light switch outside patient bedrooms which enabled them to safely carry out evening observations with minimal disturbance for patients. Appropriate visiting arrangements were in place at the hospital and there were designated areas which offered patients a higher level of privacy if needed. There were suitable rooms where patients could make and receive calls in private.

Throughout the inspection we observed staff treating patients with dignity and respect. Staff took the time to speak with patients to understand their needs or any concerns the patients raised. Patients whom we spoke with during the inspection confirmed that staff were polite, supportive, and respectful.

Patient information and consent
The registered provider's Statement of Purpose described the aims and objectives of the service. This document contained all the relevant information required by the regulations but we were told it had not been reviewed since the service was first registered in June 2022.

The registered provider's Statement of Purpose must be reviewed to ensure it contains up-to-date and relevant information.

We observed that all patients were provided with a comprehensive and helpful information pack which detailed the hospital's Mission Statement, expectations and various processes. However, at the time of our inspection there was limited patient and carer information displayed on the ward in respect of health promotion, HIW, complaints processes and advocacy. We further noted that the patient information was displayed and provided predominantly in English.

We discussed this matter with staff who advised that translation services were accessible and all patient information could be provided in Welsh if required. We were further told that staff were in the process of removing and replacing the hospital's signage and information boards to display bi-lingual information. We were assured that all relevant patient information would be appropriately displayed when this action was complete.

At the time of our inspection there were no Welsh speaking staff or patients in the hospital. The service provider may wish to review the hospital's recruitment processes with a view to encouraging applications from Welsh speaking staff.

Communicating effectively
We witnessed staff treating patients with respect and kindness throughout the inspection. Patients appeared confident in approaching staff to engage in discussions. The patients we talked to spoke positively about their interactions with staff.

Daily handover and weekly multidisciplinary (MDT) meetings were held to discuss patient care requirements, upcoming activities within the hospital and other relevant information, such as medical appointments. The service used digital technology as a tool to support effective communication by way of online meetings and electronic information sharing in order to ensure timely patient care. Some

patients had access to mobile telephones so they could keep in touch with family and carers, depending on individual risk assessment. To ensure the safe and secure use of digital devices, patients signed a contract in accordance with hospital policy.

Care planning and provision

During the inspection we reviewed the Care and Treatment Plans (CTPs) of three patients. We found each patient had an appropriate programme of care that reflected the needs and risks of the individual patients. Patients received good physical monitoring at regular intervals and we saw strong evidence of risk assessment and management within the records. More findings on the care plans can be found in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Daily meetings were held for nursing and senior management staff to discuss any concerns, issues or incidents that had taken place the day before. We attended a handover meeting during the inspection and saw that staff demonstrated a good level of understanding of the seven patients they were caring for, and that discussions focused on what was best for the individual patient.

Equality, diversity and human rights

During the inspection we examined the records of four patients who were detained at the hospital under the Mental Health Act (the Act). The legal documentation we reviewed was compliant with relevant legislation and followed the guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code). We saw strong evidence that patients were regularly reminded of their legal status and rights. All patients had access to an Independent Mental Health Advocate who can provide information and support to patients with any issues they may have regarding their care.

The hospital had policies in place to help ensure that patients' equality and diversity were respected. Reasonable adjustments were in place so that everyone could access and use the hospital’s services on an equal basis. The service participated in an overseas recruitment process which encouraged and supported diverse staffing. The CTPs we reviewed evidenced that the social, cultural and spiritual needs of patients had been considered. Overall staff compliance with mandatory Equality, Diversity and Inclusion training was sufficiently high.

Citizen engagement and feedback

We found evidence that patients, family and carers could engage and provide feedback on the provision of care at the hospital in a number of ways. A suggestion box was available to patients, family and carers on the ward. The hospital held monthly community patient meetings which provided opportunities for patients to

raise any issues and provide feedback to ward staff. We saw minutes of meetings which showed that staff were keeping patients informed of what actions had been taken in response to issues that had been raised. Patients we spoke with during the inspection told us they felt encouraged and able to provide feedback to the service.

During the inspection we saw evidence that patient feedback was collated, recorded and discussed during Clinical Governance meetings. We were advised that patients were informed of any changes made as a result of their feedback during the following patient meeting. However, there were no information boards such as 'You said we did boards' to demonstrate that feedback was captured and acted upon where necessary, for patient and family/carer awareness.

The service should install information boards which inform patients, family and carers of changes made as a result of their feedback.

