Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

New Hall Independent Hospital, Mental Health Care (UK)

Inspection date: 13, 14 and 15 March 2023

Publication date: 15 June 2023

This summary document provides an overview of the outcome of the inspection

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Staff were committed to providing safe and effective care. Each ward had a range of facilities to support the provision of therapies and activities. The clinic rooms on each ward were clean and tidy and medication was being stored securely at all times. Staffing levels were appropriate to maintain patient safety within the wards at the time of our inspection.

However, we identified a number of issues relating to immediate patient safety during the inspection. Our concerns were dealt with under our immediate non-compliance process. This required the service to complete an immediate improvement plan telling us about the urgent actions they will take to address the issues identified.

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.

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

What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at 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.

This summary version of the report is designed for members of the public.

A full report, which 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 can be found on our website.

Quality of Patient Experience

Overall Summary

The hospital had good processes in place to help protect and promote the physical health of patients. 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.

Where the service could 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.

What we found this 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 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. 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.

Where the service could 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

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.

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.

Where the service could 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.

Staff told us:

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

We received the following comments 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."

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 appendices of the full inspection report.

When we identify concerns that pose an immediate risk to patient safety we ask the service to undertake urgent action. These concerns are outlined in the appendices and outline the action taken by the service to protect patient safety and approved by us. We also provide a detailed table of improvements identified during the inspection where we require the service to tell us about the actions they are taking to address these areas and improve the quality and safety of healthcare services. In addition, we outline concerns raised and acknowledge those resolved during the inspection.

At the appropriate time HIW asks the service to confirm action has been taken in line with management responses documented in the improvement plan. We also ask services to provide documented evidence of action taken and/or progress made.