Unannounced Inspection Report: Independent Healthcare

Monroe House | Oakview Estates Limited | Dundee
17–18 June 2015
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First published August 2015

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1 A summary of our inspection

About the service we inspected

Monroe House is an independent hospital which provides assessment and interventions for adults who have a learning disability and complex needs, including people with mental health problems and challenging behaviour. The hospital is situated in the Ardler area of Dundee, close to local amenities and public transport services.

Monroe House is registered for 20 adults and has two distinct services. ‘Etive’ provides intensive support through admission and treatment. ‘Anoach’ provides 10 beds for patients moving towards supported living. The building is a purpose built unit over two floors and all bedrooms have provision of ensuite facilities. A separate day facility, ‘Corbett Lodge’, is for people who stay in Monroe House and is also used meetings and activities. There are gardens to the rear of this facility for patients to enjoy.

The service’s focus is on rehabilitation and the improvement of the health and well-being of patients, developing trusting relationships and attaining positive outcomes.

About our inspection

This inspection report and grades are our assessment of the quality of how the service was performing in the areas we examined during this inspection.

Grades may change after this inspection due to other regulatory activity, for example if we have to take enforcement action to improve the service or if we investigate and agree with a complaint someone makes about the service.

We carried out an unannounced inspection to Monroe House on Wednesday 17 and Thursday 18 June 2015.

The inspection team was made up of two inspectors and a public partner. A key part of the role of the public partner is to talk to patients and relatives and listen to what is important to them. For a full list of inspection team members on this inspection, see Appendix 6.

We assessed the service against five quality themes related to the Healthcare Improvement Scotland (requirements as to independent healthcare services) regulations and the National Care Standards. We also considered the Regulatory Support Assessment (RSA). We use this information when deciding the frequency of inspection and the number of quality statements we inspect.

Based on the findings of this inspection, this service has been awarded the following grades:

Quality Theme 0 – Quality of information: 4 - Good
Quality Theme 1 – Quality of care and support: 4 - Good
Quality Theme 2 – Quality of environment: 4 - Good
Quality Theme 3 – Quality of staffing: 4 - Good
Quality Theme 4 – Quality of management and leadership: 3 - Adequate

The grading history for Monroe House can be found in Appendix 2 and more information about grading can be found in Appendix 4.

Before the inspection, we reviewed information about the service. We considered:

- the annual return
any notifications of significant events
the previous inspection report of 17 and 18 June 2014, and
complaints activity.

During the inspection, we gathered information from a variety of sources. This included:

- audits and surveys
- cleaning schedules
- information leaflets
- maintenance records
- the managers' monthly reports
- medication records
- minutes of meetings
- patient care records for people who use the service
- policies and procedures
- the provider’s quality strategy
- satisfaction questionnaires, and
- staff training records.

We spoke with a number of people during the inspection, including:

- two administration staff
- five people who use the service
- the assistant psychologist
- three cleaning staff
- the consultant psychiatrist
- the head chef
- three nursing staff
- the registered manager, and
- three support workers.

We inspected the following areas:

- a sample of patient bedrooms and bathrooms
- communal areas
- the kitchen
- the laundry room
- the outdoor area
- the reception area, and
- the treatment rooms.
What the service did well
We noted areas where the service was performing well. The service:

- had established morning planning meetings which had improved communication between staff and ensures that staff are informed about issues and daily events, and
- had implemented a senior support worker role to provide additional support to nursing staff, this has enabled nursing staff time for clinical service development

What the service could do better
We did find that improvement was needed in the following areas. Monroe House:

- Should use quality monitoring systems more effectively to measure and improve the quality of the service.
- Encourage patients and their representatives to be involved in care programme approach meetings.
- Should ensure that care plans are regularly reviewed.

This inspection resulted in no new requirements and nine recommendations. A requirement from the previous inspection in June 2014 has been carried forward with a revised timescale. The requirement is linked to compliance with the Act and regulations or orders made under the Act, or a condition of registration. See Appendix 1 for a full list of the requirements and recommendations.

Oakview Estates Limited, the provider, must address the requirement and the necessary improvements made, as a matter of priority.

We would like to thank all staff at Monroe House for their assistance during the inspection.
2 Progress since our last inspection

What the provider had done to meet the requirements we made at our last inspection on 10-11 December 2013 and 17-18 June 2014

Requirement

The provider must carry out a programme of refurbishment throughout the service to ensure it is fit for the provision of an independent healthcare service.

Action taken

This requirement is reported under Quality Statement 2.2. This requirement is partially met and will be carried forward with a revised timescale of 1 December 2015.

Requirement

The provider must have appropriate systems, processes and procedures for the prevention and control of infection. To do this, the provider must ensure staff have access to hand washing sinks that are compliant with current guidance.

Action taken

Appropriate hand washing sinks that are compliant with current guidance have been installed. This requirement is met.

