Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Rushcliffe Hospital - Aberavon

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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 Hospital, 6,7 and 8 January 2025.

Rushcliffe Hospital is an 18 bedded locked rehabilitation service for males. At the time of the inspection there were 16 patients at the hospital.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. No questionnaires were completed by patient or carers. Ten questionnaires were completed by staff. 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.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Most patients we spoke with said they felt safe and were able to speak with staff when needed, that they were happy at the hospital, and that staff were kind and helpful. Other data received through hospital internal feedback was also generally positive.

There was a range of activities in place providing therapies to patients, to support and stimulate them as part of their recovery. It was positive to see staff supporting patients to engage in activities.

Some health promotion was available, however there was limited information on smoking cessation and benefits around exercising.

Overall, we found that patients were provided with timely care. We found their needs were promptly assessed upon admission, and staff appropriately provided care and assisted patients when required. Staff were knowledgeable of each patient and strove to provide individualised care. We observed kindness, warmth and respect between staff and patients.

This is what we recommend the service can improve:

- Health promotion information.

This is what the service did well:

- Good team working and motivated staff
- Patients and carers spoke highly of staff and told us they were treated well.

Delivery of Safe and Effective Care

Overall summary:
We found appropriate systems and governance arrangements in place, which helped ensure the provision of safe and effective care for patients. A range of up-to-date health and safety policies were in place and various risk assessments had been completed, such as ligature point risk assessments and fire risk assessments. We also found evidence of effective clinical audit taking place, which was monitored by the clinical leads.

The environment had improved since the last inspection and environmental issues identified in the previous inspection had been resolved. There had been a recent leak in the music room which had caused some damage to the ceiling tiles and these need to be replaced.

We observed several medications rounds and noted staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately. However, we identified that the medication trolley needed to be repositioned to ensure safe and secure dispensation of medicines. This was immediately resolved by staff during the inspection.

Appropriate processes were in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies when required. Hospital staff had access to safeguarding procedures, which were supported by the Wales Safeguarding procedures, accessible via the intranet.

We saw a good standard of care planning which reflected the domains of the Welsh Measure. Care plans were detailed, individualised, and reflected a wide range of multi-disciplinary team (MDT) involvement. There was clear and documented evidence of patient involvement.

We identified that some improvements were required in the implementation of the Mental Health Act, in relation to timeliness of reviews and patient hearings.

This is what we recommend the service can improve:

- Mental Health Act administration
- Replace the ceiling tiles in music room.

This is what the service did well:

- Good standard of care planning
- Range of effective audits undertaken by clinical leads.

Quality of Management and Leadership

Overall summary:
We observed a friendly and professional staff team who were committed to providing high quality care to patients. There was dedicated and passionate leadership displayed by staff, the hospital manager and multi-disciplinary team.

There was a well-defined organisational structure in place, which provided clear lines of management and accountability. Effective systems provided access to management support during the day, with an on-call system in place at night. Staff

felt the culture on the ward was positive and said they would feel confident in raising a concern and knew the process of how to do so, and we saw evidence to confirm this.

Most staff spoke favourably about the support from colleagues working within the hospital and reported a good team-working ethos. However, some aspects of the staff questionnaires indicated that the senior management within Rushcliffe need to build and develop better communication, trust and stronger working relationships with the staff working at the hospital.

This is what we recommend the service can improve:

- Improvements in physical intervention training compliance
- Improved communication and better engagement between senior management and hospital staff.

This is what the service did well:

- Staff and patient meetings were regularly taking place
- Strong leadership provided to staff by the hospital manager, clinical lead and multi-disciplinary team.

3. What we found

Quality of Patient Experience

Patient feedback
We considered the hospitals internal patient feedback, any complaints, and patient discussion data, to help us gain an understanding of the overall patient experience. Feedback was generally positive. Most patients we spoke with said they felt safe and were able to speak with staff when needed, that they were happy at the hospital, and that staff were kind and helpful.

Health promotion, protection and improvement
The hospital had a range of facilities to support the provision of therapies and activities for patients. In addition, patients have regular access to community services for those who are authorised to leave the hospital. However, improvements could be made to the information provided to patients regarding health promotion and smoking cessation as there was limited information on display.

The registered provider must ensure that information on health promotion and smoking cessation is displayed.

