Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

New Hall Independent Hospital
New Hall Road
Ruabon
LL14 6HB

Inspection Report 2010-2011

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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 New Hall Independent Hospital on 11 January 2011 by an inspection manager, one independent healthcare reviewer and one Mental Health Act reviewer. The hospital was first registered in June 1998 and is currently registered to accommodate 37 male patients aged between 18 and 65 years of age with a mental disorder who may be detained under the Mental Health Act 1983.

The accommodation was provided in four separate units:

- Alyn ward provided an open door assessment and treatment service for nine male patients.
- Clwyd ward provided a locked door service for assessment and treatment for eight male patients.
- Glaslyn ward provided low secure accommodation for rehabilitation for 12 males.
- Tryfan ward provided accommodation for six male patients.
- The Annex was a two bedded pre-discharge ward.

New Hall is a large detached property situated in its own grounds, on the outskirts of the village of Johnstown, near Wrexham in northeast Wales. The hospital is owned by Mental Health Care (MHC), a company that provide a range of learning disability and mental health services across North Wales. MHC is a subsidiary of the Castlebeck Group Ltd.

As part of the inspection process the registered provider submitted a comprehensively completed 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 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 used within this report.

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

- A comprehensive statement of purpose and service users' guide. However, patients were not advised about how to make suggestions and comments about the patients' guide.
- A system of care documentation that included; comprehensive admission information, a nursing treatment plan, a clinical risk management assessment and risk management plans. Care plans were in place for the majority of identified needs; however, these were not reviewed in line with the timescales

identified within the care plan documentation. In addition, a care plan on diabetes failed to address the area of foot or optical care and some care plans lacked a *'key workers'* signature. There was also no care plan in place for a patient who had been the subject of restraint. Patients' notes were integrated into a single multi-disciplinary record and in relation to the Mental Health Act 1983 there was evidence, within the patient documentation, that a patient's rights were explained to them on a regular basis.

- An extensive range of policies and procedures with the date of formulation and anticipated review, however not all staff had routinely read the policies and procedures relevant to their area of work and signed a statement to this effect.
- A staff training programme was in place and this covered a range of topics including: diabetes, schizophrenia, addiction, recovery approach, Mental Health Act, supervision, Protection of Vulnerable Adults (PoVA), fire prevention and food hygiene. However, a significant number of staff had not attended training in child protection, personal searches, what constitutes a complaint and the procedures for dealing with complaints. In addition, the majority of staff required up-to-date training in first aid.
- A range of activities/therapies were on offer including; daily living/social skills development, health promotion, relapse prevention, vocational skills, budgeting, art and craft and a number of recreational activities including trips to the local amenities. A number of patients that were spoken with were satisfied with the range of activities and therapies provided at the establishment.
- A number of areas had been subject to audit including: care plans and medication. However, the audit programmes did not include: monitoring of multi-professional working in mental health teams, monitoring multi-professional contributions to clinical records, the extent and quality of direct staff-patient contact, the use of comparative information on clinical outcomes and evaluation against research findings and evidence based practice.

- A patient survey had been undertaken in July 2010 and an analysis of results was available. Following the analysis a number of recommendations had been made, however, there was no confirmation, within the self-assessment documentation, that these recommendations had been addressed.
- There was clear evidence that the management of specific patient conditions took account of the National Institute for Clinical Excellence (NICE) guidelines.

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

- A comprehensive statement of purpose and service users' guide. However, patients were not advised about how to make suggestions and comments about the patients' guide.
- A system of care documentation that included; comprehensive admission information, a nursing treatment plan, a clinical risk management assessment and risk management plans. Care plans were in place for the majority of identified needs; however, these were not reviewed in line with the timescales identified within the care plan documentation. In addition, a care plan on diabetes failed to address the area of foot or optical care and some care plans lacked a *'key workers'* signature. There was also no care plan in place for a patient who had been the subject of restraint. Patients' notes were integrated into a single multi-disciplinary record and in relation to the Mental Health Act 1983 there was evidence, within the patient documentation, that a patient's rights were explained to them on a regular basis.
- An extensive range of policies and procedures with the date of formulation and anticipated review, however not all staff had routinely read the policies and procedures relevant to their area of work and signed a statement to this effect.
- A staff training programme was in place and this covered a range of topics including; diabetes, schizophrenia, addiction, recovery approach, Mental Health Act, supervision, Protection of Vulnerable Adults (PoVA), fire prevention and food hygiene. However, a significant number of staff had not

attended training in child protection, personal searches, what constitutes a complaint and the procedures for dealing with complaints. In addition, the majority of staff required up-to-date training in first aid.