What the service had done to meet the recommendations we made at our last inspection on 10-11 December 2013 and 17-18 June 2014

Recommendation

We recommend that the service should review the use of pictorial symbols in the service and ensure these are large enough to be useful to people using the service. The review should involve speech and language therapist and ensure the symbols are large enough and recognisable to people using the service.

Action taken

The speech and language therapist had reviewed the pictorial signage for patients. The signage is now displayed to direct patients around the service and to inform patients about their therapy programme, activities and food menus for the day. This recommendation is met.

Recommendation

We recommend that the service should carry out a staff survey to allow them to engage with staff regarding any issues that are concerning them. The outcomes from the staff survey should be addressed through staff supervision to allow staff to discuss issues that are affecting morale.

Action taken

The service had not carried out a staff survey since the previous inspection. Management informed us that a staff survey is due to be carried out by July 2015. This recommendation is not met. See recommendation h on page 20.
Recommendation

*We recommend that the service should implement their plans to increase service user involvement in the multidisciplinary team meeting and staff meetings.*

Action taken

The service now invites and encourages patients to attend multidisciplinary meetings and we saw the notes of the meetings that supported this. *This recommendation is met.*

Recommendation

*We recommend that the service should ensure that where possible patients are given the help and support they need to allow them to complete satisfaction questionnaires. This will allow as wide a group as possible to give their views.*

Action taken

The service had carried out a survey with patients with staff support provided by the therapy team. *This recommendation is met.*

Recommendation

*We recommend that the service should ensure that care plans are reviewed on a regular basis.*

Action taken

This recommendation is reported under Quality Statement 4.4. *This recommendation is not met.* See recommendation i on page 20.

Recommendation

*We recommend that the service should review the minutes for meetings to ensure that all actions are clearly identified along with who is responsible for the action and the timescale for completion.*

Action taken

We reviewed the minutes of meetings and saw that it was clear who was responsible for the actions and the timescales for completion. *This recommendation is met.*
3  What we found during this inspection

Quality Theme 0 – Quality of information

<table>
<thead>
<tr>
<th>Quality Statement 0.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>We ensure that patients and carers participate in assessing and improving the quality of information provided by the service.</td>
</tr>
</tbody>
</table>

Grade awarded for this statement: 4 - Good

The information provided in Quality Statement 1.1 is also relevant here.

- No requirements.
- No recommendations.

<table>
<thead>
<tr>
<th>Quality Statement 0.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>We provide full information on the services offered to current and prospective patients. The information will help patients to decide whether our service can meet their individual needs.</td>
</tr>
</tbody>
</table>

Grade awarded for this statement: 4 - Good

We reviewed the written and online website information available for patients and families and found this was comprehensive.

The website also included a number of brochures for patients, families and carers and we found these to be in an easy-to-read format. Information could be made available in Braille, or in other languages on request. ‘Your Guide to Monroe House’ brochure had photographs, pictures and symbols to help new patients see what life is like at Monroe House. We spoke with the relationship manager who told us that potential patients and families are provided with this information as a part of the pre-admission process. If requested, the brochures were also emailed to families.

Staff told us that patients and families could come for a visit before admission to see the service and meet the people who stay there. We were also told that photographs of the service if a new service user lived some distance away and would find it difficult to visit the service before moving in.

Before any admission, an assessment is carried out by the manager and one of the doctors. This meeting provided an opportunity for discussion and any questions to be answered.

Areas for improvement

Although the information available to patients was detailed, many patients may not find it useful due to their abilities. Staff members thought that a video showing the service could be helpful for some patients. This could be put onto the website or be made available as a DVD. Some patients use a sign language called ‘Makaton’ and it may also be helpful to use this in a video to help explain what the service is like.

The information available could also be developed further to explain what to bring and that there are open visiting hours. This means that family and friends can visit a service user at any time.
Information about how to make a complaint was available in the leaflet ‘Let’s think about making a complaint’ and included reference to both the Care Inspectorate and Healthcare Improvement Scotland. This could be confusing to patients and families who wish to make a complaint. The service should make it clear that the regulator for this service is Healthcare Improvement Scotland (see recommendation a).

- No requirements.

**Recommendation a**

- We recommend that the service should ensure that Healthcare Improvement Scotland is clearly referenced as the regulator for this service in the complaints material.

**Quality Theme 1 – Quality of care and support**

**Quality Statement 1.1**

*We ensure that patients and carers participate in assessing and improving the quality of the care and support provided by the service.*

**Grade awarded for this statement: 4 - Good**

The provider’s quality strategy stated the value of listening to patients and their families in trying to shape the services delivered.

We found a variety of methods were used to gain feedback from patients on the quality of care and support. These were set out in an easy-to-read publication called ‘Having your say – no decision about me without me’. These included:

- residents meetings
- observational satisfaction questionnaires
- involvement of patients in the multidisciplinary meeting (if able)
- involvement of patients in the care programme approach (CPA) meeting (if able)
- use of the advocacy worker to represent views of patients at some meetings
- service user exit interviews, and
- the service user forum.