We observed patients at the hospital being involved in a range of activities throughout the inspection. We saw a weekly activity timetable and activities included arts and crafts, music club, community access to a local leisure centre, and walking groups. We saw that the occupational therapy department, along with the activities co-ordinator were providing a range of activities and beneficial therapeutic activities for the patient group. Staff and patients spoke highly of the engagement with patients from the activities co-ordinator and the occupational therapy (OT) staff.

Patients had good access to outdoor spaces and staff and the activity co-ordinators regularly take patients off site to use community facilities.

Services are also provided by other professionals, such as physiotherapy, dietetics, in line with individual patient needs. Patients can also access a GP service, dental service and other physical health professionals where required. We found that patient records evidenced the appropriate physical assessments and ongoing monitoring.

Dignity and respect
We found that staff at all levels engaged with patients appropriately and treated them with dignity and respect.

The staff we spoke with were enthusiastic about their roles and how they support and care for the patients. We saw most staff taking time to speak with patients and address any needs or concerns they had. This suggested that staff had responsive and caring attitudes towards patients.

All patient rooms were ensuite. Communal bathrooms were available, and we saw staff respecting the privacy of patients by knocking on bedroom and bathroom doors before entering.

All patient rooms have observation panels that can be open or closed from the outside, to enable staff to monitor a person when necessary. Patients can lock their bedroom doors, however, staff could override this when necessary.

There were nurse call points around the hospital and within patient bedrooms and bathrooms so that patients could call for help if needed.

Patients were able to personalise their rooms and store their own possessions. Personal items are risk assessed on an individualised basis, to help maintain the safety of each patient. This included the use of personal mobile phones and other electronic devices. A telephone was also available for patients to use to contact friends or family if needed, and there were electronic devices available on the units for patients to use.

Staff did not have personal alarms, but did have radios, and alarms are allocated to visitors. During discussions with the hospital manager they indicated that the company were looking to install a new alarm system. We were told that the radio system worked well in the environment and no concerns had been raised by staff around not carrying alarms.

There was also a well-equipped laundry room in place for use by patients, under supervision and patients are encouraged to manage their own laundry to promote independence.

Patient information and consent
Patient boards displayed in the hospital contained relevant information to help patients and their families understand their care. This included information such as the weekly activity timetable and advocacy services.

Registration certificates from HIW and information on how to raise a complaint were on display in the reception. This information was also available in Welsh.

Information on how to make a complaint was on display. Complaint forms were available in the patient lounge area and there was a suggestion box which allowed for anonymous complaints and suggestions to be made.

Communicating effectively

Most patients we spoke with said they felt safe and were able to speak with staff when needed. They also said they were happy at the hospital, and that staff were kind and helpful. There seemed to be mutual respect and strong relational security between staff, patients and family carers.

Throughout the inspection, we observed staff engaging and communicating in a positive and sensitive way with patients, taking time to help them understand their care, and using appropriate language or communication styles.

For specific meetings, and where applicable, patients can receive support from external bodies to provide support and guidance, such as solicitors or patient advocacy. With patients' agreement, and wherever possible, their families or carers were included in these meetings.

Care planning and provision

Patients had their own individual weekly activity planner including individual and group sessions based within the hospital and the community (when the required authorisation was in place). During the inspection we observed staff and patients engaging in activities in the hospital and in the community. Patients told us that they enjoyed the sessions that OT and the activities co-ordinator arranged for them.

We observed staff respecting patient privacy. For example, by understanding when patients preferred their own space and facilitating this whilst maintaining appropriate levels of observation.

Patients were fully involved in monthly multidisciplinary reviews. We saw evidence that care plans were person centred with support provided in a structured way to enable patients to achieve individual goals. Care plans were very detailed and personalised, this helped support the hospital in being able to deliver comprehensive care to the patients.

A handover meeting was held every weekday morning for nursing staff to update the MDT on any concerns, issues or incidents that had taken place the day before.

We attended a handover meeting during the inspection and saw that staff showed a good level of understanding of the patients they were caring for and that discussions focused on what was best for the individual patient.

Equality, diversity and human rights

We found good arrangements in place to promote and protect patient rights.

There were facilities for patients to see their families in private. Rooms were also available for patients to spend time away from other patients according to their needs and wishes.

