Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

New Hall Independent Hospital, Mental Health Care (UK)

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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

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at New Hall Independent Hospital, on 13, 14 and 15 March 2023. The hospital provides specialist care to a maximum of 10 patients aged between 18 and 64 years that have been diagnosed with both a learning disability and a mental illness. The hospital was being managed by Mental Health Care (UK) at the time of the inspection. We reviewed the following wards:

- Glaslyn Ward, a four bedded ward
- Adferiad Ward, a six bedded ward.

At the time of the inspection the hospital was providing care to six patients, with three patients on each ward.

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

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

Note the inspection findings relate to the point in time that the inspection was undertaken. This (full) report is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
The hospital had good processes in place to help protect and promote the physical health of patients. Each ward had a range of facilities to support the provision of therapies and activities. Staff had undertaken equality, diversity and inclusion training to help recognise the importance of treating all patients fairly. We observed staff treating patients with respect and supporting patients in a dignified and sensitive way. However, we felt staff could do more to undertake therapeutic observations to better engage and support patients at the hospital.

This is what we recommend the service can improve:

- The service must liaise with the local GP to ensure all patients receive their annual health checks
- Patients must have an up-to-date individual and comprehensive care and treatment plan to assist their recovery in line with the Welsh Measure
- The service must retain a record of formal and informal complaints and issues raised to help identify themes and highlight necessary improvements.

This is what the service did well:

- Easy read documentation was available to help patients understand their healthcare needs in an accessible way.

Delivery of Safe and Effective Care

Overall summary:
Staff appeared committed to providing safe and effective care. Staff members understood their individual responsibilities in relation to implementing effective infection control measures at the hospital. There were up-to-date ligature point risk assessments for each ward that detailed the actions taken to mitigate and reduce the risk of ligature. The cultural nutritional needs of patients were being met and efforts were being made to ensure patients chose healthy food options. The clinic rooms on each ward were clean and tidy and medication was being stored securely at all times. Each patient had Positive Behaviour Support (PBS) and crisis intervention plans that we found to have been completed to a good standard. The service must review the alarm system in place at the hospital to ensure all personal alarms work as required throughout all areas of the setting to help protect the safety of staff and patients.

Immediate assurances:

Throughout the inspection we identified the following immediate risks to the safety of patients, staff and visitors at the hospital:

- Ligature cutters were not available to all members of staff in a timely manner in the event of an emergency
- Access through two fire doors had been prevented due to the installation of a metal bracket on each door that had planks of wood across them which meant the fire doors could not be opened
- The fire risk assessments for both wards were out of date.

Throughout the inspection we identified the following immediate risks to the arrangements in place to safely manage a patient emergency:

- The emergency resuscitation equipment on both wards were not being checked as required to ensure the items remained safe and effective to use
- On the first night of the inspection it took staff approximately 10 minutes to locate the defibrillator that was meant to be stored within the staff office on Glaslyn Ward.

Further details of the concerns for patient safety and the immediate improvements that were required are provided in Appendix A and Appendix B.

This is what we recommend the service can improve:

- More radios need to be made available for all staff
- Medication Administration Records charts must be fully completed as required
- The service must ensure all staff are aware of their responsibilities and duties to report safeguarding concerns
- A better system must be implemented to monitor standard authorisation renewal dates and ensure renewals are submitted in good time to ensure patients are not deprived of their liberty unlawfully.

Quality of Management and Leadership

Overall summary:
Staffing levels were appropriate to maintain patient safety within the wards at the time of our inspection. We saw that suitable processes were in place for senior staff to monitor staff compliance with mandatory training and that overall compliance was high. A safety huddle was being held every morning for staff to update senior management on any concerns, issues or incidents that had taken place the day before. However, it was clear from the number of improvements we have identified throughout this report that the governance processes and systems

in place at the hospital were not identifying risks and necessary improvements to the service, particularly those in relation to immediate patient safety.

Immediate assurances:
Throughout the inspection we identified the following immediate risks to the arrangements in place to ensure that incidents were being effectively investigated, managed and scrutinised:

- We were not assured that all incidents had been reviewed by a senior member of staff and actions taken to close each incident
- Incident reports did not contain fully sufficient information to enable an appropriate review of the incident to take place
- Some medication errors that had occurred at the hospital had not yet been recorded on to the electronic data management system
- We saw no evidence that a Root Cause Analysis had been undertaken for any of the six medication errors that had occurred at the hospital in 2022.

Further details of the concerns for patient safety and the immediate improvements that were required are provided in Appendix B.

This is what we recommend the service can improve

- The service must ensure the paper file of policies is kept up-to-date at all times
- All staff must receive regular clinical supervision sessions to help their learning and development.

3. What we found

Patient and Staff Feedback

We invited patients and staff to complete HIW questionnaires during and following the inspection to obtain their views on the service provided at the hospital. While we only received a small number of completed questionnaires from patients, our patient experience reviewer spent time on the wards and spoke to many patients throughout the inspection to obtain their views.

We received 12 completed questionnaires from staff members at the hospital. Staff responses were positive, with all staff members recommending New Hall as a good place to work and agreeing that they would be happy with the standard of care provided by the hospital for themselves or for their friends or family.