A number of methods were used to gain feedback from families and carers. For example, using the family questionnaires issued at the CPA meetings and engagement with families using the family and carer forum.

We saw minutes from the residents meeting that took place in March 2015 which was attended by five patients. Everyone attending the meeting had a chance to speak up about any issues affecting them. There was no set agenda, but a list of issues included things that were important to the patients.

Observational satisfaction questionnaires had been completed by the activity staff in June 2015. This questionnaire had a section that looked at care and treatment and asked about issues such as:

- safety
• your medication
• health checks, and
• how you are handled.

The questionnaires would be completed based on observation of patients in different situations and then to measure a level of satisfaction using a three-point scale: happy, unsure or unhappy. These had been completed for all patients and provided some useful information on things that were important and areas that could be made better.

The results of this annual questionnaire were collated by the provider and presented in a colour coded pie chart. This showed high levels of satisfaction with activities, environment, care and treatment.

Three family carer questionnaires had been returned between January and June 2015. The results were collated and presented using a coloured bar chart and showed reasonable levels of satisfaction.

Areas for improvement

The method of providing feedback for each service user was not individually assessed and recorded. This meant that some methods of providing feedback were not as effective as they could be. For example, the residents meeting in March 2015 was attended by only five out of the 14 patients.

Some patients could provide feedback, but this needed special communication skills such as using Makaton or talking mats. Not all staff were able to use these methods so there may be opportunities to gain feedback from some patients that were being missed. There were other patients who would have been able to complete a service user satisfaction questionnaire with little or no support from staff, but this had not recently taken place (see recommendations b and c).

We saw two patients had no independent representation at their CPA meetings and there were no views collected from them. This was not in keeping with the provider’s values. The service should ensure that patients who need representation have this and those who can express their views are helped to do so, so these can be included in the meetings (see recommendation d).

Although 14 CPA meetings had taken place between January and June 2015, only three family members had completed the questionnaires. Families could be encouraged to give feedback regularly, to ensure their views can be taken into account at the CPA meetings.

■ No requirements.

Recommendation b

■ We recommend that the service should assess each service user and identify the best method for gaining feedback from each individual on all of the quality themes.

Recommendation c

■ We recommend that the service should provide each service user with the support they need to enable them to provide regular feedback on all of the quality themes.
Recommendation d

We recommend that the service should ensure all patients have independent representation or the chance to express their views so they can effectively input into the Care Programme Approach meetings.

Quality Statement 1.4

We are confident that within our service, all medication is managed during the service user's journey to maximise the benefits and minimise any risk. Medicines management is supported by legislation relating to medicine (where appropriate Scottish legislation) and current best practice.

Grade awarded for this statement: 4 - Good

Monroe House had good systems in place to ensure that medication was managed safely. Medications were stored appropriately and systems were in place to ensure medication was ordered and available for patients. All medications were individually prescribed.

Staff training records confirmed that staff completed medication competencies and received ongoing education from the contracted pharmacist on types and effects of medication correct administration of medication.

We saw medication fridge temperatures were monitored daily to ensure they were within safe limits.

There was appropriate controlled drug management and we saw controlled drug registers were accurately completed. The registered manager had been appointed as the Controlled Drug Accountable Officer. Policies and procedures were in place to guide staff and we saw these were regularly reviewed.

Medication was discussed and reviewed at the multidisciplinary meetings and patients also attended these. We saw in the patients’ medication records that they all had appropriate consents in place.

Easy-read information about medication was readily available for patients. Medication incidents were reported through the electronic system and we viewed minutes that showed trends and actions were discussed at the unit level governance group.

The provider had a contract with a national pharmacy company which provided next day delivery. The service level agreement was currently being reviewed. A local pharmacy supplied medications that were required urgently.

Areas for improvement

Medication that is not required regularly by a patient is sometimes referred to as PRN medication. PRN protocols when completed are a useful tool to guide staff when to administer PRN medication. We looked at six patients’ medication documentation and noted that three did not have PRN protocols in place. We also saw these protocols were recorded differently on both units. In Anoach, these were recorded in the medication prescription charts and in Etive, in the patients care records. Having the protocols beside the medication prescription charts would be easier for staff to reference when medication is being considered.
The PRN efficacy record was used when PRN medication was administered to check how effective the medication was in relieving symptoms. The form in the record directed staff to check patients every 15 minutes to grade their response to the medication. However, these forms were not being used consistently and we saw only two examples where it had been used following administration of paracetamol. We did not see examples of the forms being used to measure the effectiveness of other medications.

Anti-psychotic monitoring forms were in place for patients and the medication policy stated that these forms should be completed every month to record patients’ pulse and blood pressure. The forms were not used consistently and in two instances observations had not been recorded for 2 months. A medication audit had not been carried out as stated in the audit schedule. This audit is important to ensure compliance, and areas for improvement in the medication management system are identified and auctioned (see recommendation e).