During our discussions with staff we were told that the service conducted patient satisfaction surveys on a six-monthly basis to gain their feedback and identify any improvements required. The hospital had a complaints policy and procedure in place that provided a structure for dealing with all complaints within the hospital. Staff we spoke to during the inspection described appropriate processes to record and investigate complaints and share learning across the service. We found there were no open complaints at the time of our inspection.

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety
Overall, we found the service had processes in place to manage and review risks to help maintain the health and safety of patients, staff and visitors at the hospital. The hospital entrances were accessible to everyone and were secured at all times throughout the inspection to prevent unauthorised access. The hospital provided a clean and comfortable environment for patients and was equipped with suitable furniture, fixtures and fittings for the patient group.

A range of up-to-date health and safety policies were available for staff. There were established processes and audits in place to manage risk, health and safety and infection control. Ligature cutters were appropriately stored for use in the event of a self-harm emergency and we found up-to-date ligature point risk assessments in place at the hospital.

We found an established electronic system in place for recording, reviewing and monitoring incidents. There was a hierarchy of incident sign-off which ensured that incident reports were reviewed and finalised in a timely manner. Incident reports were produced and reviewed at hospital and organisational level so that appropriate lessons could be taken which encouraged shared learning. We found incidents were appropriately monitored and supervised to support the provision of safe care.

However, during the inspection we found several potential risks to staff and patient safety which were rectified during the inspection. We noted there were nurse call points around the wards and within patient bedrooms so that patients could summon staff when required. Staff wore personal alarms and pagers which they could use to call for assistance in an emergency. However, we were told there were not enough pagers available for staff. We discussed this matter with senior staff who confirmed that additional pagers had been ordered and delivered to the hospital but they had not yet been set up and distributed to staff. We highlighted that this posed a potential risk to staff and patient safety and the matter was appropriately resolved during the inspection.

During the inspection we reviewed the hospital's staffing rotas and found that they incorrectly detailed a healthcare support worker (HCSW) as a qualified nurse. Given that the hospital's staffing template consisted of two qualified nurses by day and one by night, we identified that the rota provided misleading information regarding hospital staffing levels which posed a risk to staff and patient safety. We

raised the issue with staff and the rota was appropriately amended during the inspection.

The hospital had a pool table for patient use and there were strict procedures in place to ensure the safe use of the pool equipment which was securely stored in a locked cupboard. Staff told us that the pool equipment sign-out process included clear instructions that the pool table must never be left unattended when in use.

However, during our evening tour of the hospital we found agency staff had left the pool table and equipment unattended whilst escorting a patient outside for a cigarette break. During this time, another unescorted patient entered the communal lounge where they had free access to these items. This posed a serious risk to staff and patient safety and we immediately raised this matter to senior staff. The matter was suitably resolved during the inspection in that the incident was recorded and shared for general staff awareness, and reported to the relevant agency concerned. Staff further completed a 'Near Miss' incident form with a view to discussing the risk at Clinical Governance meetings to promote shared learning and prevent reoccurrence.

We further recommend that the risks relating to the pool table and equipment must be incorporated into the hospital's agency staff induction and checklist process.

A number of contingency plans were in place that set out the procedures to follow in the event of a major incident occurring at the hospital. These included events such as fire, loss of water and electricity supply and severe weather conditions. We reviewed the hospital's Business Continuity Plan and found it provided comprehensive and suitable guidance for staff.

Infection prevention and control (IPC) and decontamination
Overall, the environment of care appeared to be clean and clutter free. The majority of furniture and fittings were appropriate for the patient group and in a good state of repair.

We found suitable infection prevention and control (IPC) arrangements in place in the hospital. Up-to-date policies were available that detailed the various procedures to keep the environment clean and staff and patients safe. Regular internal and external audits were completed to monitor compliance with hospital procedure.

During our inspection staff showed awareness of their responsibilities around infection prevention and control. Personal Protective Equipment (PPE) was available to staff and we observed staff using PPE correctly. Hand hygiene

facilities were available for staff, patients and visitors. The hospital's laundry facilities were observed to be in good working order.

Nutrition
Our examination of case notes and clinical entries found that patients were supported to meet their individual dietary needs and provided with diets in accordance with their medical needs. We saw evidence that patient nutritional needs were assessed on admission and throughout their stay during weekly physical health clinics. There were appropriate care planning arrangements in place to meet specific patient physical health care needs in relation to dietary intake, weight management and diabetes monitoring.

The hospital provided a varied and balanced menu which rotated on a regular basis and patients could access drinks and snacks throughout the day. We saw evidence that patients could make suggestions and contribute to the hospital menus during patient meetings. The service had introduced weekly food theme nights and organised group meal outings based on patient suggestions. Patients could purchase and store food in individual lockable cupboards and were supported to cook their own meals under the supervision of staff.