Feedback from patients, and comments and questionnaire results from staff, appear throughout the report.

Quality of Patient Experience

Health promotion, protection and improvement
The hospital had good processes in place to help protect and promote the physical health of patients. We looked at a sample of six patient records and saw evidence that patients had received appropriate physical assessments upon their admission. An action plan was then developed for each patient which stated their individual healthcare needs. Patients attended weekly 'well man' clinics for ongoing physical health checks such as weight management and monitoring.

Patients were able to access GP, dental services and other physical health professionals as required. However, we were told that the local GP would not undertake standard annual health checks of patients at the hospital.

The service must liaise with the local GP to resolve this and ensure all patients receive their annual health checks in line with Public Health Wales guidance on improving the health and wellbeing of people with a learning disability.

Each ward had a range of facilities to support the provision of therapies and activities. This included a pool table, table tennis, puzzles and arts and crafts equipment. Outdoor spaces were available and patients were individually risk assessed to be allowed access to the wider hospital grounds.

Dignity and respect
We observed staff treating patients with respect and supporting patients in a dignified and sensitive way. There appeared to be an appropriate mix of gendered staff working on the wards throughout the inspection.

Each patient had multiple members of staff assigned directly to support them with their care. There appeared to be a difference between the two wards in terms of therapeutic engagement with patients. We saw positive relationships between staff and patients on Adferiad Ward and observed activities taking place. However, we did not see any activities being undertaken on Glaslyn Ward, and we observed staff grouped together and talking between themselves, rather than engaging with patients.

The service must do more to ensure staff, particularly on Glaslyn Ward, are undertaking therapeutic observations that help best engage with and support patients at the hospital.

All patients had their own bedroom and bathroom and were able to store possessions and personalise their rooms where appropriate. Patients could close their bedroom door if appropriately risk assessed to do so. During the inspection all patients were on increased observation levels, which meant personal care activities were unable to be undertaken in private. The patients we spoke with told us that they felt treated fairly and with dignity and respect by staff. The majority of staff members who completed a questionnaire also agreed that the privacy and dignity of patients is maintained during their time at the hospital.

Patient information and consent
The hospital had a written statement of purpose that met the requirements of the regulations. A wide range of patient information was available for patients on each ward via leaflets and posters on display. This included information on the Mental Health Act and advocacy services. The contact details for HIW were also on display for patients who may wish to raise a complaint externally.

Patient status at a glance boards were located in the nursing offices on each ward. These were areas which patients could not access and therefore helped protect patient confidentiality.

We saw that a list of staff members on duty that day was displayed on doors within each ward. The service may wish to consider the potential benefit of installing a ‘Who’s who’ board containing pictures and information about each staff member working on the ward to help patients get to know staff and build good relationships.

Communicating effectively

We saw that staff took the time to speak with patients to understand their needs or any concerns the patients raised. The majority of staff members who completed a questionnaire felt that patients were informed and involved in decisions about their care.

We were told that easy read versions of documents had been created to aid understanding for patients, which we noted as good practice. We saw examples such as an easy read version of a care plan, and a leaflet that helped patients to better understand their rights under the Deprivation of Liberty Safeguards process.

Suitable visiting arrangements were in place for patients to meet visitors at the hospital. Patients had access to their own mobile phone where appropriate, but a telephone was available on each ward for patients to use if required.

Care planning and provision

During the inspection we reviewed the patient records of six patients. They were person centred and reflected the needs and risks of the individual patients. However, we did not always find up-to-date care and treatment plans in place as required by the Mental Health (Wales) Measure 2010. In one example, the care and treatment plan we saw related to the previous placement of a patient and had not been updated since being admitted to New Hall.

The service must ensure patients have an up-to-date individual and comprehensive care and treatment plan to assist their recovery in line with the Welsh Measure.

More findings on the care plans can be found in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Equality, diversity and human rights

The hospital had policies in place to help ensure that patients' equality and diversity were respected. Staff had undertaken equality, diversity and inclusion training to help recognise the importance of treating all patients fairly.

Most areas of the hospital appeared to be well equipped for patients with mobility issues. Each ward had a lift and doorways and corridors were wide and spacious. One patient in Glaslyn Ward currently needed wheelchair assistance to move around the hospital. We noted that the dining table and chairs in Glaslyn Ward were fixed to the floor and did not provide a comfortable or adequate space for the patient to eat their food at mealtimes.

The service must review the arrangements in place for this patient to ensure their needs are fully met during mealtimes.

Suitable visiting arrangements were in place for patients to meet visitors at the hospital.

Citizen engagement and feedback
We were told that patients and staff had daily informal conversations about their care. We noted that one patient would communicate through writing and we saw that staff made every effort to respond appropriately in a way that made the patient comfortable. However, we did not see any evidence of changes that had been made as a result of more formal patient feedback. For example, neither ward had a 'You said, we did' board.

The service must do more to ensure patients are kept informed of the outcomes of their feedback and any changes or improvements implemented as a result.

It also appeared that no formal record was being kept of suggestions made or issues raised by patients.

The service must retain a record of formal and informal complaints and issues raised to help identify themes and highlight necessary improvements.

Information about how patients could make a complaint or concern was on display on each ward. However, the service may wish to provide this information in an easy read version to help patients to better understand the process to follow.