We noted there was no process in place for reconciliation of medications when a service user was admitted. Chief Medical Officer (CMO)(2013) guidance states that processes should be established to ensure that an individual’s medication is confirmed as being before further prescribing (see recommendation f).

- No requirements.

**Recommendation e**

- We recommend that the service should ensure that regular audit of medication documentation is carried out, in line with the planned schedule and used to identify and action areas for improvement.

**Recommendation f**

- We recommend that the service should put systems in place to ensure medication reconciliation processes are established, including developing policies, procedures and staff education.

**Quality Theme 2 – Quality of environment**

**Quality Statement 2.1**

We ensure that patients and carers participate in assessing and improving the quality of the environment within the service.

**Grade awarded for this statement: 4 - Good**

We found that the service sought feedback from patients on the quality of the environment. The service had an observational satisfaction questionnaire and we saw feedback was recorded specifically on the environment. However, this had only been carried out recently and no action plan had yet been compiled.

We saw opportunities for patients to personalise their bedrooms which included personal items such as stereos, pictures or soft furnishings.

**Areas for improvement**

During the inspection, we were told that there will be opportunities for more service user involvement in shaping the environment at Monroe House. We were also told that there are proposals to change the layout and create different spaces for patients with differing needs.
The service could break up the colour of the walls in the corridors to help patients find important doorways, for example toilets or ignore others such as cupboards. Making changes to colour and layout would be beneficial and patients could be involved to help with this.

We observed noise levels affecting some patients and causing them distress. We saw that sometimes staff and other patients could be quite noisy. We saw quiet rooms were available, however these were not being used at the time of the inspection.

- No requirements.
- No recommendations.

**Quality Statement 2.2**

We are confident that the design, layout and facilities of our service support the safe and effective delivery of care and treatment.

**Grade awarded for this statement: 4 - Good**

Monroe House is a purpose-built unit over two floors. The service provides care for many individuals who have varying degrees of challenging behaviour and subsequently, the environment sustains regular damage.

A maintenance officer is in post and maintains the environment through regular scheduled repairs and painting. We found the maintenance schedule to be up to date. A maintenance request book was used by staff to request repairs as they are needed. Contracts were in place for the maintenance of equipment and for systems such as the fire alarm and nurse call system. Portable appliance testing was carried out to ensure this equipment was safe. At corporate level, a properties manager oversaw the building management and refurbishment programme.

We noted many features to promote a safe environment, including staff and patient alarm systems, door alarms at night and epilepsy monitors. Staff were also issued with mobile alarms and they confirmed that on pressing the alarm, assistance was received quickly.

Reception was manned within office hours and there were signing-in procedures for visitors. Contractors were supervised when carrying out work within the building.

We saw that the service was clean and we spoke with housekeeping staff and they showed us the cleaning schedules that directed their work each day.

A health and safety committee was in place and met regularly. We saw from the minutes that discussions included audits, accidents and incidents, and any building management issues.

We saw that the service had replaced hand washing sinks in the treatment rooms to ensure they met with current infection control guidelines.

We saw that plans were in place to re-design both the units, which included developing a four-bedded room discrete unit for patients with autistic traits who require a specialist environment. This unit will be in the downstairs area and will have a separate entrance and exit. It is planned that work on this unit will begin in August 2015 once the appropriate approval is received.

A four-bedded unit is being planned for the upstairs area and this will be for patients who are moving towards independent living. The current refurbishment programme has been put on
hold in the light of the new developments, however upgrading of remaining rooms will continue.

The building was monitored through annual corporate audits. A nurse had designated responsibility for ensuring good infection control practices.

We spoke with five patients who told us that they felt comfortable and safe. Feedback included:

- ‘Staff look after me, have nice room and my own shower, do all sorts of different things.’
- ‘Happy here, going home soon and getting help to get my house organised, I feel ready to move on.’

**Areas for improvement**

At the previous inspection in June 2014, we made the following requirement:

The provider must carry out a programme of refurbishment throughout the service to ensure it is fit for the provision of an independent healthcare service.

During this inspection, we saw progress which included the re-decoration of:

- all the corridors in Monroe House
- new carpets in some lounges, and
- new lounge furniture with items that are robust and hard wearing while keeping a stylish and homely appearance.

Three bedrooms had been upgraded to include safer furniture that patients would be unable to move. All bedrooms will eventually be fitted to this standard. We will continue to follow up this requirement at future inspections to make sure the service is refurbished to an adequate standard.

The service could consider the layout of medication rooms as part of the refurbishment plan. Staff reported that these rooms were small and could be a potential risk when patients’ attend to get their medication.

We viewed the outdoor smoking area and saw a lot of cigarette ends accumulated on the ground, around the bushes and the ashtray was overflowing. Only one patient smoked, therefore staff were not disposing of cigarettes in a respectful manner. Staff and patients both used this area and we discussed this with the manager who informed us that staff should not be smoking there. The staff smoking area was located at the other side of the building and arrangements should be put in place to ensure staff used the appropriate area and patients are able to enjoy a clean space (see recommendation g).