Legal documentation relating to detained patients under the Mental Health Act was compliant with the legislation. All patients had access to advocacy services, and we were told that advocates visit the hospital.

Staff told us that patients are invited to be part of their MDT meetings and that the involvement of family members or advocates was encouraged where possible.

During our discussions with staff, they demonstrated suitable regard for upholding patient rights and individual patient preferences. The Care and Treatment Plans (CTPs) we reviewed evidenced that the social, cultural, and spiritual needs of patients had been considered. We saw that the hospital had an appropriate Equality, Diversity, and Inclusion policy available to help ensure that patients' equality and diversity were respected.

Citizen engagement and feedback

There were regular patient meetings and surveys to allow patients to provide feedback on the provision of care at the hospital. Information was also available to inform relatives and carers on how to provide feedback.

There was a complaints policy and procedure in place. The policy provided a structure for dealing with all complaints within the hospital. It was evident that an independent person is assigned to investigate complaints and actions were taken in line with the registered provider's complaints policy to ensure that complaints are dealt with appropriately. We reviewed a sample of formal and informal complaints and confirmed that they had been actioned in line with the organisational complaints policy.

Delivery of Safe and Effective Care

Safe Care

Environment
Access to the hospital was via an open car park to the front. In the daytime there was a small open foyer with a locked door into reception. This was accessible via a key fob. At night this foyer is locked. Access to the ward was only possible through an air lock system at the rear of reception. The hospital is fully accessible for those with restricted mobility and wheelchairs.

It was positive to see that improvements had been made to the environment since the last inspection, however the ceiling tiles in the music room need to be replaced following a recent leak.

The registered provider must ensure that the damaged ceiling tiles in the music room are replaced.

We saw evidence of various risk assessments that had been conducted including ligature point risk assessments. We were told of the environmental checks that are completed and saw evidence of the weekly manager checks across the hospital.

We saw weekly audits of resuscitation equipment; staff had documented when these had occurred to ensure that the equipment was present and in date.

The hospital had a business continuity plan in place 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. Fire safety policies were all up to date and fire risk assessments had all been completed.

Evidence of audits were recorded electronically, and all were up to date and complete at the time of the inspection.

Managing risk and health and safety
There was an electronic system in place for recording, reviewing, and monitoring patient safety incidents. A sample of incident forms reviewed on the inspection demonstrated that staff completed detailed forms. The design and format of the forms provided staff with prompts and clear directions of what processes were needed to take place following an incident. The forms were identified as an area of noteworthy practice.

Staff confirmed that debriefs take place following incidents. The meetings we attended, and the evidence obtained during the inspection suggested that incidents and the use of physical restraint interventions are monitored and supervised robustly. The data we reviewed evidenced that restraints are rarely used at the hospital.

When physical interventions are used the techniques used are selected to best meet the needs of an individual patient and a process of risk assessment will inform this, considering risks due to age, frailty, health problems, trauma history and religious and cultural needs.

After any physical intervention incident, both patients and staff are invited to engage in a debrief focused on their psychological and physical health and wellbeing.

A range of up-to-date health and safety policies were in place.

Infection prevention and control (IPC) and decontamination
We found suitable IPC arrangements in place which were supported by a range of up-to-date policies to maintain patient and staff safety. Regular ward audits had been completed to review the cleanliness of the environment and check compliance with hospital procedures. All were appropriate and compliance was checked by senior ward staff.

We saw evidence to confirm that staff had conducted the necessary risk assessments and relevant policies and procedures were updated accordingly. Staff also explained their responsibilities in line with IPC.

We found that staff had access to and were appropriately using personal protective equipment (PPE). Staff told us that PPE was always readily available, and we saw that sufficient hand washing and drying, and sanitisation facilities were available.

Cleaning equipment was stored safely, organised appropriately and there were suitable arrangements in place for the disposal of domestic and clinical waste.

Staff compliance with mandatory IPC training was currently at 86% and was being continually monitored to ensure staff remained compliant.

Nutrition
The hospital provided patients with regular meals, making their choices from the weekly rotational menus.

Patients were supported to meet their dietary needs, and we were told that specific dietary requirements were accommodated, as appropriate.

The dining areas were clean and tidy and provided a suitable environment for patients to eat their meals.