However, we noted some issues relating to the storage and labelling of patient food items which we highlighted to staff during the inspection:

- We found various bottles of soft drinks and outdated cereal boxes in the patient lounge kitchen which had been opened but displayed no opening date, which meant that the use-by-date could not be ascertained
- The flour container in the main kitchen displayed a use-by-date label dated 1 September 2023.

The service must ensure patient food and drink is appropriately labelled to display the opening date and use-by-date. Any outdated items must be discarded.

Medicines management
We reviewed the hospital's clinic arrangements and found robust procedures in place for the safe management of medicines. Relevant policies, such as medicines management and rapid tranquillisation, were in date and available to staff. We found strong evidence of regular and supportive pharmacy input and audits which supported the hospital's processes for the management, prescribing and administration of medications. Medication was securely stored and the medication fridge was locked when not in use.

Daily temperature checks of the medication fridge and room were being completed to ensure that medication was stored at the manufacturer's advised temperature. Appropriate arrangements were in place for the storage and safe use of controlled drugs.

We viewed a sample of Medication Administration Records (MAR charts) and found they were being maintained to a good standard. The MAR charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. We found patients had individualised medication management plans and were involved in decisions about their medication wherever possible. We observed appropriate prescribing of medication in accordance with patient needs. Patient medications were regularly reviewed during MDT meetings to ensure they continued to be appropriate.

Safeguarding children and safeguarding vulnerable adults
Staff had access to the registered provider's safeguarding procedures on the intranet. There were established processes in place to ensure that staff safeguarded vulnerable adults, with referrals to external agencies as and when required.

During the inspection we viewed samples of safeguarding referrals and found strong evidence that safeguarding concerns were recorded and referred to external safeguarding agencies in line with the registered provider's policy. Staff demonstrated understanding of the All Wales safeguarding requirements and the process of making a safeguarding referral. Senior staff showed awareness of their duties and responsibilities in respect of safeguarding the particular vulnerabilities of the patient group.

The service had an appointed safeguarding lead and we viewed minutes of Clinical Governance meetings which evidenced that safeguarding was discussed as a standing agenda item, to identify any themes and opportunities for shared learning. We were provided with evidence which indicated that overall staff compliance with mandatory Safeguarding Adults and Children Training courses was high.

Patients we spoke with during the inspection told us they felt safe and supported and able to report any concerns to the ward staff. Advocacy arrangements were in place for patients to raise concerns and address any issues they might have.

However, during the inspection we noted a potential safeguarding risk whereby details of a patient's restricted contact had been included in a care plan which was accessible to the patient concerned. We highlighted our concerns to staff and

advised that the restricted contact details must be removed from the patient's care plan. This was appropriately rectified during the inspection.

A separate care plan must be completed to address safeguarding concerns relating to patients with restricted contacts.

Medical devices, equipment and diagnostic systems
We found adequate resuscitation equipment in place in the hospital. Weekly checks were being undertaken on resuscitation and emergency equipment to ensure that the equipment was present and in date.

During our discussions with staff they showed appropriate awareness of the location of the hospital's ligature cutters in case of an emergency.

Safe and clinically effective care
Over the course of our inspection, we looked at the systems and governance arrangements in place to help ensure that staff provided safe and clinically effective care for patients. There was an established system in place for recording, reviewing, and monitoring patient safety incidents. Discussions with staff and evidence obtained during the inspection confirmed that incidents were investigated and managed appropriately. There was a process of incident management and escalation in place to ensure that incident reports were reviewed in a timely manner. Staff confirmed that debriefs took place following incidents and any relevant learning was shared with staff verbally and electronically.

We found Positive Behaviour Support (PBS) plans in place to help understand, manage and reduce challenging patient behaviours. Throughout the inspection we observed staff responding to patient needs in a timely manner and managing patient risks through therapeutic observation and engagement. We saw staff undertaking safe and supportive therapeutic patient observations and found observation records were appropriately completed by nursing staff. However, we saw evidence of multiple occasions when the four-hourly review of the observation records had not been completed by qualified nursing staff as required. We further noted that when this occurred, a request was made for the Registered Mental Health Nurse concerned to complete and sign the review retrospectively, which we identified as inappropriate.

The registered provider must ensure patient therapeutic observation records are reviewed by a qualified nurse on a four hourly basis and the relevant documentation must be fully completed at the time.