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety
We looked at the processes in place at New Hall to manage and review risks to help maintain the health and safety of patients, staff and visitors at the hospital. Some suitable measures were in place, which included:

- The hospital entrances were accessible to everyone and were secured at all times throughout the inspection to prevent unauthorised access
- There were up-to-date ligature point risk assessments for each ward that detailed the actions taken to mitigate and reduce the risk of ligature
- A business continuity and emergency contingency plan was in place that set out the procedures to follow in the event of a major incident occurring at the hospital. These included events such as fire and severe weather conditions
- There were nurse call points within patient bedrooms and communal bathrooms so that patients could summon assistance if required.

However, during the inspection we identified the following immediate risks to the safety of patients, staff and visitors at the hospital:

- Ligature cutter sets were located downstairs and upstairs on both wards. However, for downstairs areas they were located within the clinic rooms, which were only accessible by the qualified nurse on each ward. This meant that if the nurse was unavailable to open the room, or was the first responder, staff would have to go upstairs to access the other ligature cutter sets which would not provide timely assistance in the event of an emergency
- During the first night of the inspection we observed that access through both fire doors in the TV lounge on Glaslyn Ward had been prevented due to the installation of a metal bracket on each door that had planks of wood placed across them. The Senior Healthcare Inspector, and a team leader at the establishment, attempted to remove the planks of wood but were unable to do so. This meant that the fire doors could not be opened, and did not provide adequate means of escape in the event of a fire
- A review of the fire risk assessment for both wards at the hospital, which was due by 15 February 2023, had not been undertaken.

Our concerns regarding these issues were dealt with under our immediate assurance process. This meant that we wrote to the service immediately following

the inspection requiring that urgent remedial actions were taken. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A and Appendix B.

Staff wore personal alarms and carried radios which they could use to call for assistance if required. However, one staff member provided the following comment in the questionnaires when asked how the hospital could improve its service:

> *"[Provide an] adequate amount of radios"*

The service must ensure there are enough radios available for all staff working at the hospital.

Furthermore, we were told of an incident that had occurred at the hospital where a staff member had been injured during an incident because their personal alarm did not sound, which meant other staff were unaware they needed help.

The service must review the alarm system in place at the hospital to ensure all personal alarms work as required throughout all areas of the setting to help protect the safety of staff and patients.

The wards were generally being kept in a good state of repair. However, we did identify the following areas for improvement:

- A patient on Adferiad Ward was ripping up the corridor flooring. We spoke with staff who informed us that new flooring was in the process of being ordered
- Some seats in the dining area on Glaslyn Ward were missing from the table frames
- The TV cabinet in the TV lounge on Glaslyn Ward had been damaged and needed to be repaired or replaced.

The service must ensure upkeep and maintenance of the wards is undertaken to provide a suitable standard of living for patients as part of their environment of care.

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

The staff members we spoke with clearly described their individual responsibilities in relation to effective infection control measures at the hospital. Staff compliance with mandatory IPC training was high at 86 per cent.

Cleaning schedules documented the cleaning being undertaken at the hospital. Hand gel dispensers were available throughout both wards for both staff and patients to use. At the time of the inspection staff were not expected to wear face masks, but we saw that face masks and other PPE were available if required. We saw staff encouraging patients to wash their hands before eating which we noted as good IPC practice.

However, we did identify the following areas which were in need of improvement:

- There were rips in the material of armchairs in the TV lounge and outside the staff office on Glaslyn Ward that needed to be replaced as they were unable to be cleaned effectively in their current condition. This was disappointing to find as this was also an issue we identified during our last onsite inspection of the hospital in March 2020
- On two occasions throughout the inspection we saw that bed pans had been left in the sink of the communal toilets on Glaslyn Ward
- We also noticed what appeared to be a dried blood stain on the wall in the TV lounge on Glaslyn Ward. The stain was cleaned once our inspectors had raised this issue with staff.

The service must rectify these issues and ensure bed pans and blood stains are removed more quickly to protect patients and staff at the hospital from the risk of cross infection and to promote a safe and secure environment.

Nutrition
We saw that the dietary needs of patients had been assessed on admission and that patients received ongoing weight management checks during their stay. It was evident that the cultural nutritional needs of patients were being met, and that efforts were being made to ensure patients chose healthy food options. We were told that new healthier meal plans had been prepared and trialled with input from patients to ensure they were engaged.

Facilities were available for patients to have hot and cold drinks. During our tour of Glaslyn Ward we found food in the kitchen fridge that only had the name of the patient on it and no other information.

The service must ensure the opening and use-by dates of food for patients is labelled to protect the health of patients.

We also identified the following issues in the kitchen on Glaslyn Ward:

- There were gaps in the daily food storage checking records
- The food cooking and cooling checking sheets were all blank
- There were gaps in the daily fridge temperature checking records
- Some recorded fridge temperatures on the sheet were above the maximum temperature, but there appeared to be no actions taken to report or escalate this.

We discussed these issues with staff and were told that staff are verbally allocated tasks to complete, such as food storage and fridge temperature checks. Due to the gaps in recording, we were not assured that there was sufficient oversight or monitoring of these processes to ensure staff were undertaking these tasks as required.

