Arolygiaeth Gofal Iechyd Cymru

Healthcare Inspectorate Wales

Independent Mental Health Service Inspection (Unannounced)

Heatherwood Court

Caernarfon, Cardigan and Chepstow Units

Ludlow Street Healthcare

Inspection date: 29 November – 1 December 2021

Publication date: 03 March 2022

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-80391-777-1

© Crown copyright 2022

Contents

1. What we did ... 3

2. Summary of our inspection ... 4

3. What we found ... 5

Quality of patient experience ... 5

Delivery of safe and effective care ... 12

Quality of management and leadership ... 21

4. What next? ... 25

5. How we inspect independent mental health services ... 26

Appendix A – Summary of concerns resolved during the inspection ... 27

Appendix B – Improvement plan ... 28

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

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 29 November 2021 and following days of 30 November and 1 December. The following sites and wards were visited during this inspection:

- Caernarfon Unit - Female Locked Mental Health Rehabilitation
- Cardigan Unit – Female Low Secure Mental Health
- Chepstow Unit – Male Low Secure Mental Health

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

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

We found a dedicated staff team that were committed to providing a high standard of care to patients. We observed that staff interacted with patients respectfully throughout the inspection.

Care records were individualised and patient focused drawing on their individual strengths. The hospital focused on providing rehabilitative care in line with Least Restrictive Practices. This was supported by a wide range of therapeutic resources within the hospital and access to the local community.

Governance arrangements for the hospital fed through to Ludlow Street Healthcare governance arrangements which facilitated a two way process of monitoring, learning and service development.

This is what we found the service did well:

- All employees were observed to interact and engage with patients respectfully
- Provided a range of suitable facilities in a well maintained environment of care
- Focused on least restrictive care to aid recovery and supported patients to maintain and develop skills
- Provided care that followed comprehensive multidisciplinary patient-centred care plans
- Established governance arrangements that provided safe and clinically effective care.

This is what we recommend the service could improve:

- Documentation for the prescribing and administration of medication
- Recording of patient involvement with their authorised leave from hospital.

There were no areas of non-compliance identified at this inspection that required immediate corrective action.

3. What we found

Background of the service

Heatherwood Court is registered to provide an independent mental health inpatient care at Heatherwood Court, Llantrisant Road, Pontypridd, CF37 1PL.

The service is registered to accommodate up to 47 persons aged between 18 and 64 across four gender specific wards:

- Caernarfon Unit – an 11 bed controlled access/egress (locked rehabilitation) environment for persons requiring care and treatment for a mental disorder. Treatment may be offered to persons who have a diagnosis of Personality Disorders, or those whose needs arise from enduring mental illnesses.

- Caerphilly Unit – a 12 bed low secure environment for persons requiring care and treatment for a mental disorder. It will cater for the needs of people with a mental disorder who may require intensive treatment over longer periods.

- Cardigan Unit – a 12 bed low secure environment for persons requiring care and treatment for a mental disorder. Treatment may be offered to persons who have a diagnosis of Personality Disorders, or those whose needs arise from enduring mental illnesses.

- Chepstow Unit – a 12 bed low secure environment for persons requiring care and treatment for a mental disorder. Treatment may be offered to persons who have a diagnosis of Personality Disorders, or those whose needs arise from enduring mental illnesses.

The service employs a staff team which includes a Registered Manager and Clinical Lead, four Unit Managers and a nursing team of registered nurses, senior support workers, and support workers.

The multi-disciplinary team also includes consultant psychiatrists, an occupational therapy team, and a psychology team. The team could also access other Ludlow Street Healthcare professionals which include physiotherapy, dietician and a speech and language team.

The hospital employs a team of catering and domestic staff along with a maintenance person. The operation of the hospital is supported by general manager and hospital administration staff, along with the overarching Ludlow Street Healthcare corporate structure.

The service was first registered on 20 December 2007.

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.

We observed that staff interacted with patients appropriately and treated patients with dignity and respect. Staff supported and engaged patients in an relaxed manner whilst maintaining professional boundaries.

There were a range of suitable activities and therapies available at Heatherwood Court, and within the community, to aid patients' rehabilitation.

The hospital had a number of ways for patients to provide their views on their care and the operation of the wards and hospital.

