Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection (Unannounced)

Ludlow Street Healthcare

Heatherwood Court

Caernarvon, Caerphilly, Cardigan & Chepstow Units

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

- Patient-centred: we place patients, service users and public experience at the heart of what we do
- Integrity: we are open and honest in the way we operate
- Independent: we act and make objective judgements based on what we see
- Collaborative: we build effective partnerships internally and externally
- Professional: we act efficiently, effectively and proportionately in our approach.

Our priorities

Through our work we aim to:

Provide assurance:	Provide an independent view on the quality of care.
Promote improvement:	Encourage improvement through reporting and sharing of good practice.
Influence policy and standards:	Use what we find to influence policy, standards and practice.

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection of Heatherwood Court on the evening of 30 October and following days of 31 October and 1 November 2017. The following sites and wards were visited during this inspection:

- Caernarvon Unit - 11 bed locked rehabilitation (female)
- Caerphilly Unit - 12 bed low secure (female)
- Cardigan Unit - 12 bed low secure (female)
- Chepstow Unit - 12 bed low secure (male)

Our team, for the inspection comprised of one HIW inspector, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one lay reviewer. The inspection was led by a HIW inspection manager.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with Act.

HIW explored how the service complied with the Care Standards Act 2000, requirements of the Independent Health Care (Wales) Regulations 2011 and met the National Minimum Standards (NMS) for Independent Health Care Services in Wales. Where appropriate, HIW also consider how services comply with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Further details about how we conduct independent mental health service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, we found evidence that the service provided safe and effective care. However, we found improvements were required in medicine management and monitoring the use of the Mental Health Act.

This is what we found the service did well:

- Provided very good range of activities and therapies for patients at the hospital and in the community
- Ward staff and senior management interacted and engaged with patients respectfully
- Focused on least restrictive care to aid recovery and supported patients to maintain and develop skills
- Completed Care and Treatment Plans reflected the domains of the Welsh Measure and were comprehensively written

This is what we recommend the service could improve:

- Practices around the management of medicines
- Monitoring the use of the Mental Health Act
- Improvement in the provision of Personal Protective Equipment
- Consistency in the provision of information for patients.

We identified regulatory breaches during this inspection regarding Medicine Management. Further details can be found in Appendix B. Whilst this has not resulted in the issue of a non compliance notice, there is an expectation that the registered provider takes meaningful action to address these matters, as a failure to do so could result in non-compliance with regulations.

3. What we found

Background of the service

Heatherwood Court is registered to provide an independent mental health hospital at Heatherwood Court, Llantristant Road, Pontypridd, CF37 1PL.

The setting is a mixed gender hospital with gender specific units. The service is registered to not exceed 47 patients and aged between 18 and 64 years; at the time of inspection there were 44 patients.

The service was first registered in December 2007.

The service employs a staff team which includes the Registered Manager, and Hospital General Manager. The multi-disciplinary team includes:

- The Medical Director, a Consultant Psychiatrist and Associate Specialist
- Clinical Lead Manager, four Unit Managers and teams of registered nurses and support workers
- Lead Psychologist, two Clinical Psychologists, a Forensic Psychologist, a Psychological Practitioner, four Psychology Recovery Workers
- Head of Therapies, Senior Occupational Therapist, Occupational Therapist, Occupational Therapy Technician, three Life Skills Coaches and a Health & Wellbeing Coach.

The team could also access Physiotherapy, Dietician and Speech and Language Therapy.

The operation of the hospital was supported by dedicated teams of administration, secretary, estates, housekeeping and catering staff.

Quality of patient experience

We spoke with patients,, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Generally we observed that ward staff, senior management and auxiliary staff interacted and engaged with patients appropriately and treated patients with dignity and respect.

Patients were provided with a range of up-to-date information to enable them to make choices regarding their care, treatment and wellbeing. However, the information was not consistently available across the hospital.

The hospital provided patients with health promotion, protection and improvement opportunities that were supported by a good range of hospital facilities. These provided patients with integrated programmes and a range of activities that supported patients to maintain and develop skills to benefit patient experience within the hospital and following discharge.

We spoke with patients across all four units of Heatherwood Court during the inspection. On the whole patients made positive comments about the care that they received and told us that they were treated with respect.

Health promotion, protection and improvement

There was a range of health promotion, protection and improvement information and initiatives available to the patients at the hospital which assisted in maintaining and improving patients' wellbeing. This included information on healthy eating, smoking cessation and personal hygiene. However, this information was not consistently displayed across all four units, with information omitted in some areas.

Staff completed health promotion checks on patient admission, however reviewing documentation on Cardigan Unit it was noted that these were not always completed.

It was noted that for patients with a learning disability diagnosis Hospital Passports[1] were not in place in the event of admission to general hospital. Senior managers confirmed that the situation would be resolved to ensure that all applicable patients have an up-to-date Hospital Passport.

Improvement needed

The registered provider must ensure that information for patients is consistently displayed across all four units.

The registered provider must ensure that staff complete health promotion checks promptly.

The registered provider must ensure that all applicable patients have an up-to-date Hospital Passport.