- A range of activities/therapies were on offer including; daily living/social skills development, health promotion, relapse prevention, vocational skills, budgeting, art and craft and a number of recreational activities including trips to the local amenities. A number of patients that were spoken with were satisfied with the range of activities and therapies provided at the establishment.
- A number of areas had been subject to audit including; care plans and medication. However, the audit programmes did not include: monitoring of multi-professional working in mental health teams, monitoring multi-professional contributions to clinical records, the extent and quality of direct staff-patient contact, the use of comparative information on clinical outcomes and evaluation against research findings and evidence based practice.
- A patient survey had been undertaken in July 2010 and an analysis of results was available. Following the analysis a number of recommendations had been made, however, there was no confirmation, within the self-assessment documentation, that these recommendations had been addressed.
- There was clear evidence that the management of specific patient conditions took account of the National Institute for Clinical Excellence (NICE) guidelines.

In respect of the other inspection findings, feedback from patients was very positive in relation to the attitude and support received from the staff group. Patients generally felt that they were treated with respect, courtesy and politeness. Inspectors observed a good rapport between patients and staff.

An advocacy service was available and an advocate visited the hospital twice a week and details of the advocacy service were displayed on the wards. A picture of the *'responsible individual'* was also on display with contact details available for patients, their relatives and staff.

In relation to the area of medicines management a brief overview of the ordering, storage, use and disposal of medicines was undertaken. A policy and procedure in relation to the self-administration of medicines was in place and no *'Controlled Drugs'* were stocked at the establishment. A British National Formulary (BNF) dated September 2010 was available as a relevant reference source. There was a comprehensive range of policies and procedures in relation to the area of medicines management available at the establishment.

The catering service for patients provided three meals a day and choice and variety was evident and specific dietary requirements were catered for. Fruit and hot drinks were available and patients were generally satisfied with the choice, variety and quality of meals provided.

A tour of the environment was undertaken and the following observations are made. On Clwyd ward there was a *'fly lamp'* that had been installed on the wall and this was plugged in via an electrical extension that was not suitable. Alyn ward required general refurbishment and redecoration. In addition, the activity room required complete refurbishment and there were a number of electrical extension leads trailing across the floor. The lounge windows were locked by staff with a key and patients could not independently access fresh air. The registered provider is required to produce an action plan of how these areas will be addressed.

In terms of the cleaning of the establishment, the cleaner informed the inspection team and registered manager that when undertaking wet moping of floors, that a kettle is boiled and tipped into the cleaning bucket for *'hot water.'* This process is completely unsatisfactory and the registered manager informed the inspection manager that it would cease with immediate effect.

A number of patient incident records in relation to restraint were examined and a number of observations were made. There was no timescale identified for the length of the restraint and a diagram to indicate the position of staff during the restraint. The inspection manager was informed that copies of the document were sent to the

Multi-Disciplinary Team to be signed off, however, there was a distinct lack of information available in relation to this process. In addition, there was no care plan for a patient who had been the subject of a number of restraints.

There was no register/record of staff vaccinations maintained at the hospital.

The varying levels of observation for patients were clearly documented and a record maintained.

Within a patient's property documentation, a list of items that were restricted were listed for a patient, however, a number had subsequently been crossed out. It was impossible to ascertain which items had been returned to the patient and a more accurate and robust system must be implemented.

The establishment practically struggled to implement the policy on the creation, maintenance and storage of records due to inadequate storage facilities and an effective corporate system to record and track information. In terms of consent there was no form in place for a patient to give or refuse consent for sending details of the treatment provided to their GP.

The inspection manager would like to thank the registered manager, head of nursing, staff and patients for their time and co-operation during the inspection visit.