Health promotion, protection and improvement

Within the hospital reception there was a range of relevant information leaflets for patients, families and other visitors. There was further patient specific information displayed on the wards, this included healthy eating and smoking cessation advice.

Heatherwood Court had a wide range of well-maintained facilities to support the provision of therapies and activities on each ward and within the hospital's therapy and activity building, 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, table tennis table and darts board. There was also a gym to undertake physical exercise and a woodwork room however activities in this area were not currently being undertaken, we were informed that they would restart during 2022.

The Hub had a therapy kitchen with three areas for learning and practicing cooking skills. There were a number of other rooms including the multi-faith room, art room, therapy rooms, an education room and computer room.

The hospital provided patients with learning opportunities with their Recovery College. This provides opportunity for patients to develop skills which can include

nationally recognised qualifications. These skills and qualification can assist patients in gaining employment.

Patients with authorised leave from the hospital were also able to utilise local community services as part of their rehabilitative programme of care. In some cases this included community based organisations which would enable patients to continue to engage with the organisations following discharge from hospital.

Each ward had a patient lounge with a television and patients had access to a range of DVDs. Patients were also able to have TVs, music players and games consoles within their bedrooms.

Each patient admitted to the hospital was assessed by an occupational therapist. Following the assessment, patients were provided with an individual timetable that included various therapeutic activities at the hospital. The individual patient activity timetables linked with the hospital facilities timetables.

Dignity and respect

We observed that all staff interacted and engaged with patients appropriately and treated patients with dignity and respect. We observed staff being respectful toward patients, including knocking on doors before entering bedrooms.

We heard staff speaking with patients in calm tones throughout our inspection. Staff that we spoke to were clearly knowledgeable about the patients and it was evident that this enabled them to have an appropriately relaxed manner when supporting patients whilst maintaining professional boundaries; this included during more challenging situations.

We were present during an incident where a patient attempted to significantly self-harm. During this we observed staff engaging with the patient in a dignified manner, using the least restrictive methods of de-escalation and physical intervention being undertaken to proportionately manage with the situation.

The hospital has four gender specific units with each patient having their own bedroom that they 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 and aerosols. were stored securely and orderly on each of the wards and patients would then request access to them when needed.

It was positive to note that dynamic risk assessments were being undertaken which meant that individual patient's risks were considered at least daily, this helped identify their current risks and therefore consider whether any changes to their individualised restrictions are required.

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 each unit. These areas appeared clean and tidy and appropriate for the patient group.

Each ward had suitable rooms for patients to meet ward staff and other healthcare professionals in private. It was positive to note that as part of structured activities patients had created seasonal decorations for the ward and hospital based events. This further reduced the clinical feel to the wards and provided a sense of patient ownership to the ward environments

There was also a visiting room, in the hospital reception area, available for patients to meet with visitors, including younger family members.

There were suitable arrangements for telephone access on each of the ward so that patients were able to make and receive calls in private. There were also arrangements in place so that patients were able to access their mobile phones based on individual patient risks.

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. Whilst the position of the information at the internal entrance to the ward and stairwell was well positioned, this may not be suitable for patients who have a downstairs bedroom and with limited leave from the ward. Therefore the registered provider should consider also providing this information on the ground floors of the wards in a main communal area.

Improvement needed

The registered provider must consider also providing the patient information displayed in the stairwell on the ground floors of the wards.

Communicating effectively

Through our observations of staff-patient interactions, it was evident 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 ward 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 and medical appointments.

The hospital also held a fortnightly patient council meeting where patient representatives meet with senior managers of the hospital to discuss the operation of the hospital and raise any areas of concern. We spoke with the patient representatives and they confirmed that they felt valued and listened to.

We saw a positive initiative where a patient, as part of their activities at the hospital, had created a regular patient magazine for other patients at the hospital. This included information on wellbeing, activities and staff getting to know you profiles.

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.

Care planning and provision

Overall there was a focus on rehabilitation with individualised patient care that was supported by reducing restrictive practices, both in care planning and ward or hospital practices.

Each patient had their own individual planner, this included individual and group sessions, based within the hospital and the community (based on individual risks).

As detailed above, the activities were varied and focused on recovery, either at the hospital or in the community. Individual patient activity participation was monitored and audited.