Dignity and respect

On the whole we observed that ward staff, senior management and auxiliary staff interacted and engaged with patients appropriately and treated patients with dignity and respect. Generally staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients.

We heard staff speaking with patients in calm tones throughout our inspection. We observed staff being respectful toward patients including prompt and appropriate interaction in an attempt to prevent patient behaviours escalating. When patients approached staff members, they were met with polite and responsive caring attitudes.

However, it was disappointing to observe that on two separate occasions during the inspection we noted groups of staff on Cardigan and Caernarvon together

[1] Hospital Passport is a document which contains important information about someone with a learning disability and provides hospital staff with important information about them and their health when they are admitted to hospital.

and not engaging with patients on the ward. Staff were engaged in conversations between themselves and dispersed upon noticing a member of our inspection team within the area. Whilst we acknowledge that staff are required to talk to each other during their shift it was apparent that on these two occasions the staff were socialising between themselves and not attempting to engage with patients on the unit.

Hospital policies and the staff practices observed contributed to maintaining patients' dignity and enhancing individualised care at the hospital. There were meetings to review and discuss practices to minimise the restrictions on patients at Heatherwood Court based on individual patient's risks.

The hospital has four gender specific units with each patient having their own bedroom which patients could access throughout the day. The bedrooms provided patients with a good standard of privacy and dignity. Patients were able to lock their bedroom doors to prevent other patients entering; staff could override the locks if required.

We observed a number of bedrooms and it was evident that patients were able to personalise their rooms. Patients had sufficient storage for their possessions within their rooms. Any items that were considered a risk to patient safety, such as razors, aerosols, etc. were stored securely and orderly on each of the wards which patients would request access to.

Bedroom doors had viewing panels so that staff could undertake observation without opening the door and potentially disturbing the patient. It was positive to note that viewing panels were in the closed position and opened to undertake observations and then returned to the closed position. This helped maintain patients' privacy and dignity.

Bedrooms were not en-suite however there were sufficient toilets and showers available on both floors of each unit. However during the first evening of our inspection there was a strong unpleasant odour within the downstairs shower room on Chepstow Unit. Patients and staff confirmed that this was a regular occurrence and the issue had not been resolved.

Each ward had suitable rooms for patients to meet ward staff and other healthcare professionals in private. There was also a visiting room, in the hospital reception area, available for patients to meet with visitors, including younger family members. However, whilst the Visitors' Room had a small selection of books and toys for younger children it could be developed further to be more welcoming for children.

There were suitable arrangements for telephone access on each of the ward so that patients were able to make and receive calls in private.

Improvement needed

The registered provider must ensure that shower facilities are maintained free from unpleasant odours.

The registered provider must consider improvements to make the Visitors' Room more welcoming for children.

Patient information and consent

There was a range of up-to-date information available within the hospital. Notice boards on the wards provided detailed and relevant information for patients.

The information on display included patient activities, statutory information, information on the Mental Health Act and advocacy provision, how to raise a complaint and information on Healthcare Inspectorate Wales.

However, we saw some inconsistency of the information displayed on noticeboards, some areas required attention to ensure that the information was consistently displayed for patients on all four units.

We were informed that as part of the regular bronze on-call audit[2] information displayed for patients was checked to ensure that it was maintained and available for patients.

There was also a lack of information in the medium of Welsh. During the inspection feedback senior managers confirmed that they would review the provision of information to ensure notices displayed that information was also available in Welsh.

[2] At three times per week the Bronze on-call member would attend the hospital to undertake an audit of the hospital out-of-hours.

Improvement needed

The registered provider must ensure that patient information is available in Welsh.

Communicating effectively

Through our observations of staff-patient interactions, it was evident that staff ensured that they communicated appropriately and effectively with patients. Staff took time to undertake discussions using words and language suitable to the individual patient. Where patients remained unclear, or what they were trying to communicate was misunderstood, staff would patiently attempt to clarify what they had said.

Each unit had daily planning meetings every morning to arrange the activities, within the hospital and the community, alongside other activities and meetings, such as care planning meetings, tribunals, medical appointments, etc.

Each unit had a weekly meeting where patients had the opportunity to provide feedback on the care that they receive at the hospital and discuss any developments or concerns. Patients on Caerphilly were complimentary about their weekly meeting stating that they received regular feedback on the issues that they raise. However, from the patients we spoke with on other wards, this was not the case. The registered provider should review the structure and content of the weekly meeting on each unit to ensure that patients received feedback on any issues that they raise.

The hospital also held a 4Wardz monthly meeting where patient representatives from each of the units could meet with senior managers of the hospital to discus the operation of the hospital and raise any areas of concern.

For individual meetings, patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. With patients' agreement, their families and carers were also included in some meetings.

Improvement needed

The registered provider must ensure that patients on all wards receive regular feedback on the issues that they raise.

Care planning and provision

There was a clear focus on rehabilitation with individualised patient care that was supported by least restrictive practices, both in care planning and ward or hospital practices.

Each patient had their own individual weekly activity planner, this included individual and group sessions, based within the hospital and the community (when required authorisation was in place).