During the inspection we witnessed staff conducting therapeutic observations of one patient from outside his room where they did not have sight of the patient

concerned. We raised this issue to staff and were informed that this arrangement caused the least distress for the patient and had been agreed by the MDT and senior management team. However, we observed that this information was not clearly documented within the patient's care plan for the awareness of all staff.

We further noted that the patient was being cared for in a separate area of the ward, away from the other patients. This arrangement was deemed to be in the best interests of the patient and was supported by senior management to ensure the safety of the patient and other patients on the ward. We examined the Care and Treatment Plan (CTP) of the patient and observed that the patient was regularly spending time on the main ward and was not being secluded from other patients.

Whilst we were assured that the patient was receiving good care, we recommended that an additional care plan must be created to fully document the individual therapeutic observation requirements of the patient and the supporting comments of senior staff. This action was appropriately completed during the inspection.

During our discussions with staff they showed understanding of the restrictive practices available to them as well as appropriate preventative measures which can reduce the need for restrictive responses to challenging behaviour. We reviewed a sample of recent restraint incidents which reflected that physical intervention is used infrequently at the hospital. The majority of the recorded incidents were low level, which demonstrated that restrictive practices were used as a last resort after other methods of de-escalation had proved unsuccessful. We found that incidents of restraint were routinely recorded, comprehensively documented and appropriately supervised in line with the registered provider's policy.

Records management

Patient records were being maintained electronically and via paper files. Paper files were securely stored on site and the electronic system was password protected to prevent unauthorised access and breaches in confidentiality.

We found well-organised paper and electronic records completed in the hospital, which were easy to navigate through clearly marked sections. Information was being captured regularly and comprehensively which provided a detailed overview of the patients and their care.

Further information on our findings in relation to patient records and care plans is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Mental Health Act Monitoring
We reviewed the statutory detention documents of four patients and spoke with staff to discuss the monitoring and audit arrangements in place. We found patients were legally detained according to guidance and legislation. There were good systems in place to support the automatic renewal of detention of patients.

We saw examples of good practice in relation to patient rights in accordance with section 132 of the Act. Patients were provided with their rights on a monthly basis as standard practice, which could be extended to three-monthly intervals if required. Patient rights information was clearly documented with an assessment of patient understanding.

We saw good processes in place regarding the leave arrangements for patients. Section 17 leave was allocated on a personalised basis and patients could also request additional leave for spontaneous events and activities if required. We found evidence that each period of leave was appropriately risk assessed, with detailed entries made in patient records by staff.

However, during the inspection we found a number of improvements were required in respect of Mental Health Act administration. We reviewed patient MHA records and found that staff were not conducting mental capacity assessments of patients in accordance with the Mental Capacity Act. We discussed this issue with staff who told us they did not complete capacity assessments at the point of administering medication as the patients were assumed to have capacity. We outlined our concerns to staff that patient capacity must be assessed by an approved clinician before carrying out care and treatment, to ensure patients have capacity to consent to their treatment and ongoing care.

An assessment of capacity must be conducted and documented before carrying out the care and treatment of patients.

We examined patient records and found that the views of the statutory consultees were not being routinely captured to support the medical treatment of patients authorised by the Second Opinion Appointed Doctor (SOAD).

The service must ensure that the views of statutory consultees are documented within patient records to support the medical treatment authorised by the Second Opinion Appointed Doctor.

We saw examples of well-completed Consent to Treatment forms during the inspection. However, we saw instances when Consent to Treatment Certificates had not been reviewed nor renewed upon the patient's admission to Rushcliffe

from a previous hospital. Additionally, within two of the four patient records we reviewed, the Consent to Treatment forms were not stored with the corresponding patient medication records for the ongoing awareness of staff. This meant that staff administering medication could not refer to the certificate to ensure that medication was prescribed under the Consent to Treatment provisions within the Act. It was concerning to note that some nursing staff we spoke with during the inspection showed limited knowledge and understanding of the legal requirement for Consent to Treatment forms and told us that they did not routinely review the forms to clarify that medication was lawfully certified before administering medications.

Patient Consent to Treatment Certificates must be reviewed and renewed upon the patient's admission to the hospital.

Consent to Treatment forms must be completed and stored with corresponding patient medication records for staff awareness.

The service must provide additional Mental Health Act training and governance oversight for staff which includes Consent to Treatment provisions under the Act.

During the inspection we identified that patient detentions were not being reviewed in a timely manner by hospital managers' review panels. We were advised that only three Power of Discharge (POD) members were available to conduct Hospital Managers' hearings for the renewal of patient detention. This met the minimum requirement for hearings to take place but resulted in unacceptable delays if one POD member was unable to attend. We saw an example whereby a patient's detention had been renewed in April 2023 but the Hospital Managers' hearing could not take place until October 2023 due to one POD member being unavailable.

