Independent Mental Health Service Inspection (Unannounced)

Ludlow Street Healthcare

Heatherwood Court

Caernarvon, Caerphilly, Cardigan & Chepstow Units

Inspection date:

19 - 21 November 2018

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

Our purpose

To check that people in Wales are receiving good care.

Our values

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 19 November and the following days of 20 and 21 November 2018. The following sites and wards were visited during this inspection:

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

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

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

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

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

2. Summary of our inspection

Overall, we found evidence that the service provided safe and effective care. However, we found improvements were required in medicines management and the staff understanding and practice of patient observations during the nights.

This is what we found the service did well:

- Provided good range of activities and therapies for patients at the hospital and in the community
- 24 hour reception and administration cover with thorough security checks for visitors
- Focused on least restrictive care to aid recovery and supported patients to maintain and develop skills

This is what we recommend the service could improve:

- On site activities are restricted to daytime hours and access is limited by availability of staff.
- Practices around the dispensing of medication
- Practices around nigh time observation of patients

We identified the service was not compliant with:

Regulation 15 (5) (a) and (b) of the Independent Health Care (Wales) Regulations 2011 regarding protecting patients against the risks associated with the unsafe use and management of medicines, and;

Regulation 15 (1) (b) of the Independent Health Care (Wales) Regulations 2011 regarding the quality of treatment and other service provision, specifically, ensuring the welfare and safety of patients.

These are serious matters and resulted in the issue of a non compliance notice to the service. At the time of publishing this report HIW has received sufficient assurance of the actions taken to address the improvements needed.

3. What we found

Background of the service

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

The setting is a mixed gender hospital with gender specific units. The service is registered to not exceed 47 patients and aged between 18 and 64 years; at the time of inspection there were 45 patients.

The service was first registered in December 2007.

The service employs a staff team which includes the interim registered manager who is currently going through the registration process, and newly appointed Hospital General Manager. The multi-disciplinary team includes:

- The Medical Director, a Consultant Psychiatrist and Associate Specialist
- Clinical Lead Manager, four Unit Managers and teams of registered nurses and support workers
- Lead Psychologist, one Clinical Psychologists, a Forensic Psychologist, a Psychological Practitioner, four Psychology Recovery Workers
- Head of Therapies, Senior Occupational Therapist, Occupational Therapist, Occupational Therapy Technician,

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

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

Quality of patient experience

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

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

Patients were provided with a range of up-to-date information to enable them to make choices regarding their care, treatment and wellbeing.

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

We spoke with patients across all four units of Heatherwood Court during the inspection. On the whole patients made positive comments about the care that they received and told us that they were treated with respect by permanent staff, however some stated that agency staff were less attentive and less understanding of individual patient needs or the patient group as a whole.

Health promotion, protection and improvement

There was a range of health promotion, protection and improvement information and initiatives available to the patients at the hospital which assisted in maintaining and improving patients' wellbeing. This included information on healthy eating, smoking cessation and personal hygiene. This information was in various formats including easy read.

Staff completed health promotion checks on patient admission.

Dignity and respect

We observed that ward staff, senior management and auxiliary staff interacted and engaged with patients appropriately and treated patients with dignity and

respect. Staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients.

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

However, some patients did express that permanent staff treated them much better than some agency staff.

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

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

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. Some concerns were identified in relation to observations which are dealt with in later sections of this report.

Bedrooms were not en-suite however there were sufficient toilets and showers available on both floors of each unit. These areas appeared clean and tidy and appropriate for the patient group. A Perspex mirror had recently been put up in one shower room on Chepstow ward. This mirror did not have a protective surround and presented a threat of harm to patients. This was highlighted to staff and removed immediately.

Each ward had suitable rooms for patients to meet ward staff and other healthcare professionals in private. There was also a visiting room, in the hospital reception area, available for patients to meet with visitors, including younger family members. There was a good range of information available within this room including a copy of the Mental Health Act Code of Practice for Wales[1].

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

Improvement needed

The registered provider must ensure that all fixtures and fittings are safe and appropriate for the patient group

The registered provider must ensure that agency staff maintain the standards of care expected and displayed by permanent staff members

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, however contact details for Healthcare Inspectorate Wales were not present on Chepstow ward.

There was also information of how to access local services such as the dentist.

We were informed that as part of the regular bronze on-call audit[2] information displayed for patients was checked to ensure that it was maintained and available for patients. This was confirmed by a number of staff we spoke with.

[1] https://gov.wales/topics/health/nhswales/mental-health-services/law/code-of-practice/?lang=en

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

The patient handbook contained useful information and was available in easy read formats.

Improvement needed

The registered provider must ensure that Healthcare Inspectorate Wales contact information is available on patient notice boards on all wards.

Communicating effectively

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

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

Each unit had a weekly meeting where patients had the opportunity to provide feedback on the care that they receive at the hospital and discuss any developments or concerns. We were informed that from the start of 2019 each ward will conduct a weekly huddle type meeting to allow both patients and staff to effectively communicate their views to each other and the hospital.

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

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

Care planning and provision

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

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

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

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

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, two therapy rooms, an education room and computer room.