The service must ensure staff complete the required safety checks as required and improve the governance and oversight of the food management process to ensure they are appropriate and safe.

Medicines management
The clinic rooms on each ward were clean and tidy, and medication was being stored securely at all times. We were told that medication stock checks are undertaken daily by clinical staff and are subject to a monthly audit by the external pharmacist.

The medication fridge on Adferiad Ward was locked when not in use and daily temperature checks of the fridge were being completed to ensure that medication was stored at the manufacturer's advised temperature. We saw some gaps in the recording of the daily temperature checks of the fridge in the clinic room on Glaslyn Ward. However, the fridge was empty because the medication for the patients on that ward did not need to be stored in the fridge. The service may wish to consider removing or turning off the fridge until medication is required to be stored in it.

We identified some improvements that were required in relation to the policies and procedures in place for medicines management:

- The medicines management policy was due for a review in 2022 and this had not yet taken place
- A rapid tranquillisation policy was not available
- The staff we spoke with were unsure where to find the latest versions of the relevant policies.

The service must take action to address these issues to ensure up-to-date guidance is available and that staff understand where to access the relevant documents.

We saw evidence that patients had individualised medication management plans and that patients had been involved in decisions about their medication. A range of easy read medication information leaflets were available for patients to access to help them understand the medication they had been prescribed.

The majority of Medication Administration Record (MAR) charts we looked at had been completed as required. The MAR charts had the relevant personal details documented. We noted that some MAR charts on Glaslyn Ward did not have a photograph of the patient. We also found some omissions in the daily entries on the MAR charts on Glaslyn Ward. A checklist was being completed daily by nursing staff to monitor compliance with a number of best practice tasks, including completion of entries on MAR charts. However, during a discussion with a staff nurse, they were unclear of the purpose of the form, and admitted they added their signature without undertaking any of the checks. This admission, along with the omissions we found, meant that we were not assured that the systems in place to monitor compliance in the clinic room, including the quality of the completion of MAR charts, were effective.

The service must ensure that MAR charts are fully completed as required. The service must also ensure all staff understand the purpose of the daily checklist to ensure it is used effectively as an audit tool.

Safeguarding children and safeguarding vulnerable adults
We were told that there were two designated safeguarding leads who had overall responsibility for ensuring patients were safeguarded appropriately while at the hospital. A register of safeguarding incidents was being maintained and we saw that incidents had been appropriately referred to external safeguarding agencies. A designated room was available for families and children to visit patients at the hospital.

Compliance among staff at the hospital with safeguarding training was high at 93 per cent. However, during our discussions with staff we were not assured that staff fully understood their duties in helping to safeguard patients or would be confident in recording incidents. There was a sense of reliance on reporting to the safeguarding leads rather than acting proactively.

The service must ensure all staff are aware of their responsibilities and duties to report safeguarding concerns and be skilled in recording them on the electronic RIVO incident management system.

Medical devices, equipment and diagnostic systems
During the inspection we looked at the arrangements in place to respond to patient medical emergencies and we identified the following immediate risks to patient safety:

- The emergency resuscitation equipment on Glaslyn Ward was not being checked as required to ensure the items remained safe and effective to use
- We were told by staff that the emergency resuscitation equipment on Adferiad Ward was being checked weekly by staff. However, there was no documented evidence available to support this
- On the first night of the inspection it took staff approximately 10 minutes to locate the defibrillator that was meant to be stored within the staff office on Glaslyn Ward.

Our concerns regarding these issues were dealt with under our immediate assurance process. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial actions were taken. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A and Appendix B.

Safe and clinically effective care
Each patient had Positive Behaviour Support (PBS) and crisis intervention plans that we found to have been completed to a good standard. They described individual triggers and behaviours that indicated escalating risk and outlined the strategies to use to de-escalate challenging behaviour without physical intervention.

Each patient had multiple members of staff assigned directly to support them with their care. A folder was available that contained key information about the patient for staff to understand the requirements of their care. However, we noted that the PBS and crisis intervention plans were not included in the folder and were only available to staff electronically. We were told that staff do not always have time to access a computer during their shift to view these documents.

The service must ensure all staff have easy access to key documentation in relation to the care of patients, for example, individual PBS and crisis intervention plans.

Comprehensive observation notes were being recorded by staff throughout each day on the presentation of each individual in order to inform the multi-disciplinary team (MDT) and identify any possible triggers should de-escalation be required. Any incidents are recorded and the number of incidents is reviewed on a monthly

basis. Recent data provided to us showed that there had been a downward trend in the number of incidents occurring at the hospital.

A safety huddle was being held every morning for staff to update the MDT and senior management on any concerns, issues or incidents that had taken place the day before. We attended one of these meetings and noted that any environmental or staffing issues were also raised and discussed.

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

We found the mixture of paper files and electronic documents hard to navigate during our review of patient records. This was particularly evident in relation to the paper files, where some documents had been filed incorrectly. We were also told that there are often delays in filing copies of electronic documents in the paper files. This meant we could not be assured that the paper files were being kept up-to-date.

The service must review its use of paper files and electronic documents to ensure all contemporaneous information regarding the care of a patient is available to staff in a timely and organised manner.

