Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Hillview Hospital

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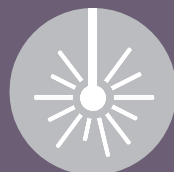

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities

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1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at Hillview Hospital on 15, 16 and 17 August 2022. The hospital has 21 beds and provides child and adolescent Mental Health Services to females aged between 13 (thirteen) to 18 (eighteen) years of age who are diagnosed with a mental disorder and who are detained under the Mental Health Act 1983. At the time of the inspection, the hospital was supported by the management and organisational structures of Regis Healthcare. The following hospital wards were reviewed during this inspection:

- Tŷ Seren
- Ebbw Ward.

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

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Feedback from the family member and carer questionnaires issued by HIW was mixed, with both positive and negative views and experiences received. The young people we spoke with during the inspection were more positive about the care they received at the hospital and about their interactions with staff. The young people could engage and provide feedback to staff on the provision of care at the hospital in a number of ways. A mental health advocate was available to the young people to provide them with support and information.

This is what we recommend the service can improve

- We were told that therapeutic activities often get cancelled at short notice. The service must ensure activities go ahead as scheduled
- Communication by the hospital to family members and carers in relation to the care and wellbeing of the young people could be improved
- A review of the visiting arrangements in operation at the hospital should take place to ensure it appropriately meets the needs of the young people and family members and carers.

This is what the service did well:

- We noted that work had been completed to make both wards look more appealing and pleasant since our previous inspection.

Safe and Effective Care

Overall summary:
We were assured that processes were in place to manage and review risks to help maintain the health and safety of the young people, staff, and visitors at the hospital. We saw improvements had been made in several areas since our previous inspection to help ensure the hospital provided safe and effective care. For instance, the quality of care and treatment plans were now in line with best practice guidance. However, as noted during our previous visit, we identified issues in relation to infection prevention and control procedures.

This is what we recommend the service can improve

- Some staff members undertaking observations could make more effort to have meaningful interactions with the young people
- All weekly checks undertaken on the resuscitation and emergency equipment must be documented

- Ensuring all staff are aware of, and follow, the procedures for escalation in line with National Early Warning Scores guidance to help protect the health and safety of the young people
- All care and treatment plans identified as necessary for the young people upon their admission must be subsequently created and acted upon.

This is what the service did well:

- The clinic rooms were organised, clean, and tidy and procedures were now in place for the safe management of medicines
- The electronic system in place to maintain patient records was comprehensive, well organised and easy to navigate.

Quality of Management and Leadership

Overall summary:
All staff members that responded to the HIW questionnaires recommended the hospital as a place to work and agreed that they would be happy with the standard of care provided for their friends or family. Some staff members did raise some issues with us and we have asked the service to consider these; for instance, comments were received asking for better communication from senior management to staff.

Following our previous inspection in November 2021, Hillview Hospital was designated as a Service of Concern in line with HIW's Escalation and Enforcement process for independent healthcare services. This was due to the number and severity of the issues we identified. We saw that improvements have been made in the governance and auditing arrangements put in place since our previous inspection which has helped provide management with better oversight of clinical and operational issues. However, we found that serious issues remained in relation to poor quality of incident reporting. As a consequence, the setting remains a Service of Concern and we will continue to monitor the service to ensure all improvements required are addressed.

3. What we found

Quality of Patient Experience

We invited family members and carers of the young people at the hospital to complete HIW questionnaires to obtain their views on the service provided at the hospital. In total, we received 12 completed questionnaires. The results reflected a difference in opinion among respondents about the care being provided at the hospital. For example, whilst almost half of the respondents rated the setting as either good or very good, over half of the respondents rated the setting as either poor or very poor. Some of the questionnaire results and comments from the family members and carers appear throughout the rest of the report.

Health promotion, protection and improvement
We looked at a sample of patient records during the inspection and saw evidence that the physical health needs of the young people had been considered in addition to their mental healthcare. All young people received a physical health assessment upon admission to the hospital. However, we noted that the assessments appeared to be generic and not tailored to the individual. For example, it appeared some sections had been copied and pasted from one set of patient records to another. Physical health assessments must focus on the individual to help prevent deterioration of their health and wellbeing and help manage their mental healthcare needs. Following admission, physical health care plans documented any required ongoing health promotion and preventative interventions, such as dietetic support and access to GPs.

The young people had access to a range of therapy facilities on the wards to support and maintain their health and wellbeing, including a gym, IT rooms and occupational therapy kitchen. Therapeutic activities were available throughout the week and both wards had outside areas available to use. However, we didn't observe any of the young people using the therapy facilities or accessing the outside areas during the period of our inspection. Furthermore, some of the young people told us that activities get cancelled at short notice; for instance, we noted that the dance class did not take place as scheduled. The service must ensure therapeutic activities are facilitated to provide a positive focus for the young people and help improve their recovery.

During the last HIW inspection in November 2021 we recommended that some aspects of the hospital environment needed improvement. During this inspection we saw that improvement work had been completed and that the wards looked more appealing and pleasant. For example, murals had been painted on the walls

of each ward. However, we found the quiet room on Tŷ Seren to be bare and bright and therefore not very relaxing or calming. During the inspection the sofa had also been removed from the quiet room and was being used as an extra chair in the lounge, which meant there were no seats available in the quiet room should any of the young people wish to use it.