The hospital had a wide range of well maintained facilities to support the provision of therapies and activities. The occupational therapy team undertook assessments that assessed patients' abilities and what therapies, support and activities would be beneficial to assist the patient's recovery.

Life skills coaches facilitated activities for patients and a Health and Wellbeing Coach provided patients with tailored exercise activities appropriate to the patient's interest and capability.

There was a designated therapy and activity unit at the hospital referred to as The Hub. The Hub facilities included the Social Hub with a café and shop which were both operated by a selection of patients. There was a games room with a pool table, tennis table and darts board. There was a woodwork room and an area for learning bike maintenance skills. There was a well equipped gym with a mix of cardio-equipment and multi-gym machines.

The Hub had a therapy kitchen with three areas for learning and practicing cooking skills. There was also a bedsit room in which patients could learn and practice daily living skills that would be beneficial for more independent living. There were a number of other rooms including the multi-faith room, art room, two therapy rooms, an education room and computer room.

Patients were able to access a range of accredited education programmes whilst at Heatherwood Court. Staff gave specific examples of supporting patients with education during their time at the hospital.

Equality, diversity and human rights

Staff practices aligned to established hospital policies and systems ensured that the patients' equality, diversity and rights were maintained.

Citizen engagement and feedback

There were regular patient meetings to allow for patients to provide feedback on the provision of care at the hospital.

There was a complaints policy and procedures in place at Heatherwood Court. The policy provides a structure for dealing with all patients' complaints for services within the hospital.

Information was also available to inform relatives and carers, including on how to provide feedback, was available in the hospital reception. However, the information available in the Visitors' Room was limited at the time of the inspection. We were informed that the information is regularly stocked and during the feedback the registered provider agreed that a regular audit would commence to ensure that sufficient information is available in the Visitors' Room.

Improvement needed

The registered provider must ensure that information is maintained and readily available in the Visitors' Room

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

The hospital environment was well maintained and equipped with suitable furniture, fixtures and fittings for the patient group.

Recent improvements to processes and audits in place to manage risk have assisted staff in providing safe and clinically effective care. However, the governance and staff practice around medicine management and monitoring the Mental Health Act require improvement

Care was provided to patients with the least restrictive philosophy of care at the forefront of staff's actions which was detailed within patient records.

Patients' Care and Treatment Plans reflected the domains of the Welsh Measure.

Managing risk and health and safety

The hospital provided individualised patient care that was supported by least restrictive practices, both in care planning and hospital or ward practices. This included individual patient Safety Support Plans which were developed with the psychology members along with individual patients.

There were processes in place to manage and review risks and maintain health and safety at the hospital, however there were inconsistencies in application across the hospital.

During our focused inspection in September 2017 we had significant concerns with regards to the practice of undertaking observations on patients when they were in their bedrooms. During the focused inspection we observed some staff only making verbal communication with the patient and failing to observe the patient to ensure that they were safe and not attempting to self-harm.

It was positive to note that since the focused inspection the registered provider had developed a training programme regarding completing patient observations

which all staff, permanent, bank and agency, were completing. This training was required to be completed prior to any new staff commencing a shift at the hospital and being monitored by the registered provider. During our inspection we observed one member of agency staff completing the training on induction to the hospital prior to commencing their shift. However, we also observed that one agency staff member was not shown the training video that was required to be watched as part of their training and induction; this member of staff was required to undertake observations as part of their shift. We informed senior managers to ensure that the situation was rectified and inform them that the correct procedures had not been completed.

We also identified during our focused inspection that not all bedroom nurse call buttons were in reach from the patient bed. This meant if a patient was unable to move from their bed they would have great difficulty in summoning assistance if required. During this inspection it was confirmed that work had been completed to ensure all nurse call buttons were in reach of the bed. The registered provider had adapted the bronze on-call audit to include the check that beds remained located in reach of the nurse call to prevent the issue re-emerging.

Staff wore personal alarms which they could use to call for assistance if required; these were allocated to staff when they entered the hospital. There were also nurse call points in communal areas as well as patient bedrooms.

Overall, the hospital was well maintained which upheld the safety of patients, staff and visitors. Staff were able to report environmental issues to the hospital estate team who maintained a log of issues and work required and completed. In addition, senior managers undertook regular audits of the hospital to review the environment.

However, during the first evening of our inspection it was identified that the electronic door fob lock to access the stairwell from the first flow of Chepstow Unit was intermittently working. The on-call manager escorting us around the hospital that evening raised a maintenance requisition and this issue was rectified during the inspection.

We were informed that the promptness to resolve this issue was typical and that the hospital estates team were responsive with quick referrals to contractors when required. Throughout the inspection, we saw the estates team responding and undertaking maintenance work to rectify environmental issues.

The furniture, fixtures and fittings at the hospital were appropriate for the patient group. There were up-to-date ligature point risk assessments in place. These

identified potential ligature points and what action had been taken to remove or manage these.

The nursing office windows on Cardigan and Caerphilly units were mostly covered by paper. Whilst this was information displayed for the benefit of patients, it minimised the observation out of the nurse office and on Caerphilly obscured the view of the observation mirror.