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

Mental Health Act Monitoring
During the inspection we looked at the current patient records of three individuals that had been detained under the Mental Health Act (the Act). All three records were found to be compliant with the Mental Health Act and Code of Practice and helped uphold the rights of patients and ensure patients were legally detained. Clear reasons were being documented to evidence why detention under the Act was the most appropriate way of providing care for patients.

We saw that statutory reports had been completed when necessary by the Responsible Clinician in line with the Code of Practice before renewing or extending the detention of the patients. The reports were comprehensive and reflected the progress of each patient during their time at the hospital.

We were told that the Mental Health Act Administrator provides Easy Read information to patients on how to apply for a hospital hearing and Mental Health

Review Tribunals. Good support was also available from the local Independent Mental Health Advocacy service to help patients with these applications, and to attend other relevant meetings when patients required help and support.

There was evidence that the mental capacity of each patient had been assessed and clearly documented. All relevant consent to treatment certificates were stored alongside the MAR charts as required. We saw that Second Opinion Appointed Doctor (SOAD) assessments had been sought when patients were deemed not to be able to provide consent.

During the inspection we also looked at the patient records of one individual that was at the hospital under the Deprivation of Liberty Safeguards process. We discovered that the standard authorisation for this patient to be deprived of their liberty at the hospital had expired 10 days prior to our inspection. We queried this with staff, who confirmed that this was the case, and that a new application had been submitted three days after the previous renewal had expired. Staff assured us that all relevant parties, including the patient, had been informed, and that the patient had agreed to stay at the hospital on an informal basis until the application was approved.

While the hospital explained the circumstances around this particular delay, we also found evidence that during the previous year, another standard authorisation for the same patient had expired and was rectified after the event.

The service must implement a better system to monitor standard authorisation renewal dates and ensure renewals are submitted in good time to ensure patients are not deprived of their liberty unlawfully.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision
We have discussed previously in the report that the service must ensure patients have an up-to-date individual and comprehensive care and treatment plan to assist their recovery in line with the Welsh Measure. However, in general, the care and treatment plans we reviewed appropriately set out the range of interventions for patients, including therapeutic and social activities, and listed who was responsible for their delivery.

We saw evidence that the social, cultural and spiritual needs of patients had been considered and that the care and treatment plans identified the strengths of the individuals to help focus on their recovery and independence. We saw written contributions from patients which indicated that patients had been involved in co-producing their care and treatment plan, which was positive. It was also clear that efforts had been made by staff to ensure relatives and family members had also been involved in the care and treatment planning process.

There was evidence of discharge and aftercare planning where applicable and we noted that patients and care co-ordinators had been involved in the process.

Quality of Management and Leadership

Governance and accountability framework
There were processes and systems in place to help the hospital review its services. These included audit activities and monthly clinical governance meetings. However, we were provided with copies of the minutes for previous clinical governance meetings at the hospital and we identified the following concerns:

- The November 2022 and January 2023 meeting minutes had blank attendee lists which meant we were not assured that relevant senior members of staff were in attendance to provide effective scrutiny
- The meeting minutes did not provide evidence of any discussions that had taken place to identify themes arising from incidents, or lessons learned. For example, all three meeting minutes we were provided with did not have any documented actions identified during the meetings.

It was clear from this, and from the improvements we have identified throughout this report, that the governance processes and systems in place at the hospital were not identifying risks and necessary improvements to the service, particularly those in relation to immediate patient safety.

The service must ensure there are more effective and proactive governance arrangements in place to check compliance with relevant regulations and best practice standards and focus on continuously improving the service it provides.

It was positive though that throughout the inspection staff were receptive to our views, findings and recommendations and took them on board. Staff appeared to work well together and were passionate about their roles. The majority of staff members who completed a questionnaire told us that the hospital encouraged teamwork and that they are supported to identify and solve problems. One staff member provided the following positive feedback in the questionnaires:

"New Hall is a good place to work with a very supportive staffing team."

Staff who completed a questionnaire told us that senior managers at the hospital try to involve staff in important decisions. However, some staff members disagreed that senior managers acted on staff feedback. The service should reflect on this finding and ensure staff feedback is actioned where appropriate.

Dealing with concerns and managing incidents
An electronic data management system called RIVO was in place for staff to report, record and investigate incidents at the hospital. During the inspection,

members of the HIW inspection team were provided with access to RIVO. Following a review of RIVO, and from observations made during the inspection, we were not assured that incidents were being effectively investigated, managed and scrutinised to prevent reoccurrence and encourage shared learning. This is because:

- All incidents that had been recorded in RIVO were assigned as 'open', and in some cases the investigation part of the incident reports had not been completed. This meant we could not be assured that each incident had been reviewed by a senior member of staff and actions taken to close each incident
- Incident reports did not contain sufficient information to enable an appropriate review of the incident to take place. For example, the fields 'What actions could have been taken that could have avoided the incident?', 'What worked well?', 'What didn't work well?' and 'Immediate actions taken to prevent reoccurrence' were blank in some incident reports we saw
- The December 2022 clinical governance meeting minutes indicated that some medication errors had occurred at the hospital but had not yet been documented on RIVO in time for a suitable discussion to have taken place on the incidents
- We saw no evidence that a Root Cause Analysis had been undertaken for any of the six medication errors that had occurred at the hospital in 2022.