Dignity and respect
Around half of the respondents to the family member and carers questionnaires said that staff were not polite to the young people and that staff were not kind and sensitive when they carried out care and treatment. Our observations were of friendly and respectful interactions taking place between staff and the young people. The young people we spoke with during the inspection were also positive about the care they received at the hospital and about their interactions with staff. They told us that they felt able to express themselves. However, the service should reflect on the questionnaire results and ensure staff are kind and sensitive to the young people when carrying out care and treatment.

The young people were able to store possessions and personalise their bedrooms with pictures and posters where appropriate. Being able to lock their bedroom and having access to private spaces was dependent on current individual risk assessments for potential self-harm. Some of the young people at the hospital were on increased observational levels by staff which meant that personal care activities were unable to be undertaken in private. We saw that arrangements were made wherever possible for female staff to observe the young people undertaking personal care activities.

Patient information and consent
An up-to-date statement of purpose was available that described the aims and objectives of the service and described what young people can expect from their stay at the hospital. Registration certificates from HIW were on display in the reception area of the building.

We saw that relevant information for the young people was on display throughout the wards. This included details about how the young people and their family members or carers could contact, and access, advocacy services. Posters displayed the New Economics Foundation five ways to wellbeing. Information about the role of HIW was also available and informed the young people how to contact the organisation should they wish.

We saw that all sensitive information regarding each young person being cared for at the hospital was kept in appropriately secure areas and kept out of sight to help protect confidentiality.

Communicating effectively

Daily meetings were being held on each ward every morning between staff and the young people to discuss upcoming activities and other relevant information, such as medical appointments. Weekly meetings were also being held to give the young people a chance to raise any issues they may have.

Just over a half of the respondents to the family member and carer questionnaires said that staff did not listen to the young people and did not listen to the family members and carers. When asked how the setting could improve the care and service it provides, some of the comments included:

> *"A weekly update by phone to parents/carers. This was initially provided, but the staff member changed roles and nobody has continued."*

> *"We have found that our daughter has received better care here than at other units. Having a point of contact really facilitated communication at the beginning. We felt heard by various levels of staff."*

The service must ensure communication to family members and carers of young people at the hospital (where contact is appropriate) is improved.

A handover meeting was being held every weekday morning for nursing staff to update the multi-disciplinary team (MDT) on any concerns, issues or incidents that had taken place the day before. We attended a handover meeting during the inspection and saw that senior nursing staff demonstrated a good level of understanding of the individuals they were caring for and that discussions focused on what was best for the young person.

Care planning and provision

During the inspection we reviewed the patient records of four young people. It was positive to note that the quality of care and treatment plans had improved since our last inspection at Hillview. We found care and treatment plans were contemporaneous, easy to navigate and well maintained. Our main findings on the care and treatment plans are detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Just over half of the respondents to the family member and carer questionnaires said that they hadn't been involved as much as they wanted to be in decisions about the young person's care. In the patient records we reviewed, we did see evidence that family members and carers had been involved in care and treatment planning. For example, family members had been invited to MDT meetings to discuss the care of the young person they cared for. However, the service may wish to consider further ways to involve family members and carers in decisions

about the young person's care where appropriate in light of the questionnaire results.

There was also evidence of the views and aspirations of the young people being recorded in their individual care and treatment plans. One respondent provided the following comment in the family member and carer questionnaires:

> *"Overall the setting has been amazing for our daughter, she's really had the best MDT team we've experienced in the 2 years of her hospital admissions."*

Equality, diversity and human rights

During the inspection we looked at the patient records of four young people that had been detained at the hospital under the Mental Health Act (the Act). The legal documentation we reviewed was compliant with relevant legislation and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code). Our main findings on the quality of the Mental Health Act documentation are detailed in the Mental Health Act Monitoring section of this report.

The hospital had policies in place to help ensure that equality and diversity was respected. We noted that some young people at the hospital had informed staff that their gender identity was now different from their sex assigned at birth and we observed staff using their preferred pronouns.

During the inspection we noted that the lift in Tŷ Seren was out of order. The same lift was also out of order during our previous inspection. We spoke to staff who assured us that the lift had been fixed since our last visit but had recently broken down again. Despite escalating this to staff, the lift was still out of order at the end of the inspection. It is important that the lift is fixed and accessible to ensure young people or visitors can use the lift if required.

The majority of the respondents to the family member and carer questionnaires said that they felt welcome to visit the setting. However, the majority of respondents also said that they were not able to visit the setting as often as they would like. This was echoed in some of the comments provided which included:

> *"Hospital restricts visits to twice a week - I want to visit daily."*

> *"Two 2 hour visits a week a permitted. I live in England and if the hospital was closer I would like to visit 3 times a week, twice seems limited."*

> *"Encourage more family visits and make them less intimidating. Family room had same dirty plates on side for 2 visits in a row."*

The service should reflect on this feedback and review the suitability of the current visiting arrangements in place at the hospital.

Citizen engagement and feedback

Regular surveys are issued to the young people and their family members and carers to understand their views and to help identify any improvements. We looked at the most recent set of survey results and saw some low satisfaction scores from the young people in relation to the comfort and environment of the hospital, and in how well staff keep the young people informed about changes to their care. However, it was also clear that staff have been having discussions about what actions they can take to address the issues and were committed to making improvements to try and increase satisfaction scores from the young people in the future. It was also positive to note the areas that achieved high satisfaction scores which were around staff friendliness, being supported to achieve recovery goals and staff awareness of individual needs.