Patients reported that the amount of time available to access these activities was restricted and had recently reduced due to a change in the working hours of the therapy department. Patients were also reliant on the availability of a staff member to supervise access to these facilities

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

Improvement needed

The registered provider must ensure that the therapy services for patients are accessible to suit the patients needs.

Equality, diversity and human rights

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

Citizen engagement and feedback

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

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

Information was also available to inform relatives and carers, including on how to provide feedback, in the hospital reception

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 clean, well maintained and equipped with suitable furniture, fixtures and fittings for the patient group.

We were satisfied that the service provided safe and clinically effective care. However, some staff practices around medicine administration and night time observation require improvement.

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

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

Managing risk and health and safety

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

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

During previous inspections concerns were raised with regards to the practice of undertaking observations on patients when they were in their bedrooms. During this inspection we observed some staff only making verbal communication with the patient and failing to observe the patient to ensure that they were safe and not attempting to self-harm. From speaking to staff and patients it was clear that previous recommendations on the way observations should be conducted were not being followed by every staff member.

This has resulted in the provider being issued with a non compliance notice relating to patient safety. HIW have received sufficient assurance that this is being addressed.

It was positive to note that the registered provider had developed a training programme regarding completing patient observations which all staff, permanent, bank and agency, were completing. This training was required to be completed prior to any new staff commencing a shift.

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

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

The furniture, fixtures and fittings at the hospital were appropriate for the patient group. There were up-to-date ligature point risk assessments in place. These identified potential ligature points and what action had been taken to remove or manage these.

During the initial tour of Chepstow ward, the door closure arm above the door of the quiet room had become loose. This was highlighted to the night manager who made arrangements for it to be appropriately repaired the next day.

The nursing office windows were beginning to become cluttered with information posters. This is an issue that has been raised at a previous inspection, and is checked as part of the night bronze audit. Whilst this was information displayed for the benefit of patients, it minimised the observation out of the nurse offices. The downstairs nurse office on Chepstow ward had been moved into a very small room with no window out onto the ward at all.

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

The hospital used the Safe Wards[3] initiative which assists staff in reducing the risk and occurrence of challenging behaviours through evidenced based practices. This helped maintain the safety of patients, staff and visitors.

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

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

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

Examples of these reports were made available to inspectors and provided detailed and easy to understand breakdowns of the types of incidents recorded.

Improvement needed

The registered provider must ensure all staff adhere to the night time observation process and conduct the appropriate level of observation for each patient as identified in their individual care plan.

The registered provider must address the ward office on Chepstow ward which is cramped and cluttered with no view of the ward or patients.

[3] http://www.safewards.net/

Infection prevention and control (IPC) and decontamination

The registered provider employs dedicated housekeeping staff for Heatherwood Court. The communal bathroom, showers and toilets were clean, tidy and clutter free. There was access to hand washing and drying facilities in all ward-kitchen and bathing areas.

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

Ward staff confirmed that they had appropriate stock of Personal Protective Equipment (PPE); these were stored in the domestic cupboards and clinical rooms.

There were hand hygiene gel dispensers at numerous points throughout the hospital and all the wards.

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

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

Nutrition

Patients were supported to meet their eating and drinking needs.

We found that patients were provided with a choice of meals on a four-week menu. We saw that a varied menu and patients told us that they had a choice of what to eat. The menu was displayed clearly on all wards. Patients could also make specific requests with the kitchen to change meals. These requests were accommodated wherever possible.

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

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

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

Medicines management

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

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

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.

We observed the lunch time controlled drug dispensing process on Chepstow and Cardigan ward. The staff nurse on Cardigan ward found half a diazepam tablet on the floor in the clinical room and commented that they thought they were half a tablet short on the morning drugs round. Diazepam is a drug liable to misuse (DLM). This drug was disposed of in the clinical waste and a record made in the DLM book.

Again on Cardigan ward the staff nurse was observed administering an oral syrup in a syringe that had been used previously. This was due to a low level of stock of single use syringes. The staff nurse also handled a tablet into a medication pot rather than use a 'not touch technique'[4] which is a breach of the Nursing Midwifery Council code of conduct.

On both Cardigan and Chepstow we saw that the drugs trolley and controlled drugs cupboard were left unlocked without staff being present during the drugs dispensing period. This was highlighted to staff at the time but the practice continued. We also saw staff on both Cardigan and Chepstow wards whilst

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[4] http://health.answers.com/Q/How_do_you_prepare_medication_using_a_non_touch_technique

carrying out the lunch time drugs round signing for medication that had been administered in the morning.

The stock levels of controlled drugs recorded on Chepstow ward were lower than what was actually in stock. This was highlighted to senior management who stated they would rectify this.

There was no hard copy of the medication management policy in the clinical room on Cardigan ward.

The registered provider must protect patients against the risks associated with unsafe use and management of medicines, ensuring there is a robust medicines management policy that is followed by all staff. These issues were dealt with through our non compliance process.

Improvement needed

The registered provider must ensure staff sign drug sheets when drugs are being administered.