We saw the rear bedrooms of the service were exposed to the road as there was no fencing. Patients were offered opaque film for their windows to improve privacy, however uptake was low. Part of the refurbishment will include re-configuration and upgrading of garden areas and fencing.

The corridor areas were not well lit. However during the inspection, we were told about a plan to replace the lighting.

- No requirements.
Recommendation g

We recommend that the service should review current staff smoking arrangements to minimise impact on patient areas.

Quality Theme 3 – Quality of staffing

Quality Statement 3.1

We ensure that patients and carers participate in assessing and improving the quality of staffing in the service.

Grade awarded for this statement: 4 - Good

We found that the service sought feedback from patients on the quality of staffing. The main evidence of this was through the observational satisfaction questionnaires. We saw that feedback was specifically recorded about:

- care staff
- key workers
- nurses
- other patients
- the manager, and
- members of the multidisciplinary team.

Although we saw examples of patients being involved with recruiting staff, we noted that this was not yet routine. A formal training programme to help involve patients in recruitment had been developed by the provider and it was hoped some patients from Monroe House would be able to take part in the future.

Area for improvement

At the time of the inspection, there had been a lot of staff changes and the process of allocating new key workers and nurses to patients was still ongoing. There, we were unable to assess how effective these relationships were.

Staff told us that the staff changes had affected two patients in particular. Consistency of staff and well-established relationships are very important for the individuals affected. They can achieve their treatment goals faster and their general well being is enhanced when they are working with, and supported by, staff they know well.

- No requirements.
- No recommendations.
Quality Statement 3.4
We ensure that everyone working in the service has an ethos of respect towards patients and each other.

Grade awarded for this statement: 4 - Good

During the inspection, we observed staff being polite and respectful. For example, we saw staff knocking on patients' bedroom doors before entering. There was mostly a calm atmosphere and staff told us that this had been getting better recently with a clearer emphasis on how to work with patients using the positive behaviour support systems.

Staff told us that they were clearer about now on how to respond to behaviours that challenge them. They also told us that the new manager had been able to support them to ensure consistent approaches were taken. This involved being polite and respectful at all times to patients, but if there was violence or verbal aggression then actions had to be taken to ensure safety. The sort of actions taken depended on agreed interventions such as de-escalation or re-direction of a service user. Physical holds were agreed in some cases as a last resort to ensure service user safety. We were told that there had been extensive staff training to ensure that this was carried out safely. To make sure appropriately trained staff were always available to intervene, a response team of two trained members of staff were identified who could be summoned if needed.

Staff were aware of the provider’s values and told us that these were emphasised during induction and through supervision and training. These were:

- safe
- sound, and
- supportive.

We saw good examples of communication passports being used to help staff know how best to communicate and care for patients’ individual needs. These communication passports had been made easy-to-read and summarised key things that were important for staff to know.

We saw patients were given a choice of when they got up or went to bed. They could eat their meals at flexible times, with staff and other patients if they wished, or on their own if this was preferred.

There was freedom to come and go around the building. Most patients were out and about and involved in various activities throughout the day. Some patients were able to go to local shops unescorted and this promoted independence.

Area for improvement
We saw some references to toys being used for activities. This is not an age appropriate term and the manager agreed to review the use of this term with staff.

- No requirements.
- No recommendations.

Quality Theme 4 – Quality of management and leadership
Quality Statement 4.1
We ensure that patients and carers participate in assessing and improving the quality of the management and leadership of the service.

Grade awarded for this statement: 4 - Good

The service user forum group was named ‘Listen up Danshell’ by patients. This forum had two representatives from Monroe House who met with representatives from the provider’s other Scottish service. Two representatives from this group also attended a UK-wide forum in June 2015. This system allows for the patient’s voice to be heard by the provider’s Board members. A summary of this recent meeting had been put together using photographs and symbols to help make it easy-to-read. It was intended to feedback the results of the event to the local groups.

Feedback was sought from commissioners of the service. We saw four questionnaires were returned following CPA meetings between January and June 2015. These showed reasonable levels of satisfaction and gave the following comments about the service:

- ‘My client has shown dramatic improvement since staying with Danshell.’
- ‘Consistent approach by the multidisciplinary team is successful.’

Area for improvement

The methods for involving patients, their families and stakeholders in improving the quality of management are still being developed. The service should continue this work and we will follow up on the new engagement approach at the next inspection.

- No requirements.
- No recommendations.

Quality Statement 4.4
We use quality assurance systems and processes which involve patients, carers, staff and stakeholders to assess the quality of service we provide.

Grade awarded for this statement: 3 - Adequate

The service submitted a limited self-assessment to Healthcare Improvement Scotland. The self-assessment is completed by the service each year and provides a measure of how the service has assessed itself against the quality themes and National Care Standards. We found adequate quality information that we were able to verify during our inspection.

A new registered manager for the service came into post in April 2015. The service has had four managers since 2013 and as such developing the service without sustained periods of stability has been challenging.