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety
Overall, we were assured that Hillview had processes in place to manage and review risks to help maintain the health and safety of the young people, staff and visitors at the hospital. The hospital car park was protected by a locked gate and the main entrance to the building was locked to prevent unauthorised access. These were secured at all times throughout the inspection.

We saw that a range of up-to-date health and safety policies were in place. We noted that the service had implemented weekly Quality Walkarounds (QWRs) in response to our previous inspection at the hospital. The QWRs were undertaken by senior members of staff and helped to identify any improvements needed in terms of the environment of both wards. Regular health and safety audits were being completed and submitted to the corporate team at Regis Healthcare to monitor compliance. The majority of respondents to the family member and carer questionnaires agreed that the environment was clean and tidy, that it was easy to find their way around and that they felt safe when they visited.

The furniture, fixtures and fittings at the hospital appeared appropriate for the young people. There were comprehensive up-to-date ligature point risk assessments in place. We saw that actions had been taken in response to previous audits to manage any identified risks. There were a number of ligature cutters located throughout the hospital for use in the event of a self-harm emergency.

Staff wore personal alarms which they could use to call for assistance if required. There were also nurse call points around the wards and within each bedroom so that the young people could summon assistance if required. We were provided with personal alarms during the inspection in line with the hospital's personal alarms policy.

Infection prevention and control (IPC) and decontamination
During our previous inspection we found improvements were needed to ensure IPC procedures suitably protected young people, staff, and visitors at the hospital. We saw that improvements had been made since our last visit. The hospital was clean and tidy and bathroom bins were not overflowing. Relevant audits such as IPC and hand hygiene were taking place and the QWRs have been a positive step to monitoring compliance.

However, as during our last inspection, we again saw evidence during our visit in multiple areas of the hospital of what appeared to be dried blood stains following self-harm incidents. It should be noted that these areas were cleaned once our inspectors had raised this issue with staff. We acknowledge that managing incidents to protect the young person is the priority. However, systems must be implemented to ensure any blood stains are cleaned more quickly following an incident to protect the young people and staff at the hospital from the risk of cross infection and to promote a safe and secure environment.

Cleaning schedules documented the cleaning being undertaken at the hospital. However, we noted that the schedules weren't always completed as required each day.

Appropriate procedures appeared to be in place to help control the risk of transmitting COVID-19 throughout the hospital. We were told that the young people are tested for COVID-19 on arrival and self-isolate on a separate ward until a negative test is received. The service should ensure this period of isolation does not impact negatively on the young people. The majority of respondents to the family member and carer questionnaires agreed that, in their opinion, COVID-19 infection control measures were being followed at the hospital.

We saw that compliance among staff for IPC training was relatively high at 82 per cent. We were told that all staff were expected to complete their outstanding training by the end of September 2022.

Nutrition
A dietician was available at the hospital who was responsible for ensuring the nutrition and hydration needs of the young people were being met. We found suitable processes in place to meet individual needs. Each young person had a nutrition care plan in place which were being reviewed regularly. 24-hour food and fluid intake charts were being maintained and monitored by the dietician. Any issues were escalated by the dietician to the MDT if necessary.

The young people were being provided with a variety of hot and cold meals throughout the day by the hospital. The menu included healthy choices in addition to traditional children's meals. We were told that feedback on the menus is welcomed by kitchen staff and discussed in the weekly meetings with the young people.

During the previous inspection we highlighted the need to introduce the labelling of individual food and drinks. We noted that attempts had been made in this regard. For example, cereals all had labels to say when they were opened. However, we did not see use by dates. We also saw individual drinks and food in

the kitchen fridges on both wards that had no labels on to indicate which young person they belonged to. The service must ensure that food and drink items contain details on when a product is opened, the use by date and the young person's name.

A large proportion of the young people were receiving the nutrients and fluids they required through a nasogastric (NG) tube. Many of these young people were admitted to the hospital already using an NG tube. We noted that some of the young people being NG fed were at an appropriate weight for their height and age, or were managing some oral intake. In these instances, the justification for continuing with NG feeds was not always apparent in the care and treatment plans. It was also unclear in some cases whether the young person should keep their NG tube in situ or whether it is removed after feeding. The risks and decisions around this must be accurately recorded in the care and treatment plans of each young person requiring an NG tube.

Medicines management

During the previous inspection we raised issues in relation to poor medicines management procedures and the upkeep of the clinical environments. We saw a marked improvement in relation to these issues during this inspection meaning that we were assured that procedures were now in place for the safe management of medicines. This is because:

- Relevant policies, such as medicines management and rapid tranquillisation, were in date and available to staff
- The clinic rooms on both wards had been refurbished since our previous visit and were now well organised, clean, and tidy
- All medicines were being stored appropriately in lockable cupboards and fridges
- Daily temperature checks of the medication fridges and clinic rooms were being completed to ensure that medication was stored at the manufacturer's advised temperature
- Robust internal and external audits were being undertaken on a daily and weekly basis
- Electronic Medication Administration Records (MAR charts) were comprehensive and were being maintained to a good standard
- all relevant consent to treatment certificates were stored alongside the MAR charts as required
- Appropriate arrangements were in place for the storage and safe use of controlled drugs and drugs liable to misuse.

We saw that an audit proforma had been introduced which has been an effective tool to help monitor compliance at the hospital with best practice standards of medicines management.

During our review of patient records we saw that there appeared to be a relatively high use of medications being administered via the intramuscular (IM) route. It was positive to note during our discussions with staff that this high usage had already been identified in meetings and that senior staff had requested closer monitoring of future use of IM injections. We became aware during the inspection that there was a shortage of promethazine for IM injections. The service must ensure that appropriate alternative arrangements are made for those young people prescribed it.

