Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Heatherwood Court
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Inspection 2010-2011

Healthcare Inspectorate Wales
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18 October 2010	Mr John Powell and two Independent Healthcare Reviewers.

Introduction

Independent healthcare providers in Wales must be registered with Healthcare Inspectorate Wales (HIW). HIW acts as the regulator of healthcare services in Wales on behalf of the Welsh Ministers who, by virtue of the Government of Wales Act 2006, are designated as the registration authority.

To register, they need to demonstrate compliance with the Care Standards Act 2000 and associated regulations. HIW tests providers' compliance by assessing each registered establishment and agency against a set of '*National Minimum Standards',* which were published by the Welsh Assembly Government and set out the minimum standards for different types of independent health services. Further information about the standards and regulations can be found on our website at: **www.hiw.org.uk**

Readers must be aware that this report is intended to reflect the findings of the inspection episode. Readers should not conclude that the circumstances of the service will be the same at all times.

Background and Main Findings

An unannounced inspection was undertaken to Heatherwood Court on 18 October 2010 by an Inspection Manager and two reviewers. The hospital was first registered in December 2007 and is currently registered to provide low secure services for patients with mental disorder who may be detained under the Mental Health Act 1983. The hospital is owned by Ludlow Street Healthcare Ltd.

As part of the inspection process the registered provider submitted a completed a self-assessment form and an extensive range of supporting documentation to demonstrate how they meet the National Minimum Standards for Private and

Voluntary Healthcare Services. The inspection focused upon the analysis of a range of documentation including the examination of patient records and discussion with the chief executive of the organisation, the registered manager, the deputy manager and a range of staff employed at the hospital. In addition, a number of patients were also interviewed and feedback obtained from both patients and staff has been documented within this report.

A number of key areas were considered within the inspection process including; the areas of risk assessments, managing disturbed behaviour, complaints, appropriateness of patients accommodated, catering, environment of care, staffing and internal quality monitoring and governance processes.

In respect of the main inspection findings, the registered provider had in place:

- A comprehensive statement of purpose that detailed the range of services available at the hospital including the treatment and services provided. A patient guide was also available.
- Comprehensive care documentation and risk assessments were routinely undertaken for each patient and a random sample of patient documentation was examined during the visit. Each entry in the patients' notes was dated, timed and signed. However, the Responsible Clinician made entries in their own section of the clinical notes which therefore did not constitute a single multi-disciplinary record that was chronologically ordered to reflect the care given to patients over time. In addition, there was an incident with a patient that was clearly documented in the daily progress notes; however, no care plan had been formulated in response to the incident. Also patient involvement in their care planning process could be improved.

- An initial pre-admission assessment of patients was undertaken, however, more comprehensive multi-disciplinary team pre-admission meetings were being introduced to ensure appropriate admissions were made taking into account patient assessments.
- Managing disturbed behaviour was an ongoing challenge and the registered provider had undertaken a range of actions to help reduce this including audits that identified specific trigger factors.
- A registered nurse competency framework had been introduced and a development framework for care support workers was being introduced at the time of the inspection. In addition, the induction programme was being further developed.
- A registered nurse competency framework had been introduced and a development framework for care support workers was being introduced at the time of the inspection. In addition, the induction programme was being further developed.
- An extensive range of policies and procedures with the date of formulation and review were available, however a significant number of staff had not signed to confirm that they had read and understood a number of key policies including; the Protection of Vulnerable Adults (PoVA), the Care Programme Approach (CPA) and Section 17 leave.
- A staff training programme was in place and this included a range of statutory topics such as fire prevention, first aid, health and safety, manual handling, Protection of Vulnerable Adults (PoVA) and infection control. Other training undertaken included, the Mental Capacity Act, equality and diversity and autism. However, from the information submitted as part of the self assessment process a number of staff had not undertaken training in; child protection, suicide/self harm, personality disorders and the Mental Health Act.
- In terms of activities there were extensive facilities within the hospital including a fully equipped gym, recreational and social area and a small cinema. Occupational Therapists delivered numeracy and literacy courses and a number of patients had received '*Basic Skills'* accreditation. A vocational skills coach and a gym instructor had been appointed. In

addition, there was a programme of activities, however, a number of patients that were spoken to were critical of a lack of activities and planned sessions being cancelled due to a lack of staff. In addition, there was a lack of suitable software to enable all the patients to access the available computer.

