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29 July 2014

Dear Mr Bartley,

**Re: Visit undertaken to Heatherwood Court on the 8<sup>th</sup>, 9<sup>th</sup> and 10<sup>th</sup> July 2014**

As you are aware Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to Heatherwood Court independent hospital on the 8<sup>th</sup>, 9<sup>th</sup> and 10<sup>th</sup> July 2014. Our visit highlighted areas that are noteworthy and include:

- The good rapport observed between staff and patients during our visit.
- Challenging behaviour was observed to be well managed by staff.
- A range of mandatory training had been attended by staff and 100% of staff had attended restraint training.
- A good programme of monthly dialectical behaviour therapy (DBT)<sup>1</sup> training.
- Wards were observed to be clean with a good standard of decoration throughout the hospital.
- A range of patient information was available at ward level.

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<sup>1</sup> Dialectical behaviour therapy (DBT) is a psychological therapy for people with borderline personality disorder (BPD), especially those with self-harming behaviour or suicidal thoughts.

- Clear evidence of multi disciplinary team (MDT) input into the care planning process.
- The Hub<sup>2</sup> remains a very positive initiative and the beginnings of an enterprise philosophy was pleasing to note.

Our visit also highlighted a number of issues. We provided a verbal overview of our concerns to your registered manager at the end of our visit on 10<sup>th</sup> July 2014. A summary of these, which include regulatory breaches is set out below:

Issue of concern	Regulation
<p>1. A sample of 3 sets of patient care plans were examined and the following observations were made:</p> <ul style="list-style-type: none"> <li>a. Patient A on Caernarvon ward had a care plan on weight management which did not mention the patient being weighed and therefore the effectiveness of the plan could not be adequately monitored.</li> <li>b. Absconding information was not fully completed for patient A.</li> <li>c. There was a lack of patient signatures and information in the 'record of discussion with client' for patient A.</li> <li>d. The levels of observation care plan for A was not sufficiently robust/specific and the 1:1 observations were not adequately defined within the document.</li> <li>e. The ligaturing care plan for patient A was not sufficiently detailed.</li> <li>f. The care plan for patient A on verbal aggression towards peers lacked the detailing of trigger factors and sufficient detail for dealing with the behaviours.</li> <li>g. There was a lack of evidence of reviews taking place for patient A.</li> <li>h. There was a lack of documented evidence of patient involvement in the care planning process for patient B on Caernarvon ward.</li> <li>i. For patient C (Cardigan ward) their risk assessment/management plan on 'non compliance with medication' stated a care plan was needed, but there was no care plan on this area available and the patient had been refusing medication.</li> </ul> <p>The areas identified must to be addressed.</p>	<p>Regulation 15 (1) (a) (b) &amp; (c)</p>

<sup>2</sup> The Hub is the activity/vocational skills centre.

<p>2. A review of the treatment room/clinic on Cardigan ward was undertaken and the following issues were identified:</p> <ol style="list-style-type: none"> <li>a. The controlled drug book stated that Tramadol was not a controlled drug. This is incorrect.</li> <li>b. The controlled drug book had numerous alterations/crossing out of dates and writing over other entries. This made it difficult to ascertain what had happened.</li> <li>c. There was no quantity listed in the quantity received column entitled receipt of drugs when drugs had been received.</li> <li>d. Medication was signed for prior to administration (see page 11 of the controlled drugs book) cancelled was written in when in fact the drug was not administered.</li> <li>e. Xylopect ointment for patient D was not in stock and had never been administered.</li> <li>f. For patient D, there was no maximum dosage for as when required (PRN) Ibuprofen.</li> <li>g. Patient E was prescribed Daktacort cream for an abdominal skin flap but no staff knew anything about this and there was no mention of this in any care plan.</li> <li>h. There was no evidence of appropriate action taken following some of Ashton's pharmacy audits.</li> </ol> <p>The above areas identified must be addressed.</p>	<p>Regulation 15 (5) (a) &amp; (b)</p>
<p>3. A comprehensive review of ward based activities is required. During our visit there were insufficient ward based activities observed and patients complained about the lack of meaningful activities on the wards.</p>	<p>Regulation 15 (1) (a) (b) &amp; (c)</p>
<p>4. A number of patients from Caernarvon, Cardigan and Caerphilly wards complained of a lack of psychological sessions or in some circumstances reduced sessions. Psychology sessions must be adhered too, and in extreme circumstances where rescheduling is required communication with the patient must be undertaken.</p>	<p>Regulation 20 (1) (a)</p>
<p>5. Educational opportunities must be promoted. There was a lack of educational opportunities for patients and there were many patients who would benefit from an educational programme.</p>	<p>Regulation 20 (1) (a)</p>