Medicines management
We found suitable arrangements in place for the management of medicines and safe and secure storage. We also saw evidence of regular temperature checks of medication fridges to maintain safe storage.

Medication stock is checked daily by registered staff, and weekly audits are undertaken by the clinical leads and pharmacy staff.

We observed several medication rounds, and saw staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately. However, we identified that the position of the medication trolley could potentially pose a risk when administering medication if patients are not observed or supervised. This was brought to the attention of the hospital manager who immediately ensured that all staff were briefed on repositioning the trolley when administrating medications.

The registered provider must ensure that the medication trolley is in a safe and secure position when staff are administering medication.

Medication Administration Records (MAR Charts) reviewed were fully completed by staff. This included completing all patient details on the front and subsequent pages and their Mental Health Act legal status.

Safeguarding children and safeguarding vulnerable adults
Appropriate processes were in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies when required.

Hospital staff had access to safeguarding procedures, which were supported by the Wales Safeguarding Procedures, accessible via the intranet.

Hospital staff confirmed they were confident that staff were aware of the correct procedure to follow should they have a safeguarding concern. During discussions with staff, they were able to show knowledge of the process of making a safeguarding referral.

Medical devices, equipment and diagnostic systems

There were regular clinical audits undertaken at the hospital and we saw evidence of regular auditing of resuscitation equipment. Staff had documented when this had occurred to ensure that the equipment was ready for use and in date. During staff discussions, it was evident that staff were aware of the locations of ligature cutters in case of an emergency.

Storage of oxygen complied with regulations and guidance; risk assessments are completed for the clinical areas including the storage of oxygen.

Safe and clinically effective care
Overall, we found appropriate governance arrangements in place which helped ensure that staff provided safe and clinically effective care for patients.

Staff confirmed that debriefs take place following incidents. Meetings we attended and evidence obtained during the inspection demonstrated that incidents, safeguarding referrals and use of physical interventions are monitored and reviewed.

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation.

Participating in quality improvement activities
During our discussions with staff and senior managers, we were provided with numerous examples where they were reviewing the service provision and looking to develop some aspects of the hospital.

The hospital manager was in the process of arranging face-face training with the local authority safeguarding leads, this was in addition to mandatory training.

Rushcliffe had recently set up an all-Wales managers forum, where all hospital managers come together to discuss any learning from incidents. The managers then review related policies and procedures to ensure any lessons learnt are incorporated into any policy changes.

Information management and communications technology
The computerised patient record systems were well developed and provided high quality information on individual patient care. The system was comprehensive, and easy to navigate.

There were good electronic systems in place for incident recording, clinical and governance audits, human resources, and other hospital systems, which assisted

the management and running of the hospital. Staff indicated that the electronic system was working well.

Records management
Patient records were kept electronically. The electronic system was password protected to prevent unauthorised access and any breaches in confidentiality.

Overall, we found robust systems in place to ensure that personal information relating to patients and staff were kept securely. There was a formal information governance framework in place and staff were aware of their responsibilities in respect of accurate record keeping and maintenance of confidentiality.

Mental Health Act monitoring
We reviewed the statutory detention documents of five patients, all found to be fully compliant with the MHA and Code of Practice for Wales,1983 (revised 2016) Electronic documents on the units were stored securely. The records we viewed were well organised, easy to navigate and contained detailed and relevant information and fully compliant with the legal requirements of the MHA.

We identified that there was no information in policies or procedures specifying the timeliness of CO2 forms being reviewed. In two records we reviewed the CO2 forms had not been reviewed since 2021. The Mental Health Codes of Practice states that it is good practice for regular reviews to take place.

The registered provider must ensure that improvements are made to the timeliness of CO2 forms being reviewed.

At the time of the inspection there were only three hospital managers to undertake renewals and review of detentions, it was positive to see that a recruitment process was in place. However, it is important that this process is expedited to ensure that reviews and managers hearings are completed in a timelier manner.

The registered provider must ensure that hospital manager renewals and reviews are undertaken in a timelier manner and that recruitment is expedited.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision
We reviewed the Care and Treatment Plans (CTPs) of six patients. The records evidenced a fully completed and current overall physical health assessment and standardised monitoring documentation, such as NEWS and MUST. In addition, there were standardised assessments based on the individual patient needs.