A lot of new staff have also been recruited and many we spoke with were settling into their new roles. We spoke with staff from all areas during the course of the inspection and gained very positive feedback about management and plans for the service.

There is a vacancy for a deputy manager and a clinical nurse manager with interviews due to take place in July 2015. These posts are crucial in supporting the manager in developing leadership within the service.
The provider had a quality strategy in place and this included:

- individual service reviews
- integrated governance meetings
- regional governance meetings
- unit-led governance meetings, and
- user forums.

We saw there was a range of ways that the service could monitor the quality of service delivery and these included:

- audits
- accident and incident reports
- questionnaires and surveys
- complaints and compliments
- contract monitoring, and
- multidisciplinary team meetings.

The manager reported monthly to the regional governance meeting. We looked at the most recent report and saw that this included:

- analysis of staffing, including vacancies and training
- accident and incident figures and trends
- audit activity, and
- complaints.

We saw the manager’s report included an action plan and also a review of how the service was meeting the priorities of the quality strategy.

A corporate governance team gathers key performance indicators from all the provider’s regional services and this information was used to benchmark the provider’s services against each other. We looked at regional governance reports and saw that these monitored most aspects of the services and identified areas for improvement.

The provider had a range of policies and procedures and we saw these were regularly reviewed and updated. Staff confirmed that they had access to these.

We saw systems in place to ensure doctors received their revalidation appraisal and also to ensure staff professional registration was current.

We saw from reviewing meeting minutes that staff and patients were able to contribute to service development by making suggestions for improvement.

Staff told us that communication had improved at the service. For example, during the inspection we attended the morning planning meeting. Nurses, carers, hospitality staff, maintenance and administration staff attended this to discuss the plans for each day and any issues of risk. This was a productive meeting and staff were fully engaged.

Patients we spoke with told us that their feedback about the service was listened to.
Areas for improvement

Although the provider had a comprehensive quality framework in place it was not applied consistently. For example, there was an audit plan in place that included internal unit level audits and also audits carried out by the governance team, but we found that audits in the last quarter had not been carried out. We found that the medication documentation was not fully completed and the medication audit that should have identified this had not been completed.

At the previous inspection in June 2014, we recommended that the service carry out a staff survey to allow them to engage with staff regarding any issues that are concerning them. The outcomes from the staff survey should be addressed through staff supervision to allow staff to discuss issues that are affecting morale.

During this inspection, we were that told the staff survey will be circulated this month (June 2015). We will follow this up at a future inspection (see recommendation h).

During this inspection, we reviewed three patient care plans and noted that reviews were not undertaken regularly and there was little evidence of service user involvement. Each service user had three files containing information important to their care, but we saw the person-centred files were incomplete. We saw inconsistent standard of documentation in service user files and the service had undertaken a clinical records audit and the results were poor. An action plan had been developed and we saw sample care plans had been developed. The work on updating care plans had started and it is planned that all patients will have new documentation in place by the end of July 2015. Nurses have been assigned patients to review and update care plans should be given to the layout of the care and support files to ensure information is up to date, applicable and easy to find. We will follow this up at future inspections to look at the outcome of this work (see recommendation i).

At the time of inspection, the service’s intranet was down, leaving the service with no access to the shared drive or emails. We were unable to access all documentation required. The provider should ensure plans are in place for access to information when the service fails. Staff told us that this had a great deal of impact on their ability to work and communicate effectively.

- No requirements.

Recommendation h

- We recommend that the service should carry out a staff survey to allow them to engage with staff regarding any issues that are concerning them. The outcomes from the staff survey should be addressed through staff supervision to allow staff to discuss issues that are affecting morale.

Recommendation i

- We recommend that the service should ensure care plans are reviewed on a regular basis
Appendix 1 – Requirements and recommendations

The actions that Healthcare Improvement Scotland expects the independent healthcare service to take are called requirements and recommendations.

- **Requirement:** A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the Act, regulations or a condition of registration. Where there are breaches of the Act, regulations, or conditions, a requirement must be made. Requirements are enforceable at the discretion of Healthcare Improvement Scotland.

- **Recommendation:** A recommendation is a statement that sets out actions the service should take to improve or develop the quality of the service but where failure to do so will not directly result in enforcement.