Safeguarding children and safeguarding vulnerable adults

We saw that safeguarding concerns were being referred to external safeguarding agencies. We were told that safeguarding concerns are escalated internally to senior staff which included the social worker, ward managers and the registered manager. However, there seemed to be uncertainty around whose responsibility it was to have ownership and sign-off of safeguarding concerns, and for attending multi-agency meetings in relation to ongoing safeguarding cases. Staff also told us that they rarely get feedback or updates on the outcomes of any safeguarding concerns they have raised. It is important for the outcomes of any safeguarding incidents and concerns to be shared with staff to aid learning and promote an effective safeguarding culture.

We noted that safety concerns is a standing agenda item at monthly clinical governance meetings to help identify any themes and lessons learned. We saw that compliance among staff with safeguarding training was high at 88 per cent.

Medical devices, equipment and diagnostic systems

A process was in place for staff to undertake checks on resuscitation and emergency equipment held on each ward to ensure that the equipment was present and in date. Whilst we saw evidence that such checks were taking place, we found that the last documented check undertaken on the resuscitation and emergency equipment on the Ebbw Ward was on 01 August 2022, two weeks before our inspection. Staff must ensure that all checks are recorded on the weekly log.

Safe and clinically effective care

The hospital had policies in place to help protect the safety and wellbeing of the young people and staff. The therapeutic engagement policy described approaches for staff to follow to engage positively with the young people to reduce risk and prevent harm. However, during the inspection we observed some staff undertaking observations who were not engaging with the young person. We observed the same

issue on occasions during our previous inspection. This finding was echoed by a respondent to the family member and carer questionnaires, who commented:

"Staff do not all engage with patients, just stare at wall etc."

We recognised that efforts were made following our recommendations to ensure staff engage and interact in a positive way with the young person when undertaking observations. Notices had been displayed in the corridors and an email was issued to all staff reminding them of their responsibilities. However, we found during this inspection that only 40 per cent of staff had completed their training in therapeutic observations. The service must do more to ensure all staff, including agency staff, are competent in undertaking therapeutic observations to help best engage with and support the young people at the hospital. This is a particular concern given that it was identified during the previous inspection.

We saw that the use of restrictive practices was reviewed by the MDT during individual care plan reviews. Monthly least restrictive meetings were also being undertaken by senior staff to review blanket restrictions. When asked what improvements the service could make, some respondents commented:

"Easing strict blanket restrictions."

"Restrictions mostly blanket and not based on need or persons' risk."

The hospital should consider communicating the rationale for the blanket restrictive practices in place at the hospital to family members / carers to identify whether any exceptions or amendments are warranted.

We were told that positive behavioural support training was being rolled out to staff to help reduce restrictive interventions. We saw evidence of de-escalation methods being used on young people to help reduce the need for physical interventions. All staff had undertaken Prevention Management of Violence and Aggression training. However, during our review of incident data held by the hospital we saw that a high number of restraints on young people were occurring; there had been 937 such incidents between January 2022 and July 2022.

To understand this issue in detail, we reviewed a sample of incident reports to help understand whether such restraints were justified. We found that incident reports lacked appropriate and sufficient detail to provide this assurance. This is a significant issue that was also identified during the previous inspection, and it is concerning that we did not find that progress had been made in resolving and addressing this matter. The service must provide assurance to HIW on the actions it is taking to improve the quality of incident reporting. Furthermore, the service

must provide assurance on their strategy for reducing the number of restraints at the hospital in line with the Reducing Restrictive Practice Framework for Wales.

Records management

Patient records were being maintained electronically. The electronic system was password protected to prevent unauthorised access and breaches in confidentiality. We used the system throughout the inspection and found patient records to be comprehensive and well organised, which made it easy to navigate through the sections.

Further information on our findings in relation to patient records and care plans is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Mental Health Act Monitoring

We reviewed the records of statutory detention documentation of four young people currently residing at the hospital. All records were found to be compliant with the Mental Health Act and Code of Practice. Clear reasons were being documented to evidence why detention under the Act was the most appropriate way of providing care for the young person.

It was positive to see improvements had been implemented since our last inspection, which included:

- a form had been introduced to help staff assess the mental capacity of the young people to consent to treatment which we found reflected best practice guidelines
- The Section 17 leave forms we reviewed now clearly evidenced that leave was being appropriately risk assessed and determined the conditions and outcomes of the leave for each young person
- An identification card has been introduced for staff to carry when escorting young people on their leave. The card included a photo of the young person and identified their known risks should they abscond.

The documents we viewed were well organised, easy to navigate and stored securely. All relevant consent to treatment certificates were stored alongside the electronic MAR charts as required. We saw that Second Opinion Appointed Doctor (SOAD) assessments had been sought when young people had refused to provide consent. However, there was no associated proforma available for the statutory consultees to record their views and sign and date their conclusions.

We saw that discussions held with young people about their Section 17 leave were documented within their care and treatment plans. However, we did not see any

evidence that indicated that the young person had agreed with the conditions of their leave.

A robust system of audit was in place and we were told that an audit summary report template was in the process of being developed to aid learning.

There was good support available for the young people from a local advocacy service who held a drop-in session at the hospital every two weeks. The young people we spoke with during the inspection told us that they were aware of the advocate and the support they can provide.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision
It was positive to see that the quality of the care and treatment plans we reviewed had improved considerably since our previous inspection. We saw contemporaneous daily entries and individualised care and treatment plans with allocated responsibilities across the MDT. The domains of the Welsh Measure were being reflected and objectives focussed on recovery and rehabilitation.