Furthermore, we were not assured that staff understood their role and responsibilities in relation to ensuring incidents are reported on RIVO to identify lessons learned. On one occasion we were made aware that a staff member had found a screw on the floor of the TV lounge in Glaslyn Ward. We did not get a sense that the seriousness of this was understood, and the incident had not been reported on RIVO by the time the inspection ended.

Our concerns regarding these issues were dealt with under our immediate assurance process. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial actions were taken. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix B.

Workforce planning, training and organisational development
Staffing levels were appropriate to maintain patient safety within the wards at the time of our inspection. The majority of staff who completed a questionnaire felt that there was enough staff for them to do their job properly and that there was an appropriate mix of skills at the hospital.

We saw that suitable processes were in place for senior staff to monitor compliance with mandatory training. The overall rate for staff compliance with mandatory training was 79 per cent. Staff members who completed a questionnaire told us that training helped them do their job more effectively, stay up to date with professional requirements and deliver a better patient experience. However, we did receive the following comments about training from staff in the questionnaires when asked how the setting could improve the service it provides:

> *"Become more efficient with training; often dates are given for one date and not multiple, a time frame should be given and see what suits the people wanting to do the training rather than give a date. Make others aware of training more in advance."*
>
> *"By continuing to train and retrain staff in their areas of specialty and also should a staff want to diversify."*

The service should consider this feedback to identify ways to improve the accessibility of training sessions and types of specialty training available.

It was positive to see that at the time of the inspection, 90 per cent of staff had received their annual appraisal. We saw an example of a clinical supervision template that was available to help staff identify areas of good practice and areas of self-development. The staff we spoke with during the inspection felt this process was useful. However, they reported that clinical supervision sessions are not regular enough and are often cancelled.

The service must ensure all staff receive regular clinical supervision sessions to help their learning and development.

Workforce recruitment and employment practices

A wide range of policies and procedures were available to help staff undertake their duties and responsibilities. We saw evidence that in general, policies were being reviewed and updated regularly. However, paper files of policies that were kept on the wards contained out-of-date policies and did not reflect the latest version that was available online.

The service must ensure the paper file of policies is kept up-to-date at all times.

Appropriate arrangements were in place to ensure recruitment followed an open and fair process. Checks were being undertaken to ensure staff were fit to work at the hospital. These included the provision of two references, evidence of

professional qualifications and a requirement for a recent Disclosure and Barring Service (DBS) certificate.

Newly appointed permanent staff receive a period of induction to learn about the hospital, read company policies and complete mandatory training. Staff are assessed by senior managers to ensure they have demonstrated their competence to do the job in practice.

Staff were able to contact a ‘freedom to speak up’ guardian to raise any issues they had in confidence. All staff who completed a questionnaire said that they would know how to report any concerns about unsafe practice and that they would feel secure raising concerns about patient care or other issues at the hospital.

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
On the first night of the inspection, we were told that a defibrillator was located with the emergency equipment grab bag within the staff office on Glaslyn Ward. However, when we entered the staff office, the defibrillator was not present.	We were not assured that the welfare and safety of patients would be protected in the event of a medical emergency.	We raised this issue with staff immediately during the inspection and asked staff to find the defibrillator.	Staff found the defibrillator in another room down the corridor and it was relocated back to the staff office on Glaslyn Ward.
On the first night of the inspection we were provided with a tour of Glaslyn Ward. In the downstairs TV lounge, we observed that access through both fire doors in the room had been prevented due to the	We were not assured that there was an adequate means of escape in the event of a fire to ensure the welfare and safety of patients.	We instructed the hospital to remove the planks of wood on the morning of 14 March 2023.	On 15 March 2023 we saw evidence that the planks of wood had been removed, and senior staff assured us that the planks would not be re-installed at a later date.

installation of a metal bracket on each door that had planks of wood placed across them. The Senior Healthcare Inspector, and a team leader at the establishment, attempted to remove the planks of wood but were unable to do so. This meant that the fire doors could not be opened.			

Appendix B – Immediate improvement plan

Service: New Hall Independent Hospital

Date of inspection: 13, 14 and 15 March 2023

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

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The registered person is required to provide HIW with a written resuscitation policy that sets out the policies and procedures to be followed in relation to resuscitation and must review such statement annually. This must include: • Information on the required levels of resuscitation training for staff, and required numbers of staff attaining such training, to ensure the welfare and safety of patients in an emergency	15 Quality of treatment and other service provision and 38 Resuscitation	Resuscitation policy is now completed. ILS training is booked for 31/03/2023 for all nurses. A weekly checklist book has been implemented which will be checked by senior nursing staff and managers every Monday morning to ensure this is being completed. Projection in both ward diaries has been completed for the year. Emergency grab bags, Oxygen, Ligature knives have been relocated to both nursing stations on Adferiad (upstairs and downstairs), in reception and in the nursing office upstairs on Glaslyn and in	SW MO/DF/LH/JW LH/JW/CM/GC AB/LH/JW/CM/GC	29/03/2023 31/03/2023 24/03/2023 24/03/2023