<p>6. Feedback from newly registered nurses indicated that they felt under supported in their role. A review of the system of perceptorship must be undertaken.</p>	<p>Regulation 20 (1) (a) &amp; (2) (a)</p>
<p>7. A review of day space on Cardigan and Caerphilly wards is urgently required, with a view to increasing the amount of day space/rooms available for patients.</p>	<p>Regulation 26 (2) (c)</p>
<p>8. A review of complaints was undertaken and the following observations were made:</p> <ul style="list-style-type: none"> <li>a. There was a lack of a timely acknowledgement letter issued to complainants and some complaints had no acknowledgement letter on file.</li> <li>b. Complaint reference 31/2014, made in April 2014 had no outcome on the file or complaint log and there was no evidence to the complainant as to the cause of the delay.</li> <li>c. There was no evidence of any lessons learnt.</li> <li>d. Some complaint forms had not been fully completed with outcomes.</li> </ul> <p>A review of the handling of complaints must be undertaken.</p>	<p>Regulation 24 (2) &amp; (5)</p>
<p>9. There was a lack of evidence of a supervision system for medical staff. A robust system of supervision for medical staff must be implemented.</p>	<p>Regulation 20 (2) (a)</p>
<p>10. A review of ward management arrangements is required specifically for the manager managing two challenging wards.</p>	<p>Regulation 20 (1) (a) &amp; (b)</p>

### **Mental Health Act Monitoring – The Administration of the Act**

We reviewed the statutory detention documents of 6 of the detained patients being cared for on 3 of the wards at the time of our visit. The following points were identified and needs to be included in your action plan:

- 11. There was no evidence of medical scrutiny by medical professionals in relation to the Mental Health Act (MHA) 1983. Evidence of medical scrutiny must be available.
- 12. The rights of patients to access Independent Mental Health Advocacy (IMHA) services were not recorded.

13. The record of assessment of capacity for patients D and F, Cardigan ward by the new Responsible Clinician (RC) was not available. This must be completed immediately.
14. Contact numbers of IMHA services to be available for patients, as some posters were not seen with this information.

You are required to submit a detailed action plan to HIW by **19<sup>th</sup> August 2014** setting out the action you have already taken as well as that which you intend to take to address each of the above issues. The action plan should set out timescales and details of who will be responsible for taking the action forward. When the plan has been agreed by HIW as being appropriate you will be required to provide monthly progress updates.

On receipt of this letter you are required to comment on the factual accuracy of the issues detailed and on receipt of your action plan, a copy of this management letter, accompanied by your action plan will be published on our website.

We may undertake a further visit to ensure that the above issues have been properly addressed and we will undertake more frequent visits if we have concerns that necessary action is not being taken forward in a timely manner.

Please do not hesitate to contact me should you wish to discuss the content of this letter.

A copy of this letter is being sent to Mr Carwyn Price, Registered Manager at Heatherwood Court hospital.

Yours sincerely



**Mr John Powell**  
Head of Regulation

cc Mr Carwyn Price, Heatherwood Court, Llantrisant Road, Penycoedcae,  
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