The hospital maintained a Daily Disposition Record which highlighted concerns and risks to the next shift. Staff confirmed that there was a process in place where they were able to increase enhanced observations if required, and where applicable increase staffing numbers to facilitate this.

The hospital used the Safewards initiative which assists staff in reducing the risk and occurrence of challenging behaviours through evidenced based practices. This helped maintain the safety of patients, staff and visitors.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the system that included the names of patient(s) and staff involved, a description, location, time and length of the incident. Any use of restraint was documented, including who was involved and the body positions of each person involved in the restraint.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner by a member of the clinical team involved in the individual patient's care and an employee responsible for hospital health and safety.

Regular incident reports were produced and reviewed at hospital and organisation level so that the occurrence of incidents could be reviewed and analysed. Additional reports could be produced as required to look at specific areas as required. The incident reporting system and reporting schedules ensured that incidents were recorded, reviewed and monitored to assist in the provision of safe care at Heatherwood Court.

Improvement needed

The registered provider must ensure that staff do not attach items to nursing office windows.

Infection prevention and control (IPC) and decontamination

The registered provider employs dedicated housekeeping staff for Heatherwood Court. Apart from the one shower room identified earlier, the communal bathroom, showers and toilets were clean, tidy and clutter free. There was access to hand washing and drying facilities in all ward-kitchen and bathing areas. However, we noticed that on Chepstow, Cardigan, and Caerphilly units there were hand hygiene notices missing.

Cleaning equipment was stored and organised appropriately. Generally, throughout the inspection, we observed the hospital to be visibly clean and clutter free

Ward staff on Chepstow Unit confirmed that they had appropriate stock of Personal Protective Equipment (PPE). However, the other two units we checked (Cardigan and Chepstow) only had access to PPE gloves and no other equipment. Staff confirmed that they would be able to access PPE if required however there would be an unnecessary delay whilst these were provided from elsewhere within the hospital.

The hand hygiene gel dispensers on Cardigan Unit had been limited due to the misuse of the contents and to prevent the dispensers being damaged and used as an object to cause harm. The registered provider must ensure that appropriate arrangements are in place for staff, visitors and patients to access hand hygiene gel on Cardigan Unit to assist in infection control measures.

A system of regular audit in respect of infection control was described. This was completed with the aim of identifying areas for improvement so that appropriate action could be taken where necessary. Staff confirmed that cleaning schedules were in place to promote regular and effective cleaning of the wards and were aware of their responsibilities around infection prevention and control.

Designated plastic bins were used for the safe storage and disposal of medical sharps, for example, hypodermic needles. These were stored safely.

Improvement needed

The registered provider must ensure that hand hygiene notices are in place as required.

The registered provider must ensure that all wards have Personal Protective Equipment (PPE) readily available.

The registered provider must ensure that appropriate arrangements are in place for staff, visitors and patients to access hand hygiene gel on Cardigan Unit to assist in infection control measures.

Nutrition

Patients were supported to meet their eating and drinking needs.

We found that patients were provided with a choice of meals on a four-week menu. We saw that a varied menu and patients told us that they had a choice of what to eat. Whilst the menu was displayed clearly on Cardigan Unit, this was not replicated across all wards.

Drinks were available throughout the day and patients had secure storage for their own snacks along with fresh fruit being readily available. Most patients told us that they enjoyed the food and felt that it was of good quality.

One of the patients' fridges on Caerphilly Unit had damaged food items which appeared to be due to ice build up at the back of the fridge.

As part of patients' individual recovery programmes, patients had access to the kitchens on the wards to make their own meals and snacks.

We checked a sample of food charts and weight charts for those patients requiring them, these were completed appropriately.

Improvement needed

The registered provider must ensure that menus are displayed on all wards.

The registered provider must ensure that the fridge on Cardigan Unit is operating properly and damaged items removed.

Medicines management

Medication was stored securely with cupboards and medication fridges locked. There were medicines management processes in place at Heatherwood Court, however we saw that the application of these were inconsistent across the hospital.

The hospital had Daily Nursing Medication Competency checklist to assist staff in safe medicine management. It was evident that these were completed as

required on Chepstow Unit which assisted to maintain safe medicines management for that ward. However, these not regularly completed by all applicable staff on Cardigan and Caerphilly units.

There was evidence that there were regular temperature checks of the medication fridge to ensure that medication was stored at the manufacturer's advised temperature. However, three gaps were noted in the temperature log during October on Cardigan Unit.

Despite our focused inspection in September 2017 identified that the Controlled Drugs cupboard on Cardigan Unit contained a Drug Liable to Misuse (DLM) that belonged to a patient (dated May 2017) no longer accommodated at the hospital. We highlighted this repeat issue and these were appropriately disposed of during this inspection.

During the night shift the hospital has one registered nurse per ward. This poses a difficulty in the dispensing of controlled drugs where two registered nurses[3] are required to sign that controlled medication has been administered. We were informed that if controlled medication is required then a registered nurse will attend from another ward to permit this. However, on review of the controlled drug book on Cardigan Unit there was an instance during October of the controlled drugs only being signed for by one registered nurse. During the inspection feedback senior managers' confirmed that they were reviewing arrangements for controlled drugs during the night shift.