Achievements and Compliance

Within the previous inspection report three regulatory requirements had been identified, an action plan had been received by HIW and all of the regulatory requirements had been addressed.

In relation to achievements a specialist in the treatment of addictions had been appointed and visited New Hall for one day a week. This specialist facilitated group and individual patient therapy programmes.

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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 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.

Condition number	Condition of Registration	Judgement
1.	The number of persons accommodated in the establishment at any one time must not exceed 37 (**thirty seven**) persons as specified below: a) Glaslyn Ward - Low secure - 12 beds. b) Clwyd Ward - Intensive Nursing Support Unit - nine beds. c) Alyn Ward - Open Rehabilitation Unit - nine beds. d) Tryfan Ward - Intensive Rehabilitation Unit - six beds. e) Bungalow - Pre Discharge Unit - two beds.	Compliant
2.	The registered person is **registered only**: a) To provide (subject to condition 4) below psychiatric treatment intended to rehabilitate males between the ages of 18 (eighteen) and 65 (sixty-five) years with a mental disorder. Within a) above to accommodate persons who may be liable to be detained under the Mental Health Act 1983.	Compliant

Condition number	Condition of Registration	Judgement
3.	The registered person **must not admit** the following categories of patient: a) Persons who do not have a primary diagnosis of mental disorder. b) Persons diagnosed with a learning disability. c) Persons in an acute, disturbed phase of their mental disorder. d) Persons who require care and treatment in conditions of medium or high security. e) Persons with a primary diagnosis of brain injury or drug or alcohol abuse and who are undergoing a detoxification programme. f) Persons with a terminal illness requiring specialist palliative care.	Compliant
4.	The **minimum staffing levels** for the establishment will be provided as specified in the agreed Statement of Purpose dated 23 August 2010 and as updated from time to time. Additional staffing must be provided as required to meet the needs of patients accommodated at New Hall. Any changes to the minimum staffing levels must be agreed by Healthcare Inspectorate Wales in writing, 28 days prior to those changes being introduced.	Compliant
5.	The Registered Manager must ensure that there is a suitably qualified experienced senior, Registered Nurse - Mental Health (Nursing and Midwifery Council Register), appointed to the position of lead nurse/clinician.	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 almost 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 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 met
C6	Patients' views are obtained by the establishment and used to inform the provision of treatment and care and prospective patients.	Standard almost 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 not inspected
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 not 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 almost 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 almost met
C20	Patients receive treatment using equipment and supplies that are safe and in good condition.	Standard met

Number	Standard Topic	Assessment
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 not inspected
C27	The risk of patients, staff and visitors acquiring a hospital acquired infection is minimised.	Standard almost met
C28	Patients are not treated with contaminated medical devices.	Standard met
C29	Patients are resuscitated appropriately and effectively.	Standard almost met
C30	Contracts ensure that patients receive goods and services of the appropriate quality.	Standard met
C31	Records are created, maintained and stored to standards which meet legal and regulatory compliance and professional practice recommendations.	Standard not met
C32	Patients are assured of appropriately competed health records.	Standard not 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 met
M6	Staff training.	Standard almost met
M7	Risk assessment and management.	Standard met
M8	Suicide prevention.	Standard not inspected
M9	Resuscitation procedures.	Standard almost met
M10	Responsibility for pharmaceutical services.	Standard not inspected
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 not inspected
M15	Patients with developmental disabilities.	Standard not inspected
M16	Electro-Convulsive Therapy (ECT).	Standard not inspected
M17	Administration of medicines.	Standard met
M18	Self-administration of medicines.	Standard met
M19	Treatment for addictions.	Standard met
M20	Transfer of patients.	Standard met
M21	Patient discharge.	Standard not inspected
M22	Patients' records.	Standard 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 met
M28	Patients' money.	Standard not inspected
M29	Restrictions and security for patients.	Standard met
M30	Levels of observation.	Standard met
M31	Managing disturbed behaviour.	Standard met