- A number of audit reports were available at the establishment and these focused on a number of areas including; serious untoward incidents and the Mental Health Act paperwork. However, a more comprehensive clinical audit programme was required and the Inspection Manager was informed that this was being developed. A comprehensive analysis of patient questionnaires had been undertaken in March 2010; however, the report submitted to HIW lacked an action plan of how the issues identified would be addressed.
- The following observations are made in relation to the environment of care:

  Cardigan - A low secure service for twelve female patients and the environment of care was generally well maintained.

  Caernarvon - A low secure service for twelve male patients, the environment was generally well maintained however, a number of sharp edges were noted on the ends of the radiators. This clearly is a risk and needs to be addressed. In addition, the vision panels in the bedroom doors were left in the open position and this would not preserve the privacy and dignity of patients. Clearly this area would need to be risk assessed; however, it is unacceptable for all of these panels to be left in the open position.

  Caerphilly - A low secure service for twelve female patients, in terms of the garden areas Caerphilly and Caernarvon wards shared a garden area. However, a female patient was in this area and there was no staff members were present and not located in the immediate vicinity. Given that the hospital provides a low secure service this is not appropriate.

  Chepstow – A low secure service for twelve patients of the same gender. In addition, there was no child friendly visiting area available within the hospital.

An additional psychologist had been in post since August 2010 and there was some service development that was required in this area specifically in relation to the multi-disciplinary team. There were two General Practitioner (GP) clinics held at the hospital every week and patients also had access to a private GP.

In relation to staff appointments, on the day of the inspection the inspection team were informed that a major recruitment drive had been undertaken and approximately 15 staff had been appointed. The appointments were for both registered nurses and care staff.

In relation to the area of medicines management a brief overview of the ordering, storage, use and disposal of medicines was undertaken on Caernarvon ward. Unfortunately on Caernarvon ward it was not possible to dispense medication directly to patients. This in practice meant that the registered nurses, who dispensed drugs would have to dispense medication into an appropriate container, lock the medicines cupboard, leave the treatment room and office to dispense medication to patients. This situation is unsatisfactory and requires an urgent review. Controlled drugs were stocked and administered to patients and a signature was obtained when these drugs were administered to a patient. A British National Formulary (BNF) dated September 2010 was available as a relevant reference source. Newly qualified registered nurses undertook a medication administration assessment during their mentorship period. There was a range of comprehensive policies and procedures in relation to the area of medicines management.

Staff performance was not routinely reviewed on an annual basis and there was a lack of staff supervision. The inspection team were informed that this area was being developed and improved. An internal system for auditing recruitment processes had been established by the registered provider.

A patient questionnaire regarding catering had been distributed to patients and feedback was generally positive. However, during the visit and patient interviews there were concerns about a lack of food choice and sandwiches were the only choice for some meals. Issues concerning catering were discussed within patient meetings and a food comments book had been introduced on each of the wards.

Some choice and variety was evident and specific dietary requirements were catered for. In addition, the registered provider had appointed two dieticians to focus upon patients' nutritional assessments, dietary advice and healthier lifestyles. This was a very positive initiative.

The inspection manager would like to thank the patients, registered manager, deputy manager and staff employed at the hospital for their time and co-operation during the unannounced inspection visit.

Achievements and Compliance

Within the previous inspection report eight regulatory requirements had been identified, an action plan had been received and six of the regulatory requirements had been addressed. The two outstanding requirements were in relation to all members of staff must receive training in child protection and the involvement of patients in the care planning process.

In relation to achievements the appointment of two dieticians to focus upon patients' nutritional assessments, dietary advice and healthier lifestyles was very positive and there was a very open culture to ensuring that all incidents at the hospital were reported appropriately.

Registration Types

This registration is granted according to the type of service provided. This report is for the following type of service

Description
Independent hospital service type: **Independent hospitals with overnight beds providing medical treatment for mental health (including patients detained under the Mental Health Act 1983).**

Conditions of Registration

This registration is subject to the following conditions. Each condition is inspected for compliance. The judgement is described as Compliant, Not Compliant or Insufficient Assurance.