There was evidence that the young people had been involved in the care and treatment process, with individual voices being well reflected within the documentation. Each young person had associated detailed risk assessments and safety plans which included regular review of the therapeutic observation levels.

We saw that the National Early Warning Score (NEWS) tool was being used to help identify any deterioration in the health of the young people. However, some of the NEWS charts we reviewed showed that actions such as increased monitoring or escalation were not always being taken when the NEWS score warranted it. The service must ensure staff follow the NEWS guidance to appropriately escalate potential signs of deterioration to help protect the health and safety of the young people.

We noted that some assessments undertaken on young people following their admission indicated a need for specialised care and treatment plans to be created, such as wound management or behavioural support plans. However, we could not always find these in the documentation. The service must ensure that all required care and treatment plans identified for the young people upon their admission are subsequently created. Furthermore, the service should review the existing care and treatment plans in place for each young person and assess whether there are any missing care and treatment plans that need to be created.

There was evidence of discharge and aftercare planning, and we noted that care co-ordinators had been involved in the process.

Quality of Management and Leadership

Staff Feedback

We invited staff to complete HIW questionnaires following the inspection to obtain their views on the service provided at the hospital. In total, we received 27 completed questionnaires. Staff responses were mostly positive, with all respondents recommending the hospital as a place to work and agreed that they would be happy with the standard of care provided for their friends or family. Some of the questionnaire results and comments from staff members appear throughout the report.

Governance and accountability framework

It was positive that throughout the inspection staff and senior managers were receptive to our views, findings and recommendations. We saw nursing staff working as a team during our time at the hospital. During the meetings we observed we saw the MDT working well together and it was clear they understood the needs of the young people well. Each MDT member was provided with time to voice their opinion.

It has been positive to see an improvement in the governance and auditing arrangements in place since our previous inspection. This has helped provide management with better oversight of clinical and operational issues. Agendas for clinical governance meetings showed a wide range of standing items to help ensure that the hospital focussed on all aspects of the service.

The majority of staff who completed a questionnaire agreed that they knew who the senior managers at the hospital were, that they were visible, and that they were committed to patient care. However, approximately half of staff who completed a questionnaire said that communication between senior management and staff was not effective and that senior managers do not try to involve staff in important decisions. The questionnaire asked staff a question about how the hospital could improve the service it provides, and comments included:

> *"Better communication from senior management."*
>
> *"There needs to be better communication between staff and management. There seems to be systemic issues surrounding communication throughout the setting at all levels."*
>
> *"More communication with hcw [healthcare workers]. Less of an us and them approach to hcw and the rest of the hospital"*

The senior managers at the hospital should consider and reflect on this aspect of staff feedback.

Dealing with concerns and managing incidents

We saw information about how the young people could make a complaint or raise a concern on display throughout the hospital. The young people we spoke with during the inspection informed us that they knew how to make a complaint should they wish to do so. Almost all of the respondents to the family member and carer questionnaires also said that they knew how to raise a concern. However, one respondent commented:

> *"Staff/managers do not respond to my complaints or concerns."*

While we looked at a sample of complaints and noted they had been acknowledged, the service should ensure that all complaints or concerns are responded to in line with the complaint policy.

The majority of staff who completed a questionnaire told us that if they were concerned about unsafe practice at the hospital they would know how to report it. Staff also agreed that they would feel secure raising concerns about patient care or other issues at the hospital. One staff member suggested the following improvement in the questionnaires:

> *"More IT/computers for incident reporting. More staff to enable incident reports to be completed after incidents rather than delayed."*

We have previously mentioned in the report that the service must focus on improving the quality of incident reporting to ensure management can effectively identify areas for improvement. The service should reflect on this feedback as part of its response to HIW.

Workforce planning, training and organisational development

The majority of staff who completed a questionnaire agreed that there were enough staff at the hospital to enable them to do their job properly and that there was an appropriate mix of skills. However, one staff member commented:

> *"More staff is needed to handle difficult times safely."*

At the time of our inspection there appeared to be sufficient numbers of appropriately trained staff to meet the assessed needs of the young people at the hospital. However, it was clear from discussions with staff, and from a review of the staffing rotas, that a high proportion of agency staff have been used at the

hospital to cover any staffing shortfalls. One respondent to the family member and carer questionnaires commented:

> *"Regular staff (some of whom are agency staff working at the hospital regularly) know the patients better, interact with them better and are able to support them better."*

We were told that wherever possible the same agency staff members are used who are familiar with the hospital to provide consistency for the young people. However, due to the reliance on agency staff there was a high prevalence of male staff working at the hospital. This was a similar finding from our previous inspection at the hospital. We were told that strategies were in place to retain staff and that the recruitment of permanent staff would focus on employing female staff to help meet the needs of the young people. Further efforts to recruit a diverse nursing team may also help provide more opportunity to develop therapeutic relationships. The service must continue to be mindful when employing agency staff to ensure the proportion of agency staff working at the hospital does not impact on the safety of the care being provided to the young people.

We reviewed the mandatory training statistics for staff at the hospital and found that completion rates were generally high. The majority of staff members who completed a questionnaire told us that the training helped them do their job more effectively, helped them stay up to date with professional requirements and helped them to deliver a better patient experience.