It was also noted that the page continuation details on the controlled drug logs were not always completed. These assist in reconciling controlled drug totals.

There was an instance where only one nurse had adjusted the balance of the Lorazepam and reduce the balance by two ampules; this was not countersigned and staff continued with the reduced balance without any further action taken. We informed Senior management at the hospital and they stated they would investigate this discrepancy.

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[3] Two registered nurses are required to account for the use of Controlled Drugs, or one registered nurse with a non-registered nurse member of staff that had been trained to assist registered nurses.

We identified that there was out of date Lorazepam stored within Caerphilly clinic, expired September 2017. It was confirmed that no out of date medication had been administered. The out of date medication was appropriately disposed of during the inspection.

The Medication Administration Record (MAR) Charts reviewed contained the patients name and in all but one MAR Chart recorded their Mental Health Act legal status. MAR Charts included copies of the consent to treatment certificates and MAR Charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered.

Staff had access to relevant registered provider policies. However, the clinic room on Cardigan Unit did not have up to date copies of policies for Medicine Management, Rapid Tranquilisation and As Required Medication readily available.

Improvement needed

The registered provider must ensure that staff are completing the required checklists to assist maintaining safe medicine management practices.

The registered provider must ensure that staff record medication fridge temperatures.

The registered provider must ensure that appropriate processes are in place to dispense Controlled Drugs during night shifts.

The registered provider must ensure that Controlled Drug Logs are completed in full.

The registered must ensure that staff regularly audit expiry dates of medication to ensure that no out of date medication is stored at the hospital.

The registered provider must ensure that up to date copies of relevant policies are available in each of the hospital's clinic rooms.

Safeguarding children and safeguarding vulnerable adults

There were established processes in place to ensure that staff on both wards safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

The General Manager monitored the training completion rates with regards to safeguarding children and safeguarding vulnerable adults to ensure staff's compliance with mandatory training.

Medical devices, equipment and diagnostic systems

There was a weekly audit of resuscitation equipment, staff had documented when these had occurred to ensure that the equipment was present. Whilst the vast majority of items were in date we identified that one item of hand sanitizer was over a year out of date and one instrument required its annual calibration.

During the inspection feedback we discussed with the registered provider our reoccurring concerns about the location of the resuscitation equipment being held near reception in the GP's room; some distance from Caerphilly and Cardigan units. We also suggested that the registered provider consider if one set of resuscitation equipment was sufficient for up to 47 patients. The registered provider confirmed they would consider relevant guidance and review the location and quantity of resuscitation equipment at the hospital and implement changes the review may recommend.

Improvement needed

The registered provider must ensure all resuscitation equipment is in date.

The registered provider must review the quantity and location of the hospital resuscitation equipment.

Safe and clinically effective care

Generally we found that arrangements were in place to promote safe and effective care to patients. However, inconsistencies in staff practices, including the areas of concern identified under "Medicine Management" require addressing to ensure that there is safe and clinically effective care across the hospital.

Records management

Patient records were a combination of paper files that were stored and maintained within the locked nursing office, with electronic information, which were password-protected. We observed staff storing the records appropriately during our inspection.

Whilst there were detailed care records for patients, these were spread across a number of paper and electronic files which made it more difficult to navigate

and review. The number of different patient records could result in staff missing information or not reviewing the most up to date information.

Improvement needed

The registered provider should look at consolidating the nursing records, as far as practical. Minimising duplication and providing easier access to specific information.

Mental Health Act Monitoring

We reviewed the statutory detention documents of two patients across one ward, Chepstow Ward. We also reviewed the governance and audit processes that were in place for monitoring the use of the Mental Health Act (the Act) across all four wards.

It was confirmed that on transfer of a patient to Heatherwood Court from another hospital the Act detention documentation was not routinely scrutinised to ensure that detention was compliant with the Act, as guided by Mental Health the Code of Practice for Wales (the Code) paragraph 35.18. The registered provider was reliant on the previous detaining authority for validating the statutory detention documentation.

In addition to validating the detention, scrutiny of the statutory documentation would assure whether the patient's Nearest Relative[4] has been identified or what actions have been taken to ensure a patient has a Nearest Relative.

Patients at Heatherwood Court were not offered copies of their detention papers as is their statutory right, Code paragraph 4.14.

There was no record that patients were routinely provided with information on their rights with regards to medication, Code paragraph 24.37.

The Consent to Treatment CO2 Certificate[5] in use at the hospital had reference to the previous Code that was updated in October 2016. The registered

[4] A person defined by the Act who has certain rights and powers under the Act in respect of a patient for whom they are the nearest relative.

provider must ensure that their documentation is updated to include references to the current Code.

The registered provider did not have appropriate patient information for patients that were detained under 'notional' Section 37[6]. The information provided was relevant to detention with a court's restriction on discharge under Section 41. The registered provider must ensure that patients are provided with their rights relevant to the section that they are detained under.

Hospital Managers[7] were inconsistent in recording the details behind their decisions of Hospital Manager Hearings[8] and whether or not the patient had been informed of the decision as guided by the code, paragraphs 38.42 - 38.44.