Strategies for prevention and management of behaviours of concern were contained in patient care plans and risk management profile. Staff were provided with skills to manage and defuse difficult situations through training.

Comprehensive Positive Behavioural Support plans are written by the Psychology team. There is dedicated high quality focus on the importance of engaging in activities both on and off the unit supported by a dedicated team including OTs.

It was positive to see that care files clearly showed patient involvement in care discussions, which were patient focussed and signed by the patient. Records also included evidence of the patient voice to reflect their views.

There was evidence that care plans are reviewed regularly by staff and updated to reflect current needs and risks. Physical health monitoring is consistently recorded in patient records. Risk management plans were good with detailed risk assessments and risk management strategy plans, these plans also evidenced physical health considerations for staff to consider when engaging with patients.

In addition, there was evidence of active planning and discharge planning for long term placements.

Quality of Management and Leadership

Staff Feedback
We invited staff to complete HIW questionnaires following the inspection to obtain their views on the service provided at the hospital. In total, we received ten responses from staff at the setting. We also spoke to staff during the inspection.

Staff told us that the culture at the hospital was positive, and that they would feel confident in raising a concern and knew the process of how to do so. However, the questionnaire results indicated that staff felt that some professional conduct issues were ignored by senior management and that there was a lack of trust with senior management who did not work at the hospital.

Although not noted during the inspection, some staff in the questionnaire suggested that breaches of professional conduct are not dealt with and have been ignored, the staff questionnaire also indicated that male staff get promoted because they are needed. The questionnaire results also suggested a lack of trust in senior management team who do not work at the hospital.

There were some positive comments on the current hospital manager from the questionnaire, comments included:

"Current manager very good, listens to staff"

The registered provider needs to ensure that when staff report issues of professional conduct that the issues are dealt with fairly and impartially and that staff are aware that the matters have been dealt with and investigated impartially.

The registered provider should reflect on this feedback and look to improve relationships between the company senior management team and hospital staff.

Governance and accountability framework
There was a clear organisational structure in place which provided clear lines of management and accountability. They defined these arrangements during the day, with senior management and on-call systems in place for the night shift.

It was positive to see that senior staff attended when notified of the inspection team's arrival and were on hand to provide additional support.

There was clear, dedicated and passionate leadership from hospital staff, who are supported by committed multidisciplinary teams and the hospital manager. Staff were able to describe their roles and appeared knowledgeable about the care needs of most patients they were responsible for.

During our time at the hospital, we observed a positive culture with good relationships between staff who we observed working well together as a team. Most staff spoke positively about the leadership at the hospital. Most staff also spoke favourably about the support from colleagues working within the hospital and reported a good team-working ethos at the hospital.

Arrangements were in place to quickly share information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helped to maintain patient safety and continuous improvement of the service provided.

Dealing with concerns and managing incidents
There was a complaints policy and procedure in place. The policy provided a structure for dealing with all complaints at the hospital.

We reviewed a sample of informal and formal complaints and saw that an independent person was assigned to investigate the complaint. Actions were taken in line with the organisation's complaints policy to ensure that complaints were dealt with appropriately at the hospital.

Arrangements were in place to quickly share information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helps to promote patient safety and continuous improvement of the service provided.

Workforce recruitment and employment practices
Staff we interviewed spoke passionately about their roles, and throughout the inspection we observed a strong cohesive team working together. Staff were able to access most documentation requested by the inspection team in a prompt and timely manner, demonstrating that there are good governance systems in place.

There were systems in place to ensure that recruitment followed an open and fair process. We were told staff references were checked prior to employment. Disclosure and Barring Service (DBS) checks were undertaken, and professional qualifications were checked. Therefore, we were assured that recruitment was undertaken in an open and fair process.

Newly appointed staff undertook a period of induction under the supervision of the experienced hospital staff. Staff showed us documentary evidence and talked us through the systems of induction in place.

The staffing numbers at the hospital were currently at a good level, however there was a vacant psychologist post which the hospital was currently trying to recruit into. The assistant psychologist was receiving telephone supervision from another psychologist in the Rushcliffe company; however, it would benefit the assistant psychologist and patients if the psychologist vacancy is filled.

We were provided with a range of policies, all of which were up to date.