Equality, diversity and human rights

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

Mental Health Act detention papers had been completed correctly to detain patients at the hospital. Since our previous inspection in 2019 we noted improvements to the application of the Mental Health Act and following the guidance as set out in the Mental Health Act Code of Practice for Wales 2016.

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.

There were established processes and audits in place to manage risk, health and safety, medicine management and infection control. This enabled staff to continue to provide safe and clinically effective care. However, areas of improvement were identified in regards to prescribing and administration of medication.

Care records were individualised and patient focused drawing on their individual strengths and risks. 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.

Legal documentation to detain patients under the Mental Health Act was compliant with the requirements of the legislation.

Managing risk and health and safety

Heatherwood Court had processes in place to manage and review risks and maintain health and safety at the hospital. The hospital provided individualised patient care that was supported by least restrictive practices, both in care planning and hospital practices.

Throughout the inspection the hospital site was secured by the main hospital gate, with entry gained either via an intercom to reception or with electronic key fobs for employees. Entry on and off each ward was secured by electronic locks that required a key fob.

On entry in to the hospital building all staff were provided with a set of keys that were allocated via reception and a log of who has which set of keys was maintained. All staff were required to secure their keys to their belt to ensure that they were not lost or taken off their person whilst at the hospital. All staff had to return their set of keys to enable them to leave the hospital building. This process helped ensure that keys were kept safe and not lost at the hospital or taken out of the hospital building.

Overall, the hospital was well maintained which contributed to the safety of patients, staff and visitors. The furniture, fixtures and fittings at the hospital were appropriate for the patient group.

Staff were able to report environmental issues to the hospital estates team who maintained a log of issues and work required and completed. We were informed that the hospital estates team were responsive and made referrals to contractors quickly when required. We observed some areas of wards that had marked or damaged paint work, it was confirmed that there is a regular review and maintenance of ward areas to rectify these matters in a timely manner.

There were nurse call points around the wards and within patient bedrooms so that patients could summon assistance if required. Staff wore personal alarms which they could use to call for assistance if required. There was a system for alarms to be allocated to staff and visitors when they entered the hospital.

The registered provider had an electronic incident recording system that all incidents were entered on to. The system allowed for analysis of incidents including; the nature of the incident, where the incident happened, dates and times and who was involved in the incident. The incident data was used to assist individual care planning and identifying the required staffing resources for the hospital.

There were weekly audits of resuscitation equipment; staff had documented when these had occurred to ensure that the equipment was present and in date. There were ligature cutters located throughout the hospital in case of an emergency.

Improvement needed

The registered provider must ensure damages and marks to paint work are rectified in a timely manner.

Infection prevention and control (IPC) and decontamination

There were appropriate arrangements in place to safely manage infection prevention and control at the hospital.

We saw evidence to confirm that the hospital conducted necessary risk assessments and updated relevant policies and procedures to meet the additional demands of the COVID-19 pandemic. Staff we spoke to were aware of infection control obligations. The registered provider had COVID-19

documentation to support staff and ensure that staff remained compliant with policies and procedures.

On arrival at hospital visitors and staff were required to show proof of recent negative Lateral Flow Test (LFT) or complete one on arrival. The arrangements for completing a LFT on arrival were reviewed and we were assured that these arrangements minimised the risk of cross contamination if a person arrives who is Covid positive.

There was a regular audit of the infection control arrangements in place. This was completed with the aim of identifying areas for improvement, so that appropriate action could be taken where necessary.

The registered provider employed dedicated housekeeping staff for the hospital. Throughout the inspection we observed that overall the hospital was visibly clean and free from clutter. Cleaning equipment was on the whole stored and organised appropriately, however improvements were required on Caernarfon Unit.

Cleaning schedules were in place to promote regular and effective cleaning of the hospital, and on the whole staff were aware of their responsibilities around infection prevention and control. However we spoke with one member of the housekeeping staff who was unclear on the cleaning schedule and requirements, it is important that staff understand how their role and responsibilities align with the hospital IPC arrangements.

There were hand hygiene products available in relevant areas of the hospital such as ward clinic and food preparation areas; these were accompanied by appropriate signage. Staff also had access to infection prevention and control and decontamination personal protective equipment when required.