<table>
<thead>
<tr>
<th>Quality Statement 0.2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Requirement</strong></td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td><strong>Recommendation</strong></td>
</tr>
<tr>
<td>We recommend that the service should:</td>
</tr>
<tr>
<td>a ensure that Healthcare Improvement Scotland is clearly referenced as the regulator for this service in the complaints material (see page 10).</td>
</tr>
</tbody>
</table>

National Care Standards – Independent Hospitals (Standard 9.2 – Expressing your views)

<table>
<thead>
<tr>
<th>Quality Statement 1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Requirement</strong></td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td><strong>Recommendations</strong></td>
</tr>
<tr>
<td>We recommend that the service should:</td>
</tr>
<tr>
<td>b assess each service user and identify the best method for gaining feedback from each individual on all of the quality themes (see page 11).</td>
</tr>
</tbody>
</table>

National Care Standards – Independent Hospitals (Standard 9.2 – Expressing your views)
<table>
<thead>
<tr>
<th>Quality Statement 1.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requirement</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Recommendations</td>
</tr>
<tr>
<td>We recommend that the service should:</td>
</tr>
<tr>
<td>e</td>
</tr>
<tr>
<td>ensure that regular audit of medication documentation is carried out, in line with the planned schedule and used to identify and action areas for improvement (see page 13).</td>
</tr>
<tr>
<td>National Care Standards – Independent Hospitals (Standard 20 – Medicines management)</td>
</tr>
<tr>
<td>f</td>
</tr>
<tr>
<td>put systems in place to ensure medication reconciliation processes are established, including developing policies, procedures and staff education (see page 13).</td>
</tr>
<tr>
<td>National Care Standards – Independent Hospitals (Standard 20 – Medicines management)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Statement 2.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requirements</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Recommendation</td>
</tr>
<tr>
<td>We recommend that the service should:</td>
</tr>
<tr>
<td>g</td>
</tr>
<tr>
<td>review current staff smoking arrangements to minimise impact on patient areas (see page 16).</td>
</tr>
<tr>
<td>National Care Standards – Independent Hospitals (Standard 15 – Your environment)</td>
</tr>
</tbody>
</table>
## Quality Statement 4.4

<table>
<thead>
<tr>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>We recommend that the service should:</strong></td>
</tr>
<tr>
<td><strong>h</strong> carry out a staff survey to allow them to engage with staff regarding any issues that are concerning them. The outcomes from the staff survey should be addressed through staff supervision to allow staff to discuss issues that are affecting morale (see page 20).</td>
</tr>
<tr>
<td>This was previously identified as a recommendation in the August 2014 inspection report for Monroe House.</td>
</tr>
<tr>
<td><strong>i</strong> ensure care plans are reviewed on a regular basis (see page 20).</td>
</tr>
<tr>
<td>This was previously identified as a recommendation in the August 2014 inspection report for Monroe House.</td>
</tr>
</tbody>
</table>

### Requirement carried forward from our 17-18 June 2014 inspection

<table>
<thead>
<tr>
<th>The provider must:</th>
</tr>
</thead>
<tbody>
<tr>
<td>carry out a programme of refurbishment throughout the service to ensure it is fit for the provision of an independent healthcare service (see page 15).</td>
</tr>
</tbody>
</table>

Revised timescale: by 1 December 2015

*SSI 2011 No. 182 - Regulation 10(2)(b) - The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

National Care Standards – Independent Hospitals (Standard 15 – Your environment)
### Appendix 2 – Grading history

<table>
<thead>
<tr>
<th>Inspection date</th>
<th>Quality of information</th>
<th>Quality of care and support</th>
<th>Quality of environment</th>
<th>Quality of staffing</th>
<th>Quality of management and leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-11 December 2013</td>
<td>Not assessed</td>
<td>4 - Good</td>
<td>3 - Adequate</td>
<td>2 - Weak</td>
<td>3 - Adequate</td>
</tr>
<tr>
<td>17-18 June 2014</td>
<td>Not assessed</td>
<td>4 - Good</td>
<td>3 - Adequate</td>
<td>4 - Good</td>
<td>4 - Good</td>
</tr>
</tbody>
</table>
Appendix 3 – Who we are and what we do

Healthcare Improvement Scotland was established in April 2011. Part of our role is to undertake inspections of independent healthcare services across Scotland. We are also responsible for the registration and regulation of independent healthcare services.

Our inspectors check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. They do this by carrying out assessments and inspections. These inspections may be announced or unannounced. We use an open and transparent method for inspecting, using standardised processes and documentation. Please see Appendix 5 for details of our inspection process.

Our work reflects the following legislation and guidelines:

- the National Health Service (Scotland) Act 1978 (we call this ‘the Act’ in the rest of the report),
- the Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011, and
- the National Care Standards, which set out standards of care that people should be able to expect to receive from a care service. The Scottish Government publishes copies of the National Care Standards online at: www.scotland.gov.uk

This means that when we inspect an independent healthcare service, we make sure it meets the requirements of the Act and the associated regulations. We also take into account the National Care Standards that apply to the service. If we find a service is not meeting the requirements of the Act, we have powers to require the service to improve.

Our philosophy

We will:

- work to ensure that patients are at the heart of everything we do
- measure things that are important to patients
- are firm, but fair
- have members of the public on our inspection teams
- ensure our staff are trained properly
- tell people what we are doing and explain why we are doing it
- treat everyone fairly and equally, respecting their rights
- take action when there are serious risks to people using the hospitals and services we inspect
- if necessary, inspect hospitals and services again after we have reported the findings
- check to make sure our work is making hospitals and services cleaner and safer
- publish reports on our inspection findings which are always available to the public online (and in a range of formats on request), and
- listen to your concerns and use them to inform our inspections.
Complaints

If you would like to raise a concern or complaint about an independent healthcare service, we suggest you contact the service directly in the first instance. If you remain unhappy following their response, please contact us. However, you can complain directly to us about an independent healthcare service without first contacting the service. Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Telephone: 0131 623 4300
Email: comments.his@nhs.net
Appendix 4 – How our inspection process works

Inspection is part of the regulatory process.