Copies of statutory detention papers on patient ward files were not systematically filed with statutory forms copied back to back with other statutory forms. Therefore ward staff would not be able to easily assure themselves that an individual patient's detention was compliance with the Act.

Copies of expired Section 17 Leave authorisations and Consent to Treatment Certificates were not always marked as no longer valid which means staff could refer to them in error; as per guidance in the Code paragraphs 27.17 and 25.87 respectively.

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[5] A CO2 confirms the patient has capacity to consent to treatment and is consenting to treatment to the treatment authorised on the document.

[6] On expiry of the custodial restrictions of their criminal sentence (the date the person would have been released from prison), if the patient continues to require further treatment they can remain detained within hospital as if subject to an unrestricted Section 37 hospital order, commonly referred to as notional section 37.

[7] The organisation (or individuals) responsible for the operation of the Act in a particular hospital.

[8] A hearing by the hospital managers held to review the detention of a patient in hospital.

Improvement needed

The registered provide must ensure that detained patients have an identified Nearest Relative

The registered provide must offer patients copy of their detention papers.

The registered provide must ensure that patients are provided with information on their rights with regards to medication.

The registered provide must ensure that patients are provided with information on their rights with regards to their section of detention.

The registered provide must ensure that the reasoning for the outcome of a Hospital Managers Hearing is clearly documented and whether the patient has been informed of the outcome.

The registered provider must ensure that copies of statutory detention papers are systematically filed and available to ward staff.

The registered provider must ensure that expired documentation is clearly marked as no longer valid.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

We reviewed the care plans of a total of five patients.

The Care and Treatment Plans reflected the domains of the Welsh Measure with measurable objectives.

Individual Care and Treatment Plans drew on patient's strength and focused on recovery, rehabilitation and independence. These were developed with members of the multi-disciplinary team and included good physical health monitoring and health promotion.

However, it was also common that staff were not clearly documenting any unmet needs a patient may have whilst being cared for at the hospital. It is important that unmet needs are documented so that these can be regularly reviewed by the multi-disciplinary team to look at options for meeting those needs.

Whilst Care and Treatment Plans were regularly reviewed, the detail of the review was brief and did not evidence the progress the patient had made in achieving the objectives of their care plan.

The registered provider had difficulties in ensuring that some patients' care co-ordinators in the community attending Care and Treatment Plan reviews. There were also difficulties in receiving previous Care and Treatment Plan from community care co-ordinators. The registered provider had kept copies of correspondence to evidence the efforts they had made in contact patients' care co-ordinators.

Improvement needed

The registered provider should ensure that the evaluation against the domains of the Care and Treatment Plan are meaningful and reflect the achievements or difficulties attaining such. To inform the unmet need process and further care planning.

The registered provider must ensure that patients' unmet needs are documented in their Care and Treatment Plans.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of our inspection, staff confirmed that there were no patients subject to Deprivation of Liberty Safeguards (DoLS) authorisations. The General Manager confirmed that staff were up to date with Mental Capacity Act / Deprivation of Liberty Safeguards training.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Independent Health Care Regulations and National Minimum Standards.

We saw good management and leadership at Heatherwood Court which was supported by Ludlow Street Healthcare. We observed a committed staff team who had a good understanding of the needs of the patients at the hospital.

Recruitment was undertaken in an open and fair process with appropriate employment checks being carried out prior and regularly during employment. Staff undertook regular mandatory training, supervision and annual appraisals.

Governance and accountability framework

We found that there were well defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit and its established governance structure which enabled key/nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care. Those arrangements were recorded so that they could be reviewed.

Identified senior managers had specific responsibilities for ensuring that the programme for governance remained at the forefront of service delivery. However, as identified earlier in the report, the governance and staff practice around medicine management and monitoring the Act require improvement.

Through conversations with staff, observing multi-disciplinary team engagement, and reviewing patient records there was evidence of strong multi-disciplinary team-working at Heatherwood Court. Staff commented favourably on multi-disciplinary working stating that they felt that their views were listened to and respected by other members of staff.

It was positive that, throughout the inspection, the staff at Heatherwood Court were receptive to our views, findings and recommendations.

Dealing with concerns and managing incidents

As detailed earlier in the report, there were established processes in place for dealing with concerns and managing incidents at the hospital.

It was evident that the registered provider monitored concerns and incidents locally at Heatherwood Court and corporately through regular reporting mechanisms.

Workforce planning, training and organisational development

We reviewed the staffing establishment at Heatherwood Court with that stated within their Statement of Purpose. There were 8 registered nurses vacancies that the registered provider was attempting to recruit to.

To cover any shortfalls in fulfilling the staffing rota that may occur due to vacancies, the registered provider had a staff bank system in place and offered over-time. The registered provider also utilised agency registered nurses; reviewing staff rotas it was evident that generally the use of agency registered nurses was of regular individuals who were familiar with working at the hospital and the patient group which assisted with the continuity of care for patients.

We reviewed the mandatory training statistics for staff at Heatherwood Court and found that completion rates were very high. The electronic system provided the general manager with course and individual staff compliance details. The registered provider was in the process of developing the reporting system so that reports could be produced on individual disciplines and wards.