There were suitable arrangements in place for the disposal of waste. Appropriate bins were available to dispose of medical sharp items; however on Caernarfon Unit there were a number of sharps bins that remained open after being filled and posed a needle stick injury risk to staff. Sharps bins must be securely closed when filled and removed from the clinical area in a timely manner.

Improvement needed

The registered provider must ensure all cleaning equipment is stored and organised appropriately.

The registered provider must ensure all staff are aware of their responsibilities around infection prevention and control.

The registered provider must ensure that filled sharps bins are correctly closed and removed from clinical areas in a timely manner.

Nutrition

Patients were provided with a choice of meals on a rotational menu. The options available were extensive and included a range of healthy options; calorie information was also clearly marked alongside each option. There was a range of options available for patients with specific/special diets, including vegan, gluten intolerant and religious requirements; these were also identified on the menu.

From reviewing patient records it was evident that when required there had been input from dietician and SALT[1]. This enabled individualised dietary care plans to be completed by the multidisciplinary team to help support the patient with their nutritional and dietary needs.

Patients selected their meal options each day on an individual form, in addition to the options patients had the opportunity to score their satisfaction with the options and provide any other comments. Feedback on the menu options and consultation of changes to the menus were also undertaken via the patient council.

Fresh fruit along with hot and cold drinks were available on each of the wards and patients were able to purchase snacks when on leave from the hospital.

As well as the meals provided, patients were able to use the occupational therapy kitchen to prepare their own meals.

Medicines management

We reviewed medicine management on the three wards that we attended during the inspection; we noted improvements since our previous inspection in 2019. Overall, medicines management on the wards was safe and effective.

[1] Speech and Language Therapist assess difficulties with swallowing and communication. They can offer support through swallowing and speech exercises, dietary advice and changes to medication.

There was regular pharmacy input and audit undertaken that assisted the management, prescribing and administration of medication at the hospital. The hospital had recently established a medicines management committee to strengthen the oversight of medicine management and clinical practices.

Whilst the size and configuration of the clinic rooms made these areas appear cluttered and cramped, medication was stored securely within cupboards, medication fridges were locked and medication trolleys secured. There were appropriate arrangements for the storage and use of Controlled Drugs and Drugs Liable to Misuse; these were accurately accounted for and checked daily.

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.

The Medication Administration Records (MAR Charts)[2] reviewed contained the patient's name and their mental health act legal status. There were a few gaps where the person administering the medicine should have signed the MAR Chart, however it was noted that these were identified in regular internal and external audits, and where possible rectified. Otherwise MAR Charts were signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered.

As we identified on our previous inspection it was again noted that on occasions the registered nurse had coded the MAR chart as refused, but the reason for the patient not receiving the medication was documented within their notes as asleep or not available on the ward. The coding needs to accurately reflect the reason why a patient did not receive their medication.

MAR Charts included a copy of the most recent Consent to Treatment Certificates that authorised medication (for mental disorder) under the Mental Health Act.

Each patient had a medication care plan and the sample we reviewed were up to date. Through our review of medication records it appeared that medication is

---

[2] A Medication Administration Record is the report that serves as a legal record of the drugs administered to a patient by a health care professional. The Medication Administration Record is a part of a patient's permanent record on their medical chart.

being used proportionate to the needs of individuals, and where appropriate, other alternatives being considered first.

It was noted that on one patient's MAR Chart there an antipsychotic medicine was prescribed, however the route of administration was identified as oral or intermuscular. Whilst this the particular antipsychotic medicine can be given either as oral or intermuscular route, these should be prescribed separately. This is because when the registered nurse records that the antipsychotic medicine has been administered on the MAR Chart there is no clarity of which route was used.

Improvement needed

The registered provider must ensure that staff fully complete MAR Charts and use the correct coding why medication was not administered when applicable.

The registered provider must ensure MAR Charts are prescribed clearly to identify which route of administration has been used when medication has been administered.

Safeguarding children and safeguarding vulnerable adults

There were established processes in place to ensure that the hospital safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

The hospital monitored the training completion rates with regards to safeguarding children and safeguarding vulnerable adults to ensure staff compliance with mandatory training.

However it was noted on documentation in the staff office that the contact number for Healthcare Inspectorate Wales was incorrect. It is important that the registered provider ensures all contact information for external organisations remains up to date.