The service must :

- **Ensure Hospital Managers' hearings are undertaken in a timely manner**
- **Explore further opportunities for the recruitment of additional POD members to prevent unnecessary delays in Hospital Manager's hearings**
- **Undertake an audit of patient MHA records to identify and prevent any additional delays.**

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision
Alongside our review of statutory detention documents, we considered the application of the Mental Health (Wales) Measure 2010. We reviewed three patient Care and Treatment Plans (CTPs) and found they were of good quality. The general

standard of contemporaneous record keeping was good and the records reflected the domains of the Welsh MH measure. The CTPs were well organised and easy to navigate in both paper and electronic format. The care notes provided a full reflection of patient care and we saw clear evidence of MDT contribution from all professional disciplines recorded as appropriate.

We found patients received physical health monitoring at regular intervals and saw strong evidence of risk assessment and management in place within the records. We saw examples of good practice including the use of easy read and pictorial information to support patient understanding.

During the inspection we saw examples of comprehensive CTPs and person-centred PBS plans which contained the appropriate amount of detailed information to support patient care. However, we noted that the patient voice was not well reflected within the records. We found inconsistencies in relation to the use of the patient voice and saw instances when professional language and clinical terminology had been used to record patient views.

The service must ensure that patient records reflect the voice and views of the patient.

During our examination of patient records we found limited evidence of patient involvement and contribution to the care planning process and saw inconsistencies in care plans being signed by patients. We highlighted this issue to senior staff who showed awareness of this issue and advised they were in the process of addressing the matter with staff.

The service must ensure that patients are involved in the care planning process wherever possible and evidence this within patient records.

Quality of Management and Leadership

Governance and accountability framework
We found staff were receptive to our views, findings and recommendations throughout our inspection. During the meetings we attended staff demonstrated that they cared for the patients and staff and valued their views and opinions on how to make improvements.

There were defined systems and processes in place to support the effective operation of the hospital to ensure that the hospital focused on continuously improving its services. This was achieved through a rolling programme of audit and established governance structures which enabled key/nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

A wide range of policies and procedures were available to help staff undertake their duties and responsibilities. We saw evidence that policies were being reviewed and updated regularly. Staff we spoke to during the inspection told us they felt supported in their roles and that the leadership team was visible and approachable.

Dealing with concerns and managing incidents
We found an effective governance structure in place in terms of activities and meetings to discuss incidents, findings and issues related to patient care which supported improvements and shared learning from incidents and serious untoward events. Regular incident reports were produced and reviewed at hospital level and at corporate level, to help identify trends and patterns of behaviour. We saw evidence that complaints, incidents and safeguarding issues at the hospital were appropriately recorded, investigated and supervised.

We were told that relevant information was discussed at Clinical Governance meetings and that any learning opportunities were shared with staff verbally, electronically and in written format. However, we noted that that only regular, qualified nursing staff were provided with a corporate email address which allowed them to receive information electronically. We identified this posed a risk of other nursing staff, including the hospital's healthcare support workers, being excluded from information sharing opportunities.

The service must provide all staff with a corporate email account to support effective information sharing.

The hospital had a dedicated monthly staff meeting process in place for staff to provide feedback on their experience at the hospital. However, we noted that the staff meeting process was inconsistent and the meetings had not taken place on four occasions between February and September 2023. We discussed this matter with senior staff and were advised that the meeting process was not well-attended as staff failed or refused to attend meetings outside of their working hours, even for additional payment.

The service must ensure the hospital's staff meeting process is actively promoted and attended in order to capture staff feedback and act upon any issues raised.

Workforce planning, training and organisational development
We were informed that measures were in place to ensure the hospital's staffing levels met the registered provider's templates. However, it was clear from our discussions with staff that the service required a high use of agency staff to fill vacant shifts in the hospital. At the time of our inspection we observed that the level of patient observations and care requirements created additional pressures for staff and were informed that staff deficiencies and fluctuating patient acuity were managed with additional agency staff. Some staff we spoke with during the inspection told us that they felt there were not enough staff to meet staffing requirements and increased patient demand on the ward.

The Registered Provider must review the hospital's current staffing template to consider whether it continues to support effective patient care and staff welfare requirements.

During our inspection we noted that an agency staff member had failed to report for duty as arranged, leaving the ward short-staffed. As a result, a staff member was provided from a sister hospital to ensure the hospital's staffing levels were safe and appropriate. However, we were told that it was not always possible to source additional staff members when this issue arose. The registered provider may wish to review the hospital's temporary bank and agency staffing arrangements to ensure they are sufficiently robust and reliable.