Workforce planning, training and organisational development
The inspection team considered staff training compliance and were provided with a list of staff mandatory training compliance. Training figures provided to us on the inspection indicated that overall compliance figures were 73% for physical intervention training, there were new staff recently employed who were due to attend training. No safeholds or restraints had been undertaken by untrained individuals. One member of staff was also trained as a train the trainer in Prevention and Management of Violence or Aggression. Overall mandatory training compliance was 83%.

The registered provider must ensure that physical intervention mandatory training figures are improved.

We saw evidence of staff annual appraisals and supervision in staff files and staff told us that supervision takes place on a regular basis.

Staff who completed the questionnaires indicated that staff and the MDT would benefit from training on section 17 MHA leave and security. No further information on training requirements for staff were provided.

The registered provider must meet with the staffing group and determine what their training requirements are in relation to section 17 and security training which was highlighted in the staff questionnaire.

Staffing levels were appropriate to maintain patient safety within the hospital at the time of our inspection. We were told that agency staff are used, however when there are shortfalls the hospital will try and use staff from other Rushcliffe hospitals who were familiar with working at the hospital and the patient group.

Information from the staff questionnaire indicated that there are often staff shortages and although senior management are aware of the shortages they refuse

to cover, and then lack of coverage impacts on patient activities. Comments include

"Staff shortages are hardly ever covered. There appears to be a ban on agency or staff are refused when they ask. Almost every shift is short staffed. This is led by senior management at area and HQ level"

At the time of the inspection there was no staff shortages highlighted, and the Occupational Therapy Assistant was supporting the activities coordinator to support patient activities. However, the registered provider should review and further explore the staff shortages comments made in the staff questionnaire.

The registered provider must ensure that shift shortages are covered to enable patients to engage in activities.

From the data received in the staff questionnaires, it is important that senior Rushcliffe staff engage more with its staff and work together to become a more cohesive team who communicate, consult, and make decisions together. This would improve the working environment and build up trusting relationships between senior management and 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 summarises 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.			

Appendix B - Immediate improvement plan

Service: Rushcliffe Hospital

Date of inspection: 6 - 8 January 2025

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.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate assurances were identified during this 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 Hospital

Date of inspection: 6 - 8 January 2025

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.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Recent leak in the music room caused some damage to the ceiling tiles and these need to be replaced.	The registered provider must ensure that the damaged ceiling tiles in the music room are replaced.	Environment.	1. Damage from ceiling boards has been scraped off, filled and patch plastered, sanded and primed and stain blocked - Achieved 2. Boards have been made to match existing ceiling work - achieved	David Kwei	17.02.25 17.02.25
2.	Improve health promotion and	The registered provider must ensure that more information is provided on	Patient information.	1. New Health Promotion board to	Shannen Sharp	17.02.25

	smoking cessation information	health promotion and smoking cessation.		be ordered - achieved (17.02.25) 2. Smoking Cessation advice/information to be added to the health promotion board 3. Healthy balanced lifestyle information will also be added to Health promotion board 4. Health Promotion boards will be rotated for different areas/topics on a monthly rotational basis 5. Health Promotion Section to be added to Clinical Governance minutes for monthly review (Achieved) 6. Men's Health Group is in process of being developed and implemented		01.03.25 01.03.25 31.03.25 17.02.25 18.03.25

				and run by a male nurse		
3.	Medication trolley needed to be repositioned to ensure safe and secure dispensation of medicines. This was immediately resolved by staff during the inspection.	The registered provider must ensure that all staff area aware of the positioning of the medication trolley when administering medication.	Medication Management.	Action was addressed during the inspection. Trolley was repositioned to the recommended area and secured to the wall	Shannen Sharp	07.01.25
4.	There was no information in policies or procedures specifying the timeliness of CO2 forms being reviewed. In two records we reviewed the CO2 forms had not been reviewed since 2021.	The registered provider must ensure that improvements are made to the timeliness of CO2 forms being reviewed.	Mental Health Act Monitoring.	1. We are currently auditing this as part of our MDT file audit on a 4 weekly basis 2. We will incorporate a new procedure regarding CO2 monitoring alongside our medication procedures	Shannen Sharp	18.03.25 31.03.25