Workforce recruitment and employment practices

We saw that procedures were in place to ensure recruitment followed an open and fair process. Prior to employment, potential staff must provide two references and evidence of professional qualifications. An appropriate Disclosure and Barring Service (DBS) check must also be provided to help ensure staff are fit to work at the hospital.

Newly appointed permanent staff receive a period of induction to learn about the hospital, read company policies and complete mandatory training. Staff are assessed by senior managers after six months to ensure they have demonstrated their competence to do the job in practice. We were told that agency staff undertake a two-hour induction during their first shift which includes a tour of the hospital and guidance on how to use the personal alarms. Agency staff are also briefed on the individual risks, triggers, and de-escalation strategies of each young person on the ward they have been allocated to.

A whistleblowing policy was in place should staff wish to raise any concerns directly with the hospital director, registered provider or an alternative appropriate body if required.

4. Next steps

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 immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: 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.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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.

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.			

Appendix B - Immediate improvement plan

Service: Hillview Hospital

Date of inspection: 15, 16 and 17 August 2022

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate non-compliance concerns about patient safety were identified on this inspection.				

Appendix C - Improvement plan

Service: Hillview Hospital

Date of inspection: 15, 16 and 17 August 2022

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	Standard/ Regulation	Service action	Responsible officer	Timescale
Physical health assessments undertaken must be tailored to the individual rather than follow a generic template.	Health promotion, protection and improvement	• RC discussed with the Speciality Doctors the process for completing the physical health assessments. All young people are assessed at admission regarding physical health concerns. Any physical health concerns will be captured within a care plan and these will be reviewed monthly. • All care plans have been reviewed for young people to ensure they are individualised. • PCA team assessment of careplans planned for the 16th December • Link in RC with doctors in the region to encourage sharing of best practices. An RGN post has been advertised on the Elysium website. Applicants will be interviewed in due course.	RC and Speciality Doctor MDT PCA team Regional Services Director Regional Services Director	December 2022 December 2022 December 2022 Complete January 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The quiet room on Tŷ Seren must be reviewed to ensure it adequately provides seating and a comfortable and relaxing space for the young people to de-stimulate when necessary.	Health promotion, protection and improvement	This has been reviewed and new seating has been placed into the quiet room. For the quiet room to be discussed in ward meeting with staff to ascertain their views on the quiet room at the commencement of the refurbishment work For the quiet room to be discussed in the community meetings to ascertain their views on the quiet room. As Elysium have recently taken over Hillview and a refurb programme will be developed, patients views will be included in this refurbishment programme.	Ward Manager Ward Manager Regional Estates/Services Director/Hospital Director	Completed December 2022 May 2023
The service must ensure therapeutic activities take place as scheduled.	Health promotion, protection and improvement	Plan in place to ensure that activities take place as scheduled: Including: • Calendar to be updated and cast to ward Television's daily • Planned activity sessions to be discussed and confirmed in morning meetings • Nursing teams to contact department heads (of team facilitating the session) should a facilitator not begin the session within 5 minutes.	OT OT Nursing Team	Completed Completed Completed April 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		• The Occupational Therapy Lead or Clinical Lead sends a weekly activities update to the registered manager for the purpose of monitoring. • Once Elysium's systems have been rolled out at Hillview, team members will be using meaningful week, which is an electronic system. This enables easy reviews of activity, hours per patient being offered, how many hours have been accepted or declined. This information will be reviewed in Clinical Governance each month.	Regional Services Director & HD	
The service must improve its communication to family members and carers of the young people at the hospital in relation to their care and wellbeing (where contact is appropriate).	Communicatin g effectively	The family forum has been introduced. The first one was held on the 6th December 2022. The regional services director and senior team attended this meeting. In the first meeting with families, a plan was agreed on frequency of family forums, they decided they would like the forums to be monthly initially, a time was also agreed. The families and carers were asked for topics they would like to have a presentation on during family forum to gather more information, they	Regional Services Director	Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		suggested meal support and information on reducing restrictive practice. Following a discussion with the families it was agreed the service will explore the possibility of DBT and group family therapy for the families. Agreement was sought on other forms of communication. Monthly newsletter were offered and carers felt this would be beneficial. For ward managers to link in with family members to discuss this action and ascertain their thoughts on how they would like to be commuciate with ward managers to ensures nurses contact family each week. Family members and carers will be involved in Clinical Governance meetings, providing them a forum to give feedback on communication.		December 2022 February 2023
The lift on Tŷ Seren must be fixed.	Equality, diversity and human rights	This lift is now working. Service plan is in place for quarterly servicing and call out agreement	H & S Lead	Completed October 2022.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The service must review its visiting arrangements, including frequency of visits, to ensure they meet the needs of the young people and family members and carers.	Equality, diversity and human rights	Following the HIW visit, we are not limiting frequency of visits and depending on how many families are booked in we will support all day visits. Hillview hospital reviewed it's visiting arrangements initially in the family forum with family members on the 6th December 2022. We discussed how to improve the visiting experience. We will also initiate individual contact with family members to discuss visiting.	Hospital Director/ Regional Services Director	February 2023
		Reducing Restrictive Interventions will involve looking at all systems & processes in the hospital which will include visiting arrangements. Hillview will adopt Elysium's policies on visitors & develop a local procedure if required. Risk assessments will be completed for all visiting arrangements to ensure they are facilitated in a safe and supportive way.	Hospital Director	February 2023
The service must ensure the process for identifying and removing blood stains following	Infection prevention and control (IPC) and	Environmental audits following each incident requiring restraint will be carried out to assure the ward team that the environment is safe including the Nurse in Charge (NIC) checking for blood stains or	Clinical Lead	November 2022