Each independent healthcare service completes an online self-assessment and provides supporting evidence. The self-assessment focuses on five quality themes:

- **Quality Theme 0 – Quality of information**: this is how the service looks after information and manages record-keeping safely. It also includes information given to people to allow them to decide whether to use the service and if it meets their needs.
- **Quality Theme 1 – Quality of care and support**: how the service meets the needs of each individual in its care.
- **Quality Theme 2 – Quality of environment**: the environment within the service.
- **Quality Theme 3 – Quality of staffing**: the quality of the care staff, including their qualifications and training.
- **Quality Theme 4 – Quality of management and leadership**: how the service is managed and how it develops to meet the needs of the people it cares for.

We assess performance by considering the self-assessment, complaints, notifications of events and any enforcement activity. We inspect the service to validate this information and discuss related issues.

The complete inspection process is described in Appendix 5.

**Types of inspections**

Inspections may be announced or unannounced and will involve physical inspection of the clinical areas, and interviews with staff and patients. We will publish a written report 8 weeks after the inspection.

- **Announced inspection**: the service provider will be given **at least 4 weeks’ notice** of the inspection by letter or email.
- **Unannounced inspection**: the service provider will **not be given any advance warning** of the inspection.

**Grading**

We grade each service under quality themes and quality statements. We may not assess all quality themes and quality statements.

We grade each heading as follows:

```
6  excellent  5  very good  4  good  3  adequate  2  weak  1  unsatisfactory
```

We do not give one overall grade for an inspection.

The quality theme grade is calculated by adding together the grades of each quality statement under the quality theme. Once added together, this number is then divided by the number of statements.
For example:

**Quality Theme 1 – Quality of care and support: 4 - Good**

Quality Statement 1.1 – 3 - Adequate  
Quality Statement 1.2 – 5 - Very good  
Quality Statement 1.5 – 5 - Very good

Add the grades of each quality statement together, making 13. This is then divided by the number of quality statements (there are 3 quality statements), making 4.3. This is rounded down to 4, giving the overall quality theme a grade of 4 - Good.

However, if any quality statement is graded as 1 or 2, then the entire quality theme is graded as 1 or 2 regardless of the grades for the other statements.

**Follow-up activity**

The inspection team will follow up on the progress made by the independent healthcare provider in relation to the implementation of the improvement action plan. Healthcare Improvement Scotland will request an updated action plan 16 weeks after the initial inspection. The inspection team will review the action plan when it is returned and decide if follow up activity is required. The nature of the follow-up activity will be determined by the nature of the risk presented and may involve one or more of the following elements:

- a planned announced or unannounced inspection
- a planned targeted announced or unannounced follow-up inspection looking at specific areas of concern
- a meeting (either face to face or via telephone/video conference)
- a written submission by the service provider on progress with supporting documented evidence, or
- another intervention deemed appropriate by the inspection team based on the findings of the initial inspection.

A report or letter may be produced depending on the style and findings of the follow-up activity.

More information about Healthcare Improvement Scotland, our inspections and methodology can be found at:  
Appendix 5 – Inspection process

We follow a number of stages in our inspection process.

**Before inspection**

The independent healthcare service undertakes a self-assessment exercise and submits the outcome to us.

We review the self-assessment submission to help inform and prepare for on-site inspections.

**During inspection**

We arrive at the service and undertake physical inspection.

We have discussions with senior staff and/or operational staff, people who use the service and their carers.

We give feedback to the service’s senior staff.

We undertake further inspection of services if significant concern is identified.

**After inspection**

We publish reports for patients and the public based on what we find during inspections. Healthcare staff can use our reports to find out what other services do well and use this information to help make improvements. Our reports are available on our website at [www.healthcareimprovementscotland.org](http://www.healthcareimprovementscotland.org)

We require services to develop and then update an improvement action plan to address the requirements and recommendations we make. We check progress against the improvement action plan.
Appendix 6 – Details of inspection

The inspection to Monroe House, Oakview Estates Limited was conducted on Wednesday 17 and Thursday 18 June 2015.

The inspection team was made up of the following members:

Karen Malloch  
Lead Inspector

Sarah Gill  
Inspector

Ken Barker  
Public Partner
## Appendix 7 – Terms we use in this report

<table>
<thead>
<tr>
<th>Terms and explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>provider</strong></td>
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<tr>
<td><strong>service</strong></td>
</tr>
</tbody>
</table>
We can also provide this information:

- by email
- in large print
- on audio tape or CD
- in Braille (English only), and
- in community languages.