Condition number	Condition of Registration	Judgement
1.	Heatherwood Court is registered to provide treatment or nursing (or both) for persons liable to be detained under the provisions of the Mental Health Act 1983. The registered person **must only** accommodate patients who require care and treatment for their mental disorder in a low secure hospital environment.	Compliant
2.	The number of persons accommodated overnight in the establishment at any one time must not exceed 48 (**forty eight**). Only persons aged between 18 (eighteen) and 65 (sixty five) years may be accommodated in the establishment.	Compliant
3	Each 12 bed unit (including its garden area) must be designated solely to accommodate patients of a specific gender. Patients must not be permitted access to accommodation designated solely for use by patients of another gender. Male and female patients must not be permitted to share any other facilities including the communal facilities unless properly supervised by staff at all times.	Compliant
4	The minimum staffing levels for the establishment will be provided as specified in the agreed Statement of Purpose (Version 6.3) dated September 2009 and as updated from time to time. Any changes to the minimum staffing levels must be agreed by Healthcare Inspectorate Wales in writing prior to those changes being introduced.	Compliant

Assessments

Healthcare Inspectorate Wales carries out on site inspections to make assessments of standards. If we identify areas where the provider is not meeting the minimum standards or complying with regulations or we do not have sufficient evidence that the required level of performance is being achieved, the registered person is advised of this through this inspection report. There may also be occasions when more serious or urgent failures are identified and the registered person may additionally have been informed by letter of the findings and action to be taken but those issues will also be reflected in this inspection report. Healthcare Inspectorate Wales makes a judgment about the frequency and need to inspect the establishment based on information received from and about the provider, since the last inspection was carried out. Before undertaking an inspection, Healthcare Inspectorate Wales will consider the information it has about a registered person. This might include: a self-assessment against the standards, the previous inspection report findings and any action plan submitted, provider visits reports, the Statement of Purpose for the establishment or agency and any complaints or concerning information about the registered person and services.

In assessing each standard we use four outcome statements:

Standard met	No shortfalls: achieving the required levels of performance.
Standard almost met	Minor shortfalls: no major deficiencies and required levels of performance seem achievable without extensive extra activity.
Standard not met	Major shortfalls: significant action is needed to achieve the required levels of performance.
Standard not inspected	This is either because the standard was not applicable, or because, following an assessment of the information received from and about the establishment or agency, no risks were identified and therefore it was decided that there was no need for the standard to be further checked at this inspection.

Assessments and Requirements

The assessments are grouped under the following headings and each standard shows its reference number:

- Core Standards
- Service Specific Standards

Standards Abbreviations:

C = Core standards
A = Acute standards
MH = Mental health standards
H = Hospice standards
MC = Maternity standards
TP = Termination of pregnancy standards
P = Prescribed techniques and technology standards
PD = Private doctors' standards

If the registered person has not fully met any of the standards below, at the end of the report, we have set out our findings and what action the registered person must undertake to comply with the specific regulation. Failure to comply with a regulation may be an offence. Readers must be aware that the report is intended to reflect the findings of the inspector at the particular inspection episode. Readers should not conclude that the circumstances of the service will be the same at all times; sometimes services improve and conversely sometimes they deteriorate.

Core Standards

Number	Standard Topic	Assessment
C1	Patients receive clear and accurate information about their treatment.	Standard met
C2	The treatment and care provided are patient-centred.	Standard almost met
C3	Treatment provided to patients is in line with relevant clinical guidelines.	Standard almost met
C4	Patients are assured that monitoring of the quality of treatment and care takes place.	Standard almost met
C5	The terminal care and death of patients is handled appropriately and sensitively.	Standard not inspected
C6	Patients' views are obtained by the establishment and used to inform the provision of treatment and care and prospective patients.	Standard met
C7	Appropriate policies and procedures are in place to help ensure the quality of treatment and services.	Standard almost met
C8	Patients are assured that the establishment or agency is run by a fit person/organisation and that there is a clear line of accountability for the delivery of services.	Standard met
C9	Patients receive care from appropriately recruited, trained and qualified staff.	Standard almost met
C10	Patients receive care from appropriately registered nurses who have the relevant skills knowledge and expertise to deliver patient care safely and effectively.	Standard met
C11	Patients receive treatment from appropriately recruited, trained and qualified practitioners.	Standard not inspected
C12	Patients are treated by healthcare professionals who comply with their professional codes of practice.	Standard not inspected
C13	Patients and personnel are not infected with blood borne viruses.	Standard met
C14	Children receiving treatment are protected effectively from abuse.	Standard not inspected
C15	Adults receiving care are protected effectively from abuse.	Standard met
C16	Patients have access to an effective complaints process.	Standard met
C17	Patients receive appropriate information about how to make a complaint.	Standard met
C18	Staff and personnel have a duty to express concerns about questionable or poor practice.	Standard met
C19	Patients receive treatment in premises that are safe and appropriate for that treatment. Where children are admitted or attend for treatment, it is to a child friendly environment.	Standard met