Improvement needed

The registered provider must ensure that all contact information for external organisations remains up to date.

Safe and clinically effective care

We found governance arrangements in place that helped ensure that staff provided safe and clinically effective care for patients.

Clinical governance arrangements for the hospital fed through to Ludlow Street Healthcare governance arrangements which facilitated a two way process of monitoring, learning and service development.

Records management

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

However the electronic record system was difficult to navigate. We were informed that this is currenly under review to enable a more user friendly system.

During the inspection we did observe at one point a patient in doorway of a ward office and it was apparent that they would have been able to view information on a nearby computer screen. It is important that staff are concious of these situations where patient confidentiality could be impacted and take apporaptie actions to minimise these from occuring.

> Improvement needed
>
> The registered provider must ensure that staff are mindful of protecting confidential information when patients are present.

Mental Health Act Monitoring

We reviewed the statutory detention documents of three patients the three wards inspected. We also spoke with the mental health act administrator to discuss the monitoring and audit arrangements in place for the hospital.

The organisation and availability of the statutory documentation and associated records had improved since our previous inspection. This enabled us to gain assurance that detentions were compliant with the Act and overall followed the guidance of the Mental Health Act Code of Practice for Wales, 2016 (the Code).

It was evident that detentions had been applied and renewed within the requirements of the Act and copies of legal detention papers were available to

ward staff at the hospital. There were clear records of patients being informed of their statutory rights regularly throughout their detention.

The renewal of detention was correctly applied on statutory forms and clearly documented within patient records. It was also evident that those patients' detentions were reviewed by the Mental Health Review Tribunal and at Hospital Manager Hearings [3], when applicable or required.

Medication was provided to patients in line with Section 58 of the Act, Consent to Treatment. Consent to treatment certificates were kept with the corresponding electronic medication record. This meant staff administering medication could refer to the certificate to ensure that medication was prescribed under the consent to treatment provisions of Section 58 of the Act.

All leave had been authorised by the responsible clinician on Section 17 Leave authorisation forms, these were up-to-date and well recorded. However, there was no record of the patient's involvement in decisions around their leave nor was it recorded to state whether the patient had received a copy of their leave form.

Improvement needed

The registered provider must ensure that there is a record of:

- The patient's involvement in decision around their leave
- Whether the patient had received a copy of their leave form.

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

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

Care plans reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed. However, despite regular review, the

[3] The organisation (or individuals) responsible for the operation of the Act in a particular hospital. Hospital managers have various functions under the Act, which include the power to discharge a patient.

maximum time between reviews was not defined, this would help ensure that staff regularly review care plans within a specified timeframe.

To support patient care plans, there were an extensive range of patient assessments to identify and monitor the provision of patient care, along with risk assessments that set out the identified risks and how to mitigate and manage them.

Individual care plans drew on patients' strengths and focused on recovery, rehabilitation and independence. It was evident that patients' views were considered on the development of the care plans and these were written with balanced input from all members of the multi-disciplinary team. Care plans supported positive behaviour and a measured approach to positive risk taking.

Care and treatment plans included good physical health monitoring and health promotion. It was also positive to note that each patient had a specific care plan in respect of COVID-19to be used when required.

All patients attended for annual GP checks, however for one patient there was no record of a GP check being undertaken in the last year, or a reason recorded why this had not occurred.

Each patient had a Safety Support Plan, which included the patient's views and wishes on how to be supported by staff. However for one patient their Safety Support Plan had not been updated since changes had been agreed in the patient record. This means that there was a risk that if staff supported the patient during an incident the patient's revised preferences would not have been followed. We confirmed that this risk had not occurred and the Safety Support Plan was updated during the inspection.

Improvement needed

The registered provider must ensure that patient records document their GP annual checks, or why they had not occurred.

The registered provider must ensure that patient Safety Support Plan are updated in a timely manner.

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.

Ludlow Street Healthcare had appointed a number of new senior members to Heatherwood Court. They all spoke enthusiastically and positively around the establishment and embedding of the new senior management team at the hospital and a focus on least restrictive philosophy of care and lessening the reliance on medication at the hospital.

We observed a committed staff team who had a good understanding of the needs of the patients at the hospital. Whilst there were ward staff vacancies we saw reasonable actions to mitigate the impact of this on patient care with the use of regular agency staff where possible.

