Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Heatherwood Court, Pontypridd
Inspection date: 8 & 9 November 2022
Publication date: 3 March 2023

This summary document provides an overview of the outcome of the inspection

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We saw passionate leadership demonstrated by the hospital director who was supported by a committed multidisciplinary team. We were told that the leadership team was approachable and supportive to staff and had a good understanding of patient needs.

Despite this, we did not see evidence of established governance arrangements around incident management and reporting incidents.

As consequence of the concerns identified during our inspection regarding incident reporting, and lack of assurance over the processes in place to report, log and learn from incidents, Heatherwood Court was identified as a Service of Concern as of 11 November 2022. HIW will work closely with the provider to ensure that progress is made against these concerns and improvements made.

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 mental health inspection at Heatherwood Court Hospital on 8 & 9 November 2023. The inspection did not use HIW's full methodology, and instead specifically focused on leadership and governance at Heatherwood Court, and the reporting and management of incidents.

Our team, for the inspection comprised of one HIW Healthcare Inspector and two clinical peer reviewers. The inspection was led by a HIW Healthcare Inspector.

This summary version of the report is designed for members of the public.

A full report, which 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 can be found on our website.

Quality of Patient Experience

Overall Summary

- This inspection focused on Leadership and Governance, the Quality of Patient experience was not considered on this inspection.

Delivery of Safe and Effective Care

Overall Summary

- This inspection focused on Leadership and Governance, the Quality of Patient experience was not considered on this inspection.

Quality of Management and Leadership

Overall Summary

- We found cohesive teamworking between the Multidisciplinary team. We saw that the leadership team was approachable and supportive to staff. We saw patient risk was being discussed at many different levels within the hospital, but despite this we could not be assured that there was established governance arrangements in place around incident management and the reporting of incidents.

What we found this service did well

- We saw that risk management plans had been completed to a high level.

- We saw patient grab sheets available for a small number of patients. These grab sheets made it easy for all staff, regular or agency, to understand the needs of the patient. This had a positive effect for the more challenging and vulnerable patients as it allowed staff to quickly seek advice on how to best help the patient during times of crisis. The grab sheets contained information on how best to de-escalate the patient, how to encourage the patient to engage in more positive behaviours and also gave a set routine on how to deal with the patient's crisis while always highlighting risk items for the patient to ensure everyone is kept safe

Where the service could improve

- We examined patient incident forms and safeguarding referrals forms. We found a number of incidents forms and safeguarding referrals that met the threshold to be notified to (HIW) under the Independent Health Care (Wales) regulations 2011[1], had not been submitted. This has been considered a regulatory breach and a noncompliance notice has been issued.

- We saw evidence that despite the post of hospital director being filled, the regulatory requirements of having a registered manager at the hospital had

[1] See: Notify us of an event | Healthcare Inspectorate Wales (hiw.org.uk)

not been complied with for over 12 months. This was due to the previous hospital director suddenly leaving and delays in appointing and registering a substantive replacement. This has been considered a regulatory breach and a noncompliance notice has been issued.

- As a consequence of the concerns identified during our inspection regarding incident reporting and lack of assurance over processes in place to report, log and learn from incidents, Heatherwood Court was identified as a Service of Concerns as of 11 November 2022. HIW will work closely with the provider to ensure that progress is made against these concerns and improvements are made.

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 appendices of the full inspection report.

When we identify concerns that pose an immediate risk to patient safety we ask the health board to undertake urgent action. These concerns are outlined in the appendices and outline the action taken by the health board to protect patient safety and approved by us. We also provide a detailed table of improvements identified during the inspection where we require the service to tell us about the actions they are taking to address these areas and improve the quality and safety of healthcare services. In addition we outline concerns raised and acknowledge those resolved during the inspection.

At the appropriate time HIW asks the health board to confirm action has been taken in line with management responses documented in the improvement plan. We also ask health boards to provide documented evidence of action taken and/or progress made.