Number	Standard Topic	Assessment
C20	Patients receive treatment using equipment and supplies that are safe and in good condition.	Standard met
C21	Patients receive appropriate catering services.	Standard met
C22	Patients, staff and anyone visiting the registered premises are assured that all risks connected with the establishment, treatment and services are identified, assessed and managed appropriately.	Standard almost met
C23	The appropriate health and safety measures are in place.	Standard not inspected
C24	Measures are in place to ensure the safe management and secure handling of medicines.	Standard met
C25	Medicines, dressings and medical gases are handled in a safe and secure manner.	Standard met
C26	Controlled drugs are stored, administered and destroyed appropriately.	Standard almost met
C27	The risk of patients, staff and visitors acquiring a hospital acquired infection is minimised.	Standard met
C28	Patients are not treated with contaminated medical devices.	Standard met
C29	Patients are resuscitated appropriately and effectively.	Standard met
C30	Contracts ensure that patients receive goods and services of the appropriate quality.	Standard not inspected
C31	Records are created, maintained and stored to standards which meet legal and regulatory compliance and professional practice recommendations.	Standard met
C32	Patients are assured of appropriately competed health records.	Standard met
C33	Patients are assured that all information is managed within the regulated body to ensure patient confidentiality.	Standard met
C34	Any research conducted in the establishment/agency is carried out with appropriate consent and authorisation from any patients involved, in line with published guidance on the conduct of research projects.	Standard not inspected

Service Specific Standards- these are specific to the type of establishment inspected

Number	Mental Health Hospital Standards	Assessment
M1	Working with the Mental Health National Service Framework.	Standard met
M2	Communication between staff.	Standard met
M3	Patient confidentiality.	Standard met
M4	Clinical audit.	Standard almost met
M5	Staff Numbers and skill mix.	Standard almost met
M6	Staff training.	Standard almost met
M7	Risk assessment and management.	Standard met
M8	Suicide prevention.	Standard met
M9	Resuscitation procedures.	Standard met
M10	Responsibility for pharmaceutical services.	Standard met
M11	The Care Programme Approach/care management.	Standard met
M12	Admission and assessment.	Standard met
M13	Care Programme Approach: care planning and review.	Standard met
M14	Information for patients on their treatment.	Standard almost met
M15	Patients with developmental disabilities.	Standard met
M16	Electro-Convulsive Therapy (ECT).	Standard not inspected
M17	Administration of medicines.	Standard almost met
M18	Self-administration of medicines.	Standard not inspected
M19	Treatment for addictions.	Standard met
M20	Transfer of patients.	Standard not inspected
M21	Patient discharge.	Standard not inspected
M22	Patients' records.	Standard almost met
M23	Empowerment.	Standard met
M24	Arrangements for visiting.	Standard met
M25	Working with carers and family members.	Standard met
M26	Anti-discriminatory practice.	Standard met
M27	Quality of life for patients.	Standard not assessed
M28	Patients' money.	Standard not assessed
M29	Restrictions and security for patients.	Standard met

M30	Levels of observation.	Standard met
M31	Managing disturbed behaviour.	Standard met
M32	Management of serious/untoward incidents.	Standard met
M33	Unexpected patient death.	Standard met
M34	Patients absconding.	Standard met
M35	Patient restraint and physical interventions.	Standard met
M41	Establishments in which treatment is provided for persons liable to be detained – information for staff.	Standard met
M42	The rights of patients under the Mental Health Act.	Standard met
M43	Seclusion of patients.	Standard not inspected
M44	Section 17 leave.	Standard met
M45	Absent without leave under Section 18.	Standard met
M46	Discharge of detained patients.	Standard met
M47	Staff training on the Mental Health Act.	Standard almost met

Schedules of Information

The schedules of information set out the details of what information the registered person must provided, retain or record, in relation to specific records.