Mandatory training completion rates were on the whole acceptable, however there were a number of modules where compliance needs to be improved, the hospital provided details of how this will be addressed.

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.

Identified senior managers had specific responsibilities for ensuring that the programme for governance remained at the forefront of service delivery. Those arrangements were recorded so that they could be reviewed both within the hospital and the wider organisational structure.

During the preceding months of our inspection there had been a number of significant changes to senior positions at the hospital. This included newly appointed Hospital Director, Clinical Director, Clinical Lead, Psychology Lead, Occupational Therapy Lead and Medical Director for Ludlow Street Healthcare.

During the inspection we spoke with each of these and there was a consistent emphasis on a least restrictive philosophy of care, lessening the reliance on medication and using evidence based alternative options. Each spoke enthusiastically and positively around the establishment and embedding of the new senior management team at the hospital, whilst being realistic of the challenges this poses.

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

Dealing with concerns and managing incidents

There was a complaints policy and procedure in place at Heatherwood Court. The policy provides a structure for dealing with all patients' complaints for services within the hospital. As well as raising a formal complaint, as highlighted earlier, there were a number of other processes for patients to provide feedback on their experiences at the hospital.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the system that included the name of patient(s) and staff involved, a description, location, time and length of the incident. Any use of physical intervention was clearly documented.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and reviewed at hospital and organisation level so that the occurrence of incidents could be reviewed and analysed. It was noteworthy that the number of incidents and use of physical intervention was on a downward trajectory during the last 12 months, with less restrictive methods being implemented to manage situations.

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation.

It was positive that the patient's view of an incident was sought, and this was the first stage of the process, which enabled the patient's views to be included in the staff debrief following an incident. As stated earlier each patient had a safety support plan, and following an incident consideration was given to whether any changes with the plan were required or wished for by the patient.

Workforce planning, training and organisational development

We reviewed the staffing establishment at Heatherwood Court with that stated within their Statement of Purpose. At the time of the inspection there were 11 registered nurse vacancies. Six of these positions appointed to and were due to start employment in the near future. The Registered Manager described the hospital's future workforce planning arrangements to fill the remaining positions.

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 along with the use of agency staff. Agency registered nurses were typically regular individuals who were familiar with working at the hospital and the patient group. This assisted with the continuity of care for patients. It was noted that where an agency nurse was scheduled to be working at the hospital longer term, they would work shifts as part of their induction supernumerary to the allocated rota; this enabled the agency staff to familiarise themselves with the service, patients and other staff members.

We reviewed the mandatory training statistics for staff at Heatherwood Court and found that completion rates were in general above 85%. The electronic system provided management with the course title and individual staff compliance details. However, there were areas of training that required improvement, one area was First Aid 67%, the hospital was in the process of training four internal trainers to cascade the training within the hospital. Another area was physical intervention 79% and break and escape at 50%, with outstanding staff booked to complete these modules by January 2022.

We were informed of processes that have been implemented since the change in senior managers at the hospital, this included regular team meetings, staff forums, 1:1 sessions, monthly staff support groups and case reflection groups. It was acknowledged by senior managers that the workforce at the hospital was dedicated, however fatigued with low morale. It was hoped that the introduction of these various arrangements would help staff feel supported and provide a range of communication channels between ward staff and senior managers at the hospital.

Improvement needed

The registered provider must ensure that deficiencies in mandatory training are addressed.

Workforce recruitment and employment practices

Staff explained the recruitment processes that were in place at Heatherwood Court and how systems were in place to ensure that recruitment followed an open and fair process. Prior to employment staff references were received, Disclosure and Barring Service (DBS) checks were undertaken and professional qualifications checked.