Staff employed by the registered provider were part of the Ludlow Street Healthcare Academy which provided staff with their mandatory training along with additional training as part of their career development. Some registered nurses were also supported to complete their Master of Science in Nursing.

The registered provider was implementing revised processes for supervision so that staff were recording formal and informal supervision which was part of their annual performance appraisal and development review (PADR).

Workforce recruitment and employment practices

Staff explained the Ludlow Street Healthcare recruitment processes that were in place at Heatherwood Court. It was evident that there were systems in place to ensure that recruitment followed an open and fair process. Prior to employment staff references were received, Disclosure and Baring Service checks were undertaken and professional qualifications checked.

Staff were required to complete a structured induction programme prior to working at Heatherwood Court.

4. What next?

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 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.

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a non-compliance notice. The issuing of a non compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

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.

5. How we inspect independent mental health services

Our inspections of independent mental health services are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of independent mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards
- Comply with the Care Standards Act 2000
- Comply with the Independent Health Care (Wales) Regulations 2011
- Meet the National Minimum Standards for Independent Health Care Services in Wales.

We also consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within independent mental health services.

Further detail about how HIW inspects mental health and independent services can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries 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
No immediate concerns were identified on this inspection	Not applicable	Not applicable	Not applicable

Appendix B – Improvement plan

Service: Heatherwood Court

Units: Caernarvon, Caerphilly, Cardigan & Chepstow

Date of inspection: 30 October - 1 November 2017

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	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The registered provider must ensure that information for patients is consistently displayed across all four units.	3. Health promotion, protection and improvement	Review all information across the four units and replace as required. NB: Some information may still differ care of gender differences and varying models of care.	Carla Rawlinson	15/12/17
The registered provider must ensure that staff complete health promotion checks promptly.	3. Health promotion, protection and improvement	Re-circulate protocol re: admission to qualified nurses. On admission when the health promotion checks are completed copies will be sent to the clinical lead for auditing. Any omissions will then be	Rebecca Conlon Rebecca Conlon	Completed From next admission

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		addressed.		
The registered provider must ensure that all applicable patients have an up-to-date Hospital Passport.	3. Health promotion, protection and improvement	Passport document sourced and completed for relevant patients (i.e. those with a diagnosed learning disability)	Rebecca Conlon	Completed
The registered provider must ensure that shower facilities are maintained free from unpleasant odours.	10. Dignity and respect	Raise maintenance and housekeeping requests. Sealant repair, floor steam clean.	Carla Rawlinson	Completed
The registered provider must consider improvements to make the Visitors' Room more welcoming for children.	10. Dignity and respect	Consideration has been given to this but no changes will be made as toys and books available have been reviewed and deemed sufficient (these are stored in boxes rather than displayed in view of our patient group) as child visits are limited in view of our efforts to ensure that child contact happens off site, preferably in family homes.	Carla Rawlinson	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that patient information is available in Welsh.	9. Patient information and consent	Updated patient handbook to signpost patients towards requesting information in the Welsh Language if required. Display notices on each unit in English and Welsh saying please ask staff if you require any information to be provided in the Welsh Language.	Carla Rawlinson	15/12/17
The registered provider must ensure that patients on all wards receive regular feedback on the issues that they raise.	18. Communicating effectively	Review processes across the units and identify best practice, discuss at 4wardz meeting and introduce one format for feedback across the site.	Unit Managers	31/12/17
The registered provider must ensure that information is maintained and readily available in the Visitors' Room	5. Citizen engagement and feedback	Create an electronic folder on Q Drive containing all carer, friends and family information. Add to Reception hospitality checklist to allow materials to be replaced when identified as removed.	Carla Rawlinson	15/12/17

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The registered provider must ensure that staff do not attach items to nursing office windows.	22. Managing risk and health and safety	Items removed; this check is to be added to the bronze on call checklist which is conducted across the site 3 times per week.	Rebecca Conlon	8/12/17
The registered provider must ensure that hand hygiene notices are in place as required.	13. Infection prevention and control (IPC) and decontamination	Review site for current notices to identify deficiencies and display notices as required.	Housekeeping Team Leader	15/12/17
The registered provider must ensure that all wards have Personal Protective Equipment (PPE) readily available.	13. Infection prevention and control (IPC) and decontamination	Apron and glove dispensers to be fitted into a cupboard in each kitchen. Cupboards to be labelled PPE.	Unit Managers	15/12/17

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that appropriate arrangements are in place for staff, visitors and patients to access hand hygiene gel on Cardigan Unit to assist in infection control measures	13. Infection prevention and control (IPC) and decontamination	Review number and location of hand gel dispensers on Cardigan Unit Identify suitable locations and replace accordingly.	Housekeeping Team Leader and Unit Manager	15/12/17
The registered provider must ensure that menus are displayed on all wards.	14. Nutrition	Menu's to be reprinted, laminated and displayed in each unit kitchen.	Helen Bevan and Unit Managers	15/12/17
The registered provider must ensure that the fridge on Cardigan Unit is operating properly and damaged items removed.	14. Nutrition	Fridge has been replaced.	Sarah Evans	Completed
The registered provider must ensure that staff are completing the required checklists to assist maintaining safe medicine management practices.	15. Medicines management	A random check of completion of the "daily nurse medication competency record" is to be added to the bronze on call checklist which is conducted 3 times per week across the site by Unit Managers.	Rebecca Conlon	8/12/17