Schedule	Detail	Assessment
1	Information to be included in the Statement of Purpose.	Compliant
2	Information required in respect of persons seeking to carry on, manage or work at an establishment.	Complaint
3 (Part I)	Period for which medical records must be retained.	Compliant
3 (Part II)	Record to be maintained for inspection.	Compliant
4 (Part I)	Details to be recorded in respect of patients receiving obstetric services.	Not applicable
4 (Part II)	Details to be recorded in respect of a child born at an independent hospital.	Not applicable

Requirements

The requirements below address any non-compliance with The Private and Voluntary Health Care (Wales) Regulations 2002 that were found as a result of assessing the standards shown in the left column and other information which we have received from and about the provider. Requirements are the responsibility of the *'registered person'* who, as set out in the legislation, may be either the registered provider or registered manager for the establishment or agency. Healthcare Inspectorate Wales will request the registered person to provide an *'action plan'* confirming how they intend to put right the required actions and will, if necessary, take enforcement action to ensure compliance with the regulation shown.

Standard	Regulation	Requirement	Time scale
C2 & M14	15 (1) & (3)	**Findings** Patient involvement in their care planning process was inadequate. **Action Required** The registered person is required to ensure that all patients are enabled to be involved and make decisions about their care plans.	Within two months of receiving this report.
C4 & M4	16 (1)	**Findings** A clinical audit programme was being developed to comply with Commissioning for Quality and Innovation (CQUIN). **Action Required** The registered person is required to ensure that a more comprehensive clinical audit programme was implemented to ensure that the use of comparative information on clinical outcomes, the presentation of performance indicators and the outcome of clinical and nursing audits.	Within three months of receiving this report the clinical audit programme to be fully implemented.

Standard	Regulation	Requirement	Time scale
C9	17 (2) (a)	**Findings** Staff performance was not routinely reviewed on an annual basis and there was a lack of staff supervision. **Action Required** The registered person is required to ensure that the performance of all staff within the establishment is reviewed on an annual basis as a minimum**.**	Within two months of receiving this report a performance management process for all staff to be fully implemented.
C22 & M17	14 (5)	**Findings** Unfortunately on Caernarvon ward, it was not possible to dispense medication directly to patients. This in practice meant that the registered nurses, who dispensed drugs, would dispense medication into an appropriate container, lock the medicines cupboard, and leave the treatment room and office to dispense medication to patients. This situation is unsatisfactory and requires an urgent review. **Action Required** The registered person is required to urgently review the system of administering patient medication to reduce the risks associated with the present system.	An action plan to be received within 28 days of receipt of this report.
C22	15 (1)	**Findings** There was a lack of evidence that the near miss reporting forms were being routinely used. **Action Required** The registered person is required to ensure that the near miss reporting forms were appropriately used.	Immediate and on-going.

Standard	Regulation	Requirement	Time scale
M5, M6 & M47	17 (2) (a)	**Findings** A number of staff had not undertaken training in: child protection, suicide/self harm, personality disorders and the Mental Health Act. **Action Required** The registered person is required to ensure that all staff receive training in: child protection, suicide/self harm, personality disorders and the Mental Health Act.	Within two months of receiving this report.
	24 (2) (b)	**Findings** There was no child friendly visiting area within the establishment. **Action Required** The registered person is required to provide a child friendly visiting area within the establishment.	An action plan of how this area will be addressed to be sent to HIW within 28 days of receiving this report.

Recommendations

Recommendations may relate to aspects of the standards or to national guidance.

They are for registered persons to consider but they are not generally enforced.

Standard	Recommendation
C3	Some areas of clinical practice need further improvement and in response to this area an action plan had been implemented to improve the induction programme and registered nurse framework.
C7	All staff should read the policies and procedures relevant to their area of work and sign a statement to this effect.
C26	It is recommended that a second signature is obtained when giving a patient a schedule three controlled drug.
M22	The Responsible Clinician should make entries in the single multi-disciplinary record that was chronologically ordered to reflect the care given to patients over time.

Healthcare Inspectorate Wales exists to promote improvement in health and healthcare. We have a statutory duty to assess the performance of healthcare organisations for the NHS and coordinate reviews of healthcare by others. In doing so, we aim to reduce the regulatory burden on healthcare organisations and align assessments of the healthcare provided by the NHS and the independent (private and voluntary) sector.