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, measurable, 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

Ward/unit(s): Caernarfon Unit, Cardigan Unit and Chepstow Unit

Date of inspection: 29 November – 1 December 2021

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 patient experience				
The registered provider must consider also providing the patient information displayed in the stairwell on the ground floors of the wards	9. patient information and consent	All information has been copied and is available on all ground floors of each ward	Lydia Bevan	04/02/2022

Delivery of safe and effective care				
The registered provider must ensure damages and marks to paint work are rectified in a timely manner	22. managing risk & health & safety 12. Environment 4. Emergency Planning Arrangements	Weekly environmental audits are completed on the unit. Any maintenance or decoration items highlighted from walk around are then uploaded to the electronic Maintenance request system and the General Manager (GM) has oversight of any outstanding items weekly and addresses. All members of the SMT have now been instructed when on the units to complete walk arounds and report any environmental / decoration issues to the GM.	Unit Managers / Lydia Bevan	04/02/2022
The registered provider must ensure all cleaning equipment organised is stored appropriately.	13. infection prevention and control (IPC) and decontamination	On Caernarfon unit all cleaning equipment has now been stored and organised appropriately and staff and patients have been notified of storing information	Nia Grinnell	04/02/2022
The registered provider must ensure all staff are aware of their responsibilities around	13. infection prevention and control (IPC) and decontamination	All housekeeping staff have now received supervision and one to one training around the cleaning schedules and requirements.	Lydia Bevan	04/02/2022

infection prevention and control				
The registered provider must ensure that filled sharp bins are correctly closed and removed from clinical areas in a timely manner.	13. infection prevention and control (IPC) and decontamination	The frequency of collections has been increased for HWC and all Unit Managers have been reminded about the importance of sealing and removing from clinical area full sharps bins and cascading this information to nurses via one to one supervisions and team meetings	Unit Managers / Clinical Lead	04/02/2022
The registered provider must ensure that staff fully complete the MAR charts and use the correct coding why medication was not administered when applicable.	15. Medicines Management	Medication audit template inserted below which is completed weekly by the unit managers to ensure accuracy of information. Clinical Lead also spot checks throughout the week. Ashton's audit is also provided monthly conducted by an external auditor which also monitors MAR entries. We are in the process of looking to convert HWC over to E-MAR system, but currently have an issue securing a GP practice.	Lee James	04/02/2022

The registered provider must ensure MAR charts are prescribed clearly to identify which route of administration has been used when medication has been administered	15. Medicines Management	The Medical Director and Clinical Lead are having one to one discussion with all of the medical and nursing staff to ensure the MAR charts are completed clearly to identify the route	Dr Marcin Flirski / Lee James	04/02/2022
The registered provider must ensure that all contact information for external organisations remains up to date.	11. Safeguarding children and safeguarding vulnerable adults	All posters to be re printed and displayed in all office and communal areas to ensure correct information held for all external agencies (including HIW).	Lydia Bevan	04/02/2022
The registered provider must ensure that staff are mindful of protecting confidential information when patients are present	20. records management	All nurses informed that if any computer screens are visible from doorways the screens are to be locked when a patient / visitor comes to the doorway to protect confidential information.	Lee James	04/02/2022
The registered provider must ensure that there is a record of the patient's involvement in decision around their leave	Mental Health Act monitoring 20. Records Management	Nurses complete a Section 17 Summary and Checklist form which includes patient discussion and a record of whether form received. Unit Managers to reinforce this with nursing team for consistent usage.	Lee James	04/02/2022

The registered provider must ensure that there is a record of whether the patient had received a copy of their leave form.	Mental Health Act monitoring 20. Records Management	Nurses complete a Section 17 Summary and Checklist form which includes patient discussion and a record of whether form received. Unit Managers to reinforce this with nursing team for consistent usage.	Lee James	04/02/2022
The registered provider must ensure that patient records document their GP annual checks, or why they had not occurred	Mental Health (Wales) Measure 2010 20. Records Management	This has been addressed with individual nurses through their supervisions and will be added to the next nurse meeting in February 2022.	Lee James	28/02/2022
The registered provider must ensure that patient Safety Support Plans are updated in a timely manner	Mental Health (Wales) Measure 2010 20. Records Management	Clinical File Audits to ensure there is a check of monthly SSP and Care Plan reviews moving forward.	Lee James	04/02/2022

Quality of management and leadership				
The registered provider must ensure that deficiencies in mandatory training are addressed.	25. Workforce planning, training and organisational development	Training compliance is addressed monthly within Local and Corporate Governance and overseen by the General Manager and Training Manager. First Aid is currently 78% and Physical Intervention is 83% with all other staff booked to attend in the next 6 weeks.	Lydia Bevan	04/02/2022

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): Sarah House

Job role: Operations Director, Ludlow Street Healthcare

Date: 7 February 2022