• Details of the procedures to be in place to ensure the contents of the emergency equipment grab bags and defibrillators are regularly checked and an accurate record of these checks is maintained. • Details of the locations of the emergency equipment grab bags and defibrillators throughout the hospital to ensure they are available to all staff in an emergency in a timely manner.		the handover room downstairs on Glaslyn ward. Defibrillators are accessible 1 on each ward and 1 in reception.		
The registered person is required to provide HIW with details of the actions taken to ensure ligature cutter sets are available to all staff in an emergency in a timely manner.	15 Quality of treatment and other service provision	Lock boxes now placed in nursing stations on each ward, reception and downstairs handover room on Glaslyn. Access has been circulated to all staff and locations has been included on staff and agency induction checklists.	AB/LH/JW/CM/GC	24/03/2023
The registered person must provide HIW with the new fire risk assessment once completed and ensure adequate means of escape in the event of a fire is provided at all times.	26 Fitness of premises	Fire risk assessment now completed. All local maintenance staff now have to contact GE (H & S Officer for MHC) prior to any repairs to fire doors.	GE/AB	24/03/2023

The registered person must review all incidents that have previously occurred at the hospital and ensure HIW has been notified of all events relating to patient safety. The registered person must also ensure all future incidents relating to patient safety are reported to HIW as required by the regulations.	31 Notification of events	Notifications have now been submitted. The registered manager will ensure that all notifications relating to patient safety, Death, AWOL, Medication errors, Safeguarding, misconduct, serious injuries, infectious outbreaks are made within the recommended timeframes.	LH/JW	18/03/2023
The registered person must provide details to HIW in relation to how improvements will be made to the reporting, recording, investigation and management oversight of all incidents occurring at the hospital. The registered person must also ensure staff are reminded of their responsibilities in relation to ensuring all incidents are reported to help protect the welfare and safety of patients at the hospital.	19 Assessing and monitoring the quality of service provision including annual returns	Detailed communication about completion of RIVO reporting has been sent and will be a standing agenda on the staff meetings. RIVO training sessions will be included in the local induction. RCA's are completed but not always uploaded onto RIVO system, communication has been sent to ensure that this now takes place. Historic RCA's have now been retrospectively added to RIVO. Manager comments and closing incidents and checks to ensure RCA have been uploaded will be carried out weekly. This has now been added to weekly calendar.	LH/JW LH/JW LH/JW LH/JW	18/03/2023 03/04/2023 18/03/2023 24/03/2023

		Lessons learned will be incorporated into Clinical Governance which is available electronically to all staff. In addition the lessons learned will be shared (anonymised) with other MHC services on a monthly basis. HIW notifications tracker now to be embedded into Clinical Governance and shared with staff via e-mail/staff meetings. Morning MDT meetings will now incorporate an incident review system which will identify any risk management concerns, HIW notifications, RCA's or Safeguarding referrals to be made.	LH/JW/DR	28/03/2023 29/03/2023 29/03/2023

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): **Linda Hull**

Job role: **Registered Manager**

Date: **29 March 2023**

Appendix C - Improvement plan

Service: New Hall Independent Hospital

Date of inspection: 13, 14 and 15 March 2023

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The service must liaise with the local GP to ensure all patients receive their annual health checks.	Health promotion, protection and improvement	Requested a face to face appointment with GP and practice manager to discuss contracts. In the interim staff nurses are completing Blood pressure, temperature, pulse, ECG, urine sample and routine bloods.	LH	26/05/2023
The service must ensure staff are undertaking therapeutic observations that help best engage with and support patients at the hospital.	Dignity and respect	Psychologist completing PBS training sessions with all staff. Wards are run in different ways according to patient's needs; Glaslyn is a low stimulus area due to patient needs as patients are noise sensitive. All patients	JH/SB	June 2023

		have scheduled activities, but these are lower stimulus on Glaslyn Ward. Al staff already work across both wards so become familiar with the different routines and individual needs of each patient.		
The service must ensure patients have an up-to-date individual and comprehensive care and treatment plan to assist their recovery in line with the Welsh Measure.	Care planning and provision	Email sent to all external teams regarding care and treatment plans to be completed under Welsh Measures, nursing team liaising with external teams to create the plan and reviewed at MDT.	LH/JW and Nursing team	Completed
The service must review the arrangements in place for the patient requiring a wheelchair to ensure their needs are fully met during meal times.	Equality, diversity and human rights	Rhino dining room table and chairs have been ordered and are due to for delivery in May.	LH	31/05/2023
The service must ensure patients are kept informed of the outcomes of their feedback and any changes or improvements implemented as a result.	Citizen engagement and feedback	Feedback is given by various means. In writing to some patients, in easy read format for some patients and in meetings with a minimum of 2 staff present and then documented	LH	Completed

		for the patient in their preference. Unfortunately, cannot have a “you said, we did” board in patient areas due to patients unable to cope with items on walls and have history of using items like this as a weapon.		
The service must retain a record of formal and informal complaints and issues raised to help identify themes and highlight necessary improvements.	Citizen engagement and feedback	Easy read complaints form to be available on the wards and complaints documented on RIVO. Continuous improvement plan to be updated regarding recent inspections. This is discussed in clinical governance and managers meeting to discuss common themes that may occur in other services.	LH	Completed
The service must ensure there are enough radios available for all staff working at the hospital.	Managing risk and health and safety	Two broken radios have been replaced and guidance sent out to staff team about allocating day/night radios to ensure that radios are charged correctly.	LH/AB	Completed