				3. We have amended our MDT minutes structure to incorporate CO2 and CO3 review		17.02.25
5.	Managers hearings were not taking place on a regular basis.	The registered provider must ensure that improvements are made to the frequency of managers hearings.	Mental Health Act Monitoring.	1. We are currently focussing on our recruitment process to add additional Managers, to ensure that Managers Hearings are being facilitated in a timely manner. (Additionally, availability of community teams/solicitors/advocates to attend Managers Hearing can fluctuate and can impact arranging of these meetings. We would therefore like it to be noted that there have been occasions when professionals needed to support and represent patients have cancelled at relatively late notice,	David Kwei	18.03.25

				which is outside of our control. As a result, this had led to these hearings not going ahead. We therefore feel that a percentage of those that did not go ahead were affected as a result of this issue and therefore not something we could always control).		
6.	Some staff in the questionnaire suggested that breaches of professional conduct are not dealt with and have been ignored.	The registered provider needs to ensure that when staff report issues of professional conduct they are dealt with impartially and fairly. This area needs to be further explored with the staff by senior management.	Workplace planning training and organisational development.	While we acknowledge that some staff fed back that this was there experience. We believe that some of these comments may not relate to recent examples. Having ran a survey in August 2024 we provided the investigation summary in September 2024 in relation CAS-INVES-11154 from a whistle-blower at the time). We had informed staff and HIW that this would be rerun again after 6 months. Which would have fallen at the beginning of March. As	David Kwei	Sent beginning of March with response by 18.03.25

				such we will take the following actions: 1). Review the original question set in our survey to cover the concerns highlighted to HIW around professional conduct, confidentiality and culture of people lacking trust in senior management. 2). Write to the staff across our welsh hospitals and care homes, outlining why we'd like them to complete the survey we will attach. This will outline various personnel up to director level they can contact be that anonymously or not. This is in order to have a number of people/options they can talk to use to inform senior managers of any concerns in more detail in confidence. 3). Review the existing raising concerns policy so that staff are clear about how to raise a staffing related grievance and /or		

				concerns in relation to conduct and separately how to use the whistleblowing procedures where the concerns relate more to the quality/and/or safety of the service. 4). Undertake further internal fact findings and investigations as deemed necessary when feedback is collated		
7.	Questionnaire results also suggested a lack of trust in senior management team who do not work at the hospital.	The registered provider should reflect on this feedback and look to improve relationships between the company senior management team and hospital staff.	Workplace planning training and organisational development.	We refer to the answer/suggested actions above. that will address this issue.	David Kwei	18.03.25
8.	Training figures provided to us on the inspection indicated that overall compliance figures for physical	The registered provider must ensure that physical intervention training figures are improved.	Workplace planning training and organisational development	1. Our training Matrix has been reviewed and updated in January 2025 and all staff have been re-enrolled on all topics	David Kwei	31.03.25

	intervention training were 73%.			2. Additional training sessions booked post inspection for required staff		17.02.25 17.02.25
9.	Staff who completed the questionnaires indicated that staff and the MDT would benefit from training on section 17 leave and security.	The registered provider must meet with the staffing group and determine what their training requirements are in relation to section 17 and security training which was highlighted in the staff questionnaire.	Workplace planning training and organisational development	1. Security Awareness training is facilitated by Assistant Director of Wales. All areas of the MDT are required to attend 2. Please see additional document of Security Awareness training slides, Completed by David Kwei 2. Section 17 policy is under review	David Kwei	18.03.25 18.03.25
10.	Information from the staff questionnaire	The registered provider must ensure that shift	Workplace planning training and	1. We are actively recruiting for	David Kwei	18.03.25

	indicated that there are often staff shortages.	shortages are covered to enable patients to engage in activities.	organisational development.	healthcare support workers and a clinical psychologist. 2. Overall, our staffing levels appear to match Statement of Purpose, however as service, we offer a wide range of activities and in the event of staff sickness, this can be affected if the shifts are not able to be covered 3. In the event of staff sickness, we explore staff cover from our internal banks staff cover, staff from other Welsh Units and if this proves to be unsuccessful, we liaise with external agencies to source additional staffing support - achieved		18.03.25 Immediately

				4. Updated monitoring and auditing systems are to be implemented to review activities offered and facilitated. This will help us identify any impacts in relation to any cancellation of activities		18.03.25

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): Shannen Sharp

Job role: Hospital Manager

Date: 19.02.2025