At the time of our inspection it was concerning to learn that the hospital had only three regular qualified nursing staff members and we noted a high number of unfilled permanent staffing vacancies. We were informed that the service struggled to recruit and retain permanent staff but there were ongoing recruitment processes to fill the vacant posts. Staff told us that the service had recently recruited six Registered Mental Health Nurses who were soon to commence working at the hospital, but there were still unfilled vacancies for four HCSWs and one Occupational Therapist post.

The registered provider must continue to actively focus on the recruitment of staff to outstanding permanent vacancies.

During the inspection some regular staff told us they found it difficult to support and assist unfamiliar agency staff in addition to performing their own duties. We were further told that agency staff were required to complete and sign an induction checklist before commencing their duties on the ward but this did not take place when agency staff members were handing over to other agency staff members. We further viewed a sample of completed induction forms and found they were not being consistently signed as received by the hospital's Human Resources department as required.

The registered provider must actively seek to use agency staff who are familiar with the hospital and patients to support continuity in patient care.

All agency staff must complete an induction to the ward.

All staff induction forms must be reviewed and signed by the Human Resources department as appropriate.

At the time of the inspection, it was positive to learn that 88 per cent of staff had received their annual appraisal and staff supervisions compliance was high at 98 per cent. Processes were in place for senior staff to monitor compliance with mandatory training via the hospital's electronic training matrix and we were provided with data which indicated that overall mandatory training compliance was generally high. However, we noted that staff had difficulty in navigating and filtering the training matrix to obtain accurate compliance data.

Following our inspection, further enquiries revealed that the training figures we had viewed during the inspection were incorrect and the true compliance was lower than previously provided for some courses. Because we were not provided with accurate training compliance data during the inspection, we could not be assured that ward staff were compliant with their mandatory training, nor that there was robust governance oversight in respect of this.

We highlighted this issue to senior staff following the inspection and requested assurances regarding staff mandatory training compliance and supervision. We were later provided with staff training compliance information dated 27 October 2023. The data indicated that that overall staff mandatory training compliance had improved since our inspection and was generally high. Senior staff confirmed that staff training was closely monitored and that any training concerns were discussed within monthly Quality Compliance Team meetings and Clinical Governance meetings. We were informed that suitable arrangements were in place for all staff

to complete their outstanding mandatory training in the near future. Staff told us that the service was in the process of expanding the competencies being delivered by their in-house training department to include a number of additional mandatory training courses, which would further increase staff training opportunities and improve overall compliance.

We were therefore assured that there was a robust programme of governance oversight in place to ensure that mandatory training was completed and regularly monitored. However, we recommend the following improvements in respect of mandatory training compliance:

- **The service provider must review the hospital's training matrix to improve ease of navigation and ensure accurate retrieval of training compliance data, to support effective governance oversight and monitoring**
- **The service provider must ensure staff are supported to complete the following outstanding mandatory training courses and update HIW upon completion:**

    - **IPC Training and Handwashing (practical)**
    - **Emergency First Aid at Work (EFAW)**
    - **Food hygiene**
    - **Mental Health**
    - **Unit Fire Warden**
    - **Self Harm**

Workforce recruitment and employment practices
An appropriate staff recruitment, selection and appointment process was in place at the hospital. Prior to employment, pre-employment checks were conducted which included enhanced Disclosure and Barring Service (DBS) checks. We were told that staff employment records were regularly reviewed by the hospital's Compliance Officer to ensure that staff were fit to work at the hospital.

Staff informed us that newly appointed permanent staff members received a week-long ward-based induction during which they were supernumerary to the usual staffing establishment at the hospital. During the induction period, new employees were overseen by experienced staff members.

A whistleblowing policy was in place should staff wish to raise any concerns about issues at the hospital. Relevant information was displayed for staff awareness and staff could also access information on the intranet as required. Senior staff advised that the registered provider's Statement of Purpose had recently been amended to

include additional information regarding the process of making a complaint and additional support services available to staff.

4. Next steps

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 immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: 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.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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.