Number	Mental Health Hospital Standards	Assessment
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 almost met
M41	Establishments in which treatment is provided for persons liable to be detained - information for staff.	Standard almost 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 not inspected
M47	Staff training on the Mental Health Act.	Standard 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.	Met
2	Information required in respect of persons seeking to carry on, manage or work at an establishment.	Met
3 (Part I)	Period for which medical records must be retained.	Met
3 (Part II)	Record to be maintained for inspection.	Met
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	15 (1)	**Findings** Some care plans were not reviewed in line with the timescales identified within the care plan documentation. In addition, a care plan on diabetes failed to address the area of foot or optical care and some care plans lacked a *'key workers'* signature. There was also no care plan in place for a patient who had been the subject of restraint. **Action Required** The registered person is required to ensure that all care plans are reviewed in line with identified timescales and that they address all the relevant areas. In addition, a care plan must be in place for all patients subject to any form of restraint.	Immediate and on-going.
C4 & M4	16 (1)	**Findings** The audit programmes did not include; monitoring of multi-professional working in mental health teams, monitoring multi-professional contributions to clinical records, the extent and quality of direct staff-patient contact, the use of comparative information on clinical outcomes and evaluation against research findings and evidence based practice. **Action Required** The registered person is required to ensure that the audit programme includes monitoring of multi-professional working in mental health teams, monitoring multi-professional contributions to clinical records, the	Within three months of receiving this report the clinical audit programme to be fully implemented.

Standard	Regulation	Requirement	Time scale
		extent and quality of direct staff-patient contact, the use of comparative information on clinical outcomes and evaluation against research findings and evidence based practice.	
C16, C29, M6 & M9	17 (2) (a)	**Findings** A significant number of staff had not attended training in personal searches, child protection, what constitutes a complaint and the procedures for dealing with complaints. In addition, the majority of staff required up-to-date training in first aid. **Action Required** The registered person is required to ensure that all staff receive training in personal searches, child protection, what constitutes a complaint, the procedures for dealing with complaints and up-to-date training in first aid.	Within 28 days of receiving this report.
C19	24 (2) (a)	**Findings** On Clwyd ward there was a *'fly lamp'* that had been installed on the wall and this was plugged in via an electrical extension that was not suitable. Alyn ward required general refurbishment and redecoration. In addition, the activity room required complete refurbishment and there were a number of electrical extension leads trailing across the floor. The lounge windows were locked by staff with a key and patients could not independently access fresh air. The registered provider is required to produce an action plan of how these areas will be addressed. **Action Required** The registered person is required to produce an action plan of how the above areas are to be addressed, identifying appropriate timescales.	Within 28 days of receiving this report.

Standard	Regulation	Requirement	Time scale
C22 & C27	14 (6) 24 (2) (d)	**Findings** The cleaner informed the inspection team and registered manager that when undertaking wet moping of floors, a kettle was boiled and tipped into the cleaning bucket for *'hot water.'* **Action Required** The registered person is required to ensure that the above practice does not take place at the establishment.	Immediate and on-going.
C31 & C32	8 (1) (f)	**Findings** The establishment practically struggled to implement the policy on the creation, maintenance and storage of records due to inadequate storage facilities and an effective corporate system to record and track information. In terms of consent there was no form in place for a patient to give or refuse consent for sending details of the treatment provided to their GP. **Action Required** The registered person is required to ensure adequate storage facilities and to implement a system to record and track information. In addition a system for a patient to give or refuse consent for sending details of the treatment provided to their GP must be developed.	Within 28 days of receiving this report.
M35	15 (1)	**Findings** A number of patient incident records in relation to restraint were examined and a number of observations were made. There was no timescale identified for the length of the restraint and a diagram to indicate the position of staff during the restraint.	Immediate and on-going.

Standard	Regulation	Requirement	Time scale
		Action Required The registered person is required to ensure that records of restraints specify the length of the restraint and identify the staff involved and their position during the restraint process.	

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	Recommendations
C1	Patients should be advised about how to make suggestions and comments about the patients' guide.
C6	Following the patient survey in July 2010 a number of recommendations had been made; the registered provider should confirm to HIW that these recommendations have been addressed.
C7	All staff should routinely read the policies and procedures relevant to their area of work and sign a statement to this effect.
C13	The establishment should keep vaccination records for all health care workers.