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
incidents is improved and made more timely.	decontaminati on	restricted items that might have been left following an incident. The NIC will ensure that they hand over to the incoming shift that all possible areas with bodily fluids was cleaned and to prompt staff during handover to act following any incident where bodily fluids may have been spilt. Cleaning equipment is available from housekeeping cupboard situated on each ward, in the nursing stations and there are body spill kits stored in the clinics. Ward staff are also allocated to cleaning duties during the night shift to ensure that areas are kept clean for the following morning. Regional Services Director met with the senior support workers and advised them on reviewing the environment following incidents involving blood to ensure the environment was clean.		
Cleaning schedules must be maintained as expected.	Infection prevention and control (IPC) and	Cleaning schedules are being checked weekly and any omissions are reviewed or actioned as required. Cleaning schedules will feed into the Elysium operational governance meeting at site monthly	H & S Lead H & S Lead	Ongoing. January 2022

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
	decontamination	Health and Safety Lead completes walk arounds to review cleaning schedules. Current cleaning schedules highlight the deep cleaning programme & frequency. Monthly IPC audits are completed, this information will be fed into Governance meetings each month.	H & S Lead H & S Lead H & S Lead	Ongoing Ongoing Ongoing
The service must ensure that food and drink items contain details on when a product is opened, the use by date and the young person's name.	Nutrition	When food is brought on to the wards, ward staff label the food with opening date & patients name. Protocol is displayed in the services for all staff to read. Senior support workers check items in the fridge when completing temperature checks during the shift and dispose of any items not clearly marked. In addition to this, kitchen staff also check the fridges to ensure there are no items that are unlabelled or past their use by dates. Patients would be informed of items which have to be discarded & an alternative will be offered	H & S Lead Clinical Lead	Ongoing.
The service must ensure the justification for NG feeds are recorded for each young person	Nutrition	Within the patients notes, the justification for patient's NG feed is recorded	Responsible Clinician & Dietian	Complete and ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
that it is deemed appropriate for.		NG feeding plans are placed on Ashtons live under clinical documents.		
Care and treatment plans must indicate whether each young person should keep their NG tube in situ or whether it is removed after feeding.	Nutrition	The NG tube is discussed in ward round and decision is based on the patient's current presenting risk as to if the tube remains in situ or is removed after feeding. The patients views are considered in ward round	Responsible Clinician & Dietian	Complete and ongoing
The service must ensure that appropriate alternative arrangements are made for the young people that have been prescribed promethazine for IM injections.	Medicines management	This issue was rectified during the visit when it was reported by Ashtons that there was a shortage of the medication. All YP prescribed Promethazine IM were prescribed different IM medication (if clinically indicated) otherwise they were prescribed Promethazine oral which was readily available.	Clinical Lead	Completed
The service must improve communication to staff on the outcome of any safeguarding incidents that they have been involved in or raised.	Safeguarding children and safeguarding vulnerable adults	A review of the morning meeting process has been conducted. All safeguardings raised are captured in the morning meeting and actions recorded. Any lessons learned will be discussed in monthly Clincal Governance and disseminated to all staff through team meetings and supervision. Depending on	Clinical Lead MDT	Completed and ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		the safeguarding concern, we would meet with staff individually to feedback if appropriate and utilise supervision and reflective practice	MDT/Hospital Director	December 2022
The service must ensure there is clearer responsibility in relation to ownership and sign off of any safeguarding concerns that have been raised.	Safeguarding children and safeguarding vulnerable adults	We have introduced a weekly safeguarding review with regional lead. This included monitoring of database.		Complete
		We have four staff booked onto Level 4 children's safeguarding. Three staff are booked on a two-day level 4 Safeguarding course on 14th and 15th December.	Regional Services Director	December 2022
		All safeguarding will be reviewed in clinical governance.	MDT	January 2023
		Safeguarding incidents are reviewed in morning meeting, actions are identified and a responsible person is identified and these actions are then tracked.	MDT	Completed
The service must ensure that all checks undertaken on the resuscitation and emergency equipment at the hospital are	Medical devices, equipment and diagnostic systems	All First Aid equipment required for Emergencies and resuscitation are checked on a weekly basis and recorded on the weekly logs. All First Aid bags have seals in place to ensure that no bag has been tampered with and that what equipment stated on	H & S	Ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
accurately recorded on the weekly logs.		the log is contained within. Oxygen at site is also checked weekly to ensure sufficient supply, location is clear and that it is in date. The 4 AEDs are checked on a monthly basis and these are documented and held within the H&S department. They are also checked weekly and this is documented on the Clinic Audit completed by the registered nurses. All calibration equipment that requires calibrating is checked on a yearly basis, or whenever needed, by Calibrate UK, they are scheduled to attend site in February 2023. The service undertakes regular random drills to assure us of readiness.		Monthly Yearly
The service must ensure all staff, including agency staff, undertaking observations on young people have completed their training in therapeutic observations.	Safe and clinically effective care	The service has a competency checklist and this includes information on risks & what observations. The service is currently checking all staff (permanent & agency) have one file. Elysium has a safe & supportive observation competency policy which will be adopted at Hillview. On the manager checklist, manager will discuss with staff about observation & check observation sheets	Clinical Lead Resource Lead HD & Clinical Lead Managers	Ongoing December 2022 February 2023 December 2022