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
We were told that there were insufficient pagers available for staff. Senior staff confirmed that additional pagers had been ordered and delivered to the hospital but had not yet been set up and distributed to staff.	This posed a potential risk to staff and patient safety.	We raised and discussed the matter with staff.	The matter was appropriately resolved during the inspection. The pagers were set up and distributed to staff.
The hospital's staffing rotas incorrectly detailed a HCSW as a qualified nurse.	The rota provided misleading information regarding hospital staffing levels which posed a risk to staff and patient safety.	We highlighted our concerns to staff and requested the rota must be amended to include correct staffing details.	The rota was appropriately amended during the inspection.
During our evening tour of the hospital, we observed that an agency staff member had left the pool table and equipment	This issue posed a serious risk to staff and patient safety as the unattended pool equipment could be	We highlighted this matter to senior staff.	The matter was suitably resolved during the inspection. The issue was raised and recorded and shared by senior staff. Staff further completed a 'Near Miss' incident

unattended whilst taking a patient outside for a cigarette break.	used to cause harm to others.		form with a view to discussing the incident at Clinical Governance meetings to promote shared learning and prevent reoccurrence.
We witnessed a potential safeguarding risk whereby details of a restricted contact had been included within a care plan which was accessible to the patient concerned.	This posed a risk to the restricted contact.	We highlighted our concerns to staff.	This was appropriately rectified during the inspection in that the restricted contact details were removed from the care plan concerned.
During the inspection we witnessed that staff were conducting therapeutic observations of one patient from outside his room where they did not have sight of the patient concerned. We were informed that this arrangement had been agreed by the MDT and senior management team but was not clearly documented within the patient's care plan for the awareness of all staff.	This posed a safety risk to the staff and patient concerned.	We raised this issue recommended that an additional care plan must be created to fully document the individual therapeutic observation requirements of the patient and the supporting comments of senior staff.	The care plan was appropriately amended during the inspection.

Appendix B - Immediate improvement plan

Service: Rushcliffe Aberdare

Date of inspection: 25 -27 September 2023

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate non compliance issues were identified during the inspection.				

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):

Job role:

Date:

Appendix C - Improvement plan

Service: **Rushcliffe Aberdare**

Date of inspection: **25-27 September 2023**

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	Standard/ Regulation	Service action	Responsible officer	Timescale
Individual patient food cupboards in the lounge area should be labelled to display patient names for general awareness.	Patient information and consent	All cupboards have been labelled for each patient.	DK	Achieved
The registered provider's Statement of Purpose must be reviewed to ensure it contains relevant and up to date information.	Patient information and consent	SOP has been reviewed ensuring all details are up to date. This will be added to our yearly audits.	DK	Achieved
The service should install information boards which inform patients, family and carers of changes made as a result of their feedback.	Citizen engagement and feedback	Information board will be displayed in entrance air lock.	SM DS	End of December 2023
The risks relating to the patient use of the pool table and equipment must be incorporated into the agency staff induction and checklist process.	Managing risk and health and safety	Agency induction booklet has been amended to include risks of pool table equipment use. Games room checklist has been	LT	Achieved

		incorporated into security checklist.		
Food and drink must be appropriately labelled to display the opening date and use-by-date. Any outdated items must be discarded.	Nutrition	All items purchased during the day by the patients are provided with labels (initials and date). This is incorporated into security checks and monthly OT audits. Storage containers are used instead of cereal boxes. Kitchen staff are responsible for refilling when empty and re-dating. Plan was discussed with patients in patient morning and weekly meetings.	LT DS	Achieved
A separate care plan must be completed to address safeguarding concerns relating to patients with restricted contacts.	Safeguarding children and safeguarding vulnerable adults	Safeguarding care plans have been devised for patients with restricted contacts. These are only accessible by staff.	DK	Achieved
The registered provider must ensure that therapeutic observation records are reviewed by a qualified nurse on a four hourly basis and the relevant documentation must be fully completed at the time.	Safe and clinically effective care	This has been reiterated to qualified staff and will continue to be done in qualified nurse staff meetings and supervisions. It has also been included as part of the manager's weekly audit.	LT	Achieved and ongoing

An assessment of capacity must be conducted and documented before carrying out the care and treatment of patients	Mental Health Act Monitoring	Capacity assessments have been conducted for current patients and will be conducted on admission for future patients. This has been added to MHA audit.	DK LM	Achieved
The service must ensure that the views of statutory consultees are documented within patient records to support the medical treatment authorised by the Second Opinion Appointed Doctor.	Mental Health Act Monitoring	When CO3 is received, before it is uploaded to patient's records, MHAA will enquiry from consultees if they had received contact from SOAD and date the contact was made. This will be documented on patient's notes. Staff have also been advised to document all communications with external parties including SOAD's in patient's clinical notes.	DK LM	Immediate effect
Patient Consent to Treatment Certificates must be reviewed and renewed upon the patient's admission to the hospital.	Mental Health Act Monitoring	This will happen with future admissions and has been added to admission checklists.	Consultant LM	Achieved
Consent to Treatment forms must be completed and stored with corresponding patient medication records for the awareness of staff.	Mental Health Act Monitoring	When patients are admitted MHAA will provide copies of consent to treatment to the nurse in charge to upload to e-prescribing records. This will be audited monthly.	LM LT	Immediate effect