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that staff record medication fridge temperatures.	15. Medicines management	A random check of fridge temperature recordings is to be added to the bronze on call checklist which is conducted 3 times per week by Unit Managers.	Rebecca Conlon	8/12/17
The registered provider must ensure that appropriate processes are in place to dispense Controlled Drugs during night shifts.	15. Medicines management	Following discussion with Ashtons Pharmacy, senior support workers will be trained.	Hazel Orr	Training due to commence in January 2017
The registered provider must ensure that Controlled Drug Logs are completed in full.	15. Medicines management	All permanent and bank nurses to undertake a medication competency assessment Omissions to be targeted at supervision with Performance Improvement Plans as required	Unit Managers	31/12/17
		Review processes in areas that were highlighted as good during inspection and share this as best practice across the site	Rebecca Conlon	31/12/17

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered must ensure that staff regularly audit expiry dates of medication to ensure that no out of date medication is stored at the hospital.	15. Medicines management	All permanent and bank nurses to have a medication competency re-administered	Unit Managers	31/12/17
The registered provider must ensure that up to date copies of relevant policies are available in each of the hospital's clinic rooms.	15. Medicines management	Out of date policies removed. New policies issued and displayed in each medication room.	Carla Rawlinson	Completed
The registered provider should look at consolidating the nursing records, as far as practical. Minimising duplication and providing easier access to specific information	20. Records management	Information and health promotion care plans currently held in physical health files are being incorporated into the main health record following discussion with NHS Wales	Unit Managers	31/12/17
The registered provide must ensure that detained patients have an identified Nearest Relative	Mental Health Act Monitoring	If the nearest relative has not been identified on a patient's admission, contact is made with the Social Worker/Care Coordinator/Commissioner to identify him/her. This information is updated onto Live Data.	Lisa Knott	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must offer patients copy of their detention papers.	Mental Health Act Monitoring	A system has been put in place when a patient is admitted so they are offered a copy of their detention paperwork if required. This will also be conveyed to patients by letter on admission with the appropriate form to complete.	Lisa Knott	Completed
The registered provider must ensure that patients are provided with information on their rights with regards to medication.	Mental Health Act Monitoring	A leaflet has been obtained entitled "Consenting to Treatment". This leaflet will be given to patients on admission and the leaflets will be inserted into patient's individual nursing files.	Lisa Knott	Completed
The registered provider must ensure that patients are provided with information on their rights with regards to their section of detention.	Mental Health Act Monitoring	All patients are given their rights on a monthly basis. All patient files rights leaflets will be checked in their nursing files. Prompt to be added to file audit template used by Unit Managers and Senior Staff Nurses.	Lisa Knott, Unit Managers and Senior Staff Nurses	Next file audit
The registered provider must ensure that the reasoning for the outcome of a Hospital Managers Hearing is clearly documented and whether the patient has been informed of the	Mental Health Act Monitoring	Hospital Managers have been written and spoken to regarding this and reminded of the Code of Practice. This will be included as an item on the	Lisa Knott Lisa Knott	Completed Next MHA audit

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
outcome.		next Mental Health Act audit.		
The registered provider must ensure that copies of statutory detention papers are systematically filed and available to ward staff.	Mental Health Act Monitoring	All statutory paperwork is provided to the ward staff for insertion into the nursing files.	Lisa Knott	Completed
The registered provider must ensure that expired documentation is clearly marked as no longer valid.	Mental Health Act Monitoring	An email and training will be provided to ward staff to ensure that this will be done in the future.	Lisa Knott	31/12/17
The registered provider should ensure that the evaluation against the domains of the Care and Treatment Plan are meaningful and reflect the achievements or difficulties attaining such. To inform the unmet need process and further care planning.	Care planning and provision	A strategic development group is now in place with a scope and terms of reference that include a target area which will address this action as described below: An agreed process and multidisciplinary and person centred format for CTP/CPA patient review which includes: Reporting on objective progress measures of patient outcome in the period since the last CPA/CTP (ie clarity re progress along the overall treatment	Andrew Hider / Carla Rawlinson	For review in March 2017

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		pathway). Reporting on the results of clinical outcome measures for all specific treatments and interventions used. Reporting on results of patient satisfaction measures. A transparent process for the use of objective clinical "decision points" as to the patient's likely ongoing need for treatment and/or the need to make preparations for transition following the CPA. A transparent process for the use of a re-engagement pathway for patients who are not engaging in treatment and intervention prescribed.		
The registered provider must ensure that patients' unmet needs are documented in their Care and Treatment Plans.	Care planning and provision	Prompt to be added to MDT minutes template regarding recording any unmet needs in Care and Treatment Plans	Medical Secretary	15/12/17

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
No concerns were identified on this inspection	Not applicable	Not applicable	Not applicable	Not applicable

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): **Carla Rawlinson**

Job role: **Registered Manager**

Date: **1 December 2017**