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The service must ensure all staff, including agency staff, are engaging with the young people to help best support them while undertaking therapeutic observations.	Safe and clinically effective care	The current observation form indicates preferences that the patient would like to engage in. All permanent staff undertake the Engaging with Young People training during the induction. Therapeutic engagement forms provide detail of what topics staff can engage with Young People. As part of the QWR process, senior staff remind staff about their responsibility to engage with young people in a bid for culture change. Occupational Therapy will be providing support to staff on the wards in relation to activities staff can utilise to engage the young people.	Clinical Lead	Ongoing
The service must provide assurance on the actions it will take to improve the quality of incident reporting.	Safe and clinically effective care	The morning meeting includes a summary of all incidents. They are reviewed in this meeting and escalated as required. All actions are logged and tracked in the morning meeting. Incident details are reviewed in full following the morning meeting by Ward Manager and Clinical Lead, Monday- Friday, to ensure the incident forms are completed to a high standard.	MDT Ward Manager & Clinical Lead	Complete January 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Training package regarding the detail and quality required within an incident form will be rolled out to all staff, permanent and agency. Where we identify individuals who require further support in relation to completing incident forms this training will be completed on a 1:1 basis. There is a plan in place to implement the use of Elysiums IRIS system, this will allow incident forms to be returned to a staff member for further detail and include an audit trail of incident forms which have been returned. Senior support workers are reviewing incidents recorded on the wards and providing support in completing the forms.	Quality and Compliance Manager	February 2023 February 2023 Ongoing
The service must provide assurance on their strategy for reducing the number of restraints at the hospital in line with the Reducing Restrictive Practice Framework for Wales.	Safe and clinically effective care	The Elysium audit for restrictive practice was undertaken on the 1st of December 2022, following the review an action plan will be devised and all actions tracked in the monthly clinical governance. Regional TMVA lead for Elysium is reviewing the training package for TMVA at Hillview and reviewing themes from incident forms. This will be reviewed in the governance meetings. Themes identified by the	Quality Lead & Regional TMVA Lead	December 2022

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		TMVA lead will translate into his training needs analysis. We completed live workshops with permanent, bank and agency staff. These workshops were completed following observations of incidents involving restraints by the TMVA lead with the individuals involved in the incident.	Regional TMVA lead	December 2022
		Weekly reports are being developed to review the number of restraints, they will cover incidents occurring Thursday- Thursday ready to be submitted on Friday’s. The only exception to the days the report is run between is on 07/12/22 due to the submission day being a Wednesday. The report will include the following:	Regional TMVA lead	December 2022
		• Breakdown of incident forms- how many pink, yellow, green and NG feeds per ward. • Further breakdown of incident forms for pink and yellow per young person, per ward. • Breakdown of safe holds- supine, standing, seated etc. • Length of safe holds in minutes.	Psychology and Quality Manager	Ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Lessons learned posters are displayed in nursing offices and staff room containing information from across Elysium. Once Lessons Learned are identified within Hillview this information will be developed into a poster monthly and displayed for staff. This information will also be discussed in supervision and Clinical Governance.	CAMHS Quality Manager	Ongoing
A proforma must be made available for the SOAD process for statutory consultees to record their views and sign and date their conclusions.	Mental Health Act Monitoring	The service has consulted widely with our central MHA offices and our legal department on drafting a proforma to capture and record views of consultees who the SOAD has had contact with and conclusions reached. The draft document to capture the above if legally accepted will be implemented in January 2022.	Responsible Clinician	January 2023
The service must ensure that the agreement of each young person with the conditions of their Section 17 leave is recorded.	Mental Health Act Monitoring	Young people have engaged with the MDT to agree section 17 leave parameters at ward rounds and will then co-sign agreement to start the process of using their section 17 leave. All patients are encouraged to sign their section 17 leave and if risks enable a copy is provided	Responsible Clinican Clinical Lead	October 2022 December 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The service must ensure staff are aware of, and follow, the procedures for escalation in line with NEWS guidance.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	Guidance is national and is available on ward - posters are displayed and there is a folder for the YP on the ward where their observations are recorded on NEWS Charts. The observations are recorded on Careblox and in the nursing handover so that oncoming nursing staff are aware of any physical health issues, what monitoring has been required and what is still needed discussed in morning meeting	Clinical Lead	December 2022
The service must ensure that all care and treatment plans identified as necessary for the young people upon their admission are subsequently created.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	There is a pre-admission & admission checklist currently in place. This supports MDT in identifying required care & treatment plans, 72 hour admission is completed before admission. The service will work towards MDT careplan.	Clinical Lead MDT	Completed & ongoing March 2023
The service must review the existing care and treatment plans in place for each young person and assess whether there are any missing care and treatment plans that need to be created.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	A site level review of careplans is being undertaken in December. We have Elysium PCA team reviewing care & treatment plans in December and an action plan will be generated following the visit and actions tracked in clinical governance meeting	PCA team & MDT & Clinical Lead	December 2022

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Careplan training will be facilitated to support the team.	Quality Lead	March 2023
The service should review the family member and carer and staff responses to the questionnaires throughout this report and provide an update on plans to address the issues raised.	Governance and accountability framework	The family & carer responses will be reviewed in the family forum in December. The action plan/report and staff responses will be reviewed in staff meetings, local ward meetings & clinical governance actions generated from responses & idea.	MDT Hospital Director	December 2022 January 2023

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): Pippa Philipson

Job role: Regional Services Director

Date: 07 December 2022