The service must provide additional Mental Health Act training and governance oversight for staff which includes Consent to Treatment provisions.	Mental Health Act Monitoring	The board have agreed for MHAA to be booked on refresher training.	AJ LM	3 months
The service must: • Ensure Managers' hearings are undertaken in a timely manner • Explore further opportunities for the recruitment of additional POD members to prevent unnecessary delays in Hospital Manager's hearings • Undertake an audit of patient MHA records to identify and prevent any additional delays.	Mental Health Act Monitoring	POD members job role will be advertised with immediate effect with the view of recruiting more POD members. Audit was already in place at time of inspection. Advised by inspectors to add 'consent to treatment uploaded to e-prescribing chart'. Audit will take place monthly.	DK LM	Immediate effect Achieved
The service must ensure that patient records reflect the voice and views of the patient.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	Clinical documents have been changed to address this. The importance of patient's involvement in care and treatment will be reiterated in supervisions and staff meetings.	DK	Achieved
The service must ensure that patients are involved in the care	Monitoring the Mental Health	As above.		

planning process wherever possible and evidence this within patient records.	(Wales) Measure 2010: Care planning and provision			
The service must provide all staff with a corporate email account to support effective information sharing.	Dealing with concerns and managing incidents	This was taken to the Board and a shared email will be set up for all staff to enhance communication and information sharing.	DK	3 months
The service must ensure the hospital's staff meeting process is actively promoted and attended in order to capture staff feedback and act upon any issues raised.	Dealing with concerns and managing incidents	Staff meetings have been arranged for the last Thursday of each month. The staff meeting dates have been sent to all staff and displayed in the staff room & nursing office.	DK	Achieved
The Registered Provider must review the hospital's current staffing template to consider whether it continues to support effective patient care and staff welfare requirements.	Workforce planning, training and organisational development	This is currently being addressed. Staff (including OT) from other sites have been supporting Aberdare Hospital in providing cover when required. COS nurses have been employed who are currently waiting to complete OSCE. The COS nurses are currently employed as support workers with no qualified nurse responsibilities until this has been completed.	DK	Immediate effect

The service provider must continue to actively focus on the recruitment of staff to outstanding permanent vacancies.	Workforce planning, training and organisational development	As above.		
The service provider must actively seek to use agency staff who are familiar with the hospital and patients to support continuity in patient care.	Workforce planning, training and organisational development	The service is doing everything in their power to fill the positions outstanding and if we are to use agency as a last resort, we would endeavour to use staff who are aware of the setting in order to promote continuity and safety of patients and staff.	DK	Immediate effect
All agency staff must complete an induction to the ward.	Workforce planning, training and organisational development	This is in place and will continue to be completed.	DK LT	Achieved and ongoing
All staff induction forms must be reviewed and signed by the Human Resources department as appropriate.	Workforce planning, training and organisational development	All staff induction forms have been updated to enable HR to review and sign in order to promote valued based recruitment and induction.	DK CM	Achieved
The service provider must review the hospital's training matrix to improve ease of navigation and ensure accurate retrieval of training compliance data, to	Workforce planning, training and	The service has updated the training matrix. The Manager and Deputy Manager will be able to navigate through the training matrix and use the information	DK	Achieved

support effective governance oversight and monitoring.	organisational development	to address training deficits and supervisions & appraisals.		
The service provider must ensure staff are supported to complete the following outstanding mandatory training courses and update HIW upon completion: • IPC Training and Handwashing (practical) - 63 per cent • Emergency First Aid at Work (EFAW) - 38 per cent. • Food hygiene - 75 per cent • Mental Health – 76 per cent • Unit Fire Warden- 50 per cent • Self Harm - 76 per cent.	Workforce planning, training and organisational development	IPC Training and Handwashing is currently at 92% Emergency First Aid at Work is currently at 44% following training on 27th- 29th November. Food hygiene training is currently at 75%. New starters have been enrolled for mandatory training. Mental Health training is currently at 76%. New starters have been enrolled for mandatory training. Unit Fire Warden Training is currently at 64% following training on 28th November. Another training session is booked for the first week of December.	DK	3 months

		Self-Harm Training is currently at 78%. New starters have been enrolled for mandatory training.		

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): David Kwei

Job role: Assistant Director/ Registered Hospital Manager

Date: 28.11.2023