The service must review the alarm system in place at the hospital to ensure all personal alarms work as required throughout all areas of the setting.	Managing risk and health and safety	Alarms do work in all areas, however staff have been advised to test and report if batteries are required. A list on the TRAKA system is now implemented for maintenance to check alarms that are reported by staff as needing battery replacements.	LH/AB	Completed
The service must ensure upkeep and maintenance of the wards is undertaken to provide a suitable standard of living for patients.	Managing risk and health and safety	Flooring has now been completed.	LH	Completed
The service must ensure that all chairs in the patient areas throughout the hospital that have ripped material must be replaced.	Infection prevention and control (IPC) and decontamination	Chairs have been ordered to replace existing damaged chairs.	LH/JW	Delivery by 31/05/2023
The service must ensure bed pans and blood stains are removed more quickly to protect patients and staff at the hospital from the risk of cross infection and to promote a safe and secure environment.	Infection prevention and control (IPC) and decontamination	Communication sent to all staff to remove bed pans and dispose of these correctly. Domestic team have been advised about stains being removed. Cleaning schedules in place for domestic	LH/JW	Completed

		staff and night-time schedules for staff to complete.		
The service must ensure the opening and use-by dates of food for patients is labelled.	Nutrition	Communication about open and use by dates has been communicated to staff team.	LH/JW	Completed
The service must ensure staff complete the required safety checks as required and improve the governance and oversight of the food management process to ensure they are appropriate and safe.	Nutrition	Catering staff have shared the importance of maintaining paperwork, fridge temperatures and Team Leaders are required to check that these have been completed and feedback to nursing team and management. Day and night schedules in place for staff to follow to know what tasks are needed to be completed.	All staff and team leaders	Completed
The service must take action to address the medicines management issues identified in this report to ensure up-to-date guidance is available and that staff understand where to access the relevant documents.	Medicines management	Medication training has been completed on 31/03/2023. Communications sent to all nursing staff clarifying medication errors and policies. Competency assessments completed with all nurses and supervisions to discuss medication issues.	LH	Completed

The service must ensure that MAR charts are fully completed as required.	Medicines management	Daily checklist with two nurses in place to be completed, importance of this document raised during supervisions and nursing meeting.	LH/JW	Completed
The service must ensure all staff understand the purpose of the daily checklist to ensure it is used effectively as an audit tool.	Medicines management	Daily checklist has been explained to all nursing staff inclusive of agency nurses. importance of this document raised during supervisions and nursing meeting.	LH/JW	Completed
The service must ensure all staff are aware of their responsibilities and duties to report safeguarding concerns and be skilled in recording them on the electronic RIVO incident management system.	Safeguarding children and safeguarding vulnerable adults	RIVO and RCA training has been delivered to all staff. Safeguarding easy read guidance has been circulated to all staff including the new safeguarding referral form and step by step guidance in reporting Safeguarding concerns.	LB	Completed
The service must ensure all staff have easy access to key documentation in relation to the care of patients.	Safe and clinically effective care	All staff have access to patient electronic folders. Agency staff have been given access as well. Allocated time for nurses to	LH/JW	Completed

		complete work and print outs completed.		
The service must review its use of paper files and electronic documents to ensure all contemporaneous information regarding the care of a patient is available to staff in a timely and organised manner.	Records management	A weekly mini case file audit will be completed of each file to ensure that the most current care plans, PBS plans and contemporaneous information is available immediately. All staff have been sent communication that if they amend/update any information this is to be printed and placed in the patients file immediately. Deputy also completing monthly audits on files.	LH/JW/AP	Actioned immediately will remain ongoing
The service must implement a better system to monitor standard authorisation renewal dates and ensure renewals are submitted in good time to ensure patients are not deprived of their liberty unlawfully.	Mental Health Act Monitoring	Mental health act administrator has now added DoLs to his systems. He will oversee the deprivation of liberty safeguards in conjunction with the hospital social worker.	DR/LB	Completed
The service must ensure there are more effective and proactive governance arrangements in place	Governance and accountability framework	The incident review meeting each morning now highlights any incident which requires a HIW	LH/JW	Completed

to check compliance with relevant regulations and best practice standards and focus on continuously improving the service it provides.		notification, safeguarding, an RCA or contact with family, external professionals, manager comments and review of incidents are now uploaded onto RIVO following the morning meeting. RCA information and lessons learned are now included into clinical governance. HIW themes, environmental themes also now in clinical governance.		
The service must ensure all staff receive regular clinical supervision sessions to help their learning and development.	Workforce planning, training and organisational development	Clinical supervision and reflective practice is offered at numerous points throughout the month and this data (sessions offered and sessions accepted) is contained within clinical governance.	SB/JH	Completed
The service must ensure the paper file of policies is kept up-to-date at all times.	Workforce recruitment and employment practices	This has now been allocated to Reception, as a new policy is circulated he will ensure that each ward top 20 policy folder is updated.	TW	Completed

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): Linda Hull

Job role: Registered Manager

Date: 19 May 2023