The registered provider must ensure medication trolleys and the drugs liable to misuse cupboard are locked when the treatment room is unoccupied.

The registered provider must ensure that single use medical items are disposed of after each use.

The registered provider must ensure that a hard copy of the medicines management policy is available in all treatment rooms.

The registered provider must ensure that staff adopt appropriate non touch techniques when administering medication

The registered provider must ensure there is an accurate recording of controlled drugs stock in each treatment room.

Safeguarding children and safeguarding vulnerable adults

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

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

Medical devices, equipment and diagnostic systems

There was a weekly audit of resuscitation equipment; staff had documented when these had occurred to ensure that the equipment was present.

During the inspection we discussed with a number of staff and managers the fact there is only one set of resuscitation equipment held near reception. Staff were comfortable that this was sufficient and could access the equipment in a timely manner should it be required.

Safe and clinically effective care

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

Records management

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

Whilst there were detailed care records for patients, these were spread across a number of paper and electronic files which made it difficult to navigate and review them. They were however, found to be of a very high standard with the only issue identified being that no record of unmet needs could be found in any of the files examined.

Improvement needed

The registered provider must ensure that unmet needs are documented for all patients

Mental Health Act Monitoring

We reviewed the statutory detention documents of four patients across Cardigan and Caerphilly wards. We also reviewed the governance and audit processes that were in place for monitoring the use of the Mental Health Act (the Act) across all four wards.

The Mental Health Act monitoring function is carried out centrally at the head office by a dedicated department. Hard copies of the relevant information are held locally within the patients care file.

Patients were routinely offered copies of their detention papers and provided with a verbal explanation. Patients were provided information on all of their rights in relation to medication and treatment along with their consent to treatment certificates. This was recorded within the Mental Health Act monitoring documents.

Section 17 leave authorisation[5] was recorded clearly and correctly. We saw evidence that there was a flexible approach to the authorisation and facilitation of this leave to suit the specific needs of the patient.

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

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

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

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

However, as referred to earlier in this report, staff were not clearly documenting any unmet needs a patient may have whilst being cared for at the hospital. It is important that unmet needs are documented so that these can be regularly

[5] http://www.legislation.gov.uk/ukpga/1983/20/section/17

reviewed by the multi-disciplinary team to look at options for meeting those needs.

The Care and Treatment Plans were regularly reviewed. They were found to be very thorough and comprehensive. Significant risks and needs are comprehensively assessed and planned. There was also evidence of Personal Emergency Evacuation Plans (PEEP) within the care files.

Mental Capacity Act and Deprivation of Liberty Safeguards

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

Quality of management and leadership

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

We saw good management and leadership at Heatherwood Court with the appointment of a new registered manager and general manager having a positive effect. The local arrangements were also well supported by the management structure within Ludlow Street Healthcare. We observed a committed staff team who had a good understanding of the needs of the patients at the hospital.

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

Governance and accountability framework

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

Identified senior managers had specific responsibilities for ensuring that the programme for governance remained at the forefront of service delivery. There have been recent changes in the senior management structure; the new appointees to these roles have a clear and structured overview of their roles within the organisation. However, as identified earlier in the report, the governance and staff practice around medicine management and night time patient observations requires more robust oversight.

Through conversations with staff, observing multi-disciplinary team engagement, and reviewing patient records there was evidence of strong multi-

disciplinary team-working at Heatherwood Court. Staff commented favourably on multi-disciplinary working stating that they felt that their views were listened to and respected by other members of staff.

It is of concern that during the night time visit, senior on site staff were unable to confidently provide information about patient and staffing levels at the hospital and on individual wards.

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

Improvement needed

The registered provider must ensure that senior staff on site have all necessary information available to them in terms of the number of patients and their needs as well as the number of staff available should this be required in an emergency.

Dealing with concerns and managing incidents

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

It was evident that the registered provider monitored concerns and incidents locally at Heatherwood Court and corporately through regular reporting mechanisms. There was also a peer review system in place to provide additional oversight and understand lessons learnt from incidents.

Workforce planning, training and organisational development

We reviewed the staffing establishment at Heatherwood Court with that stated within their Statement of Purpose. There were 12 registered nurses vacancies that the registered provider was proactively attempting to recruit to.

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

There was also a robust induction process in place where staff were not permitted onto the wards until this had been completed.

We reviewed the mandatory training statistics for staff at Heatherwood Court and found that completion rates were very high. The electronic system provided the general manager with course and individual staff compliance details.

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

The registered provider has implemented processes for supervision so that staff record formal and informal supervision for inclusion on their annual performance development review (PDR). The full PDR process is still at the introductory stage but will be taken forward by the new general manager

Workforce recruitment and employment practices

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

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

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

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

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, 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
Door closing arm in the day room within Chepstow ward had become loose	Potential for self harm by patients.	Reported to Interim Registered Manager	It was removed immediately

Appendix B – Improvement plan

Service: Heatherwood Court

Ward/unit(s): Chepstow, Cardigan, Caernarfon, Caerphilly

Date of inspection: 19, 20, 21 November 2018

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
	3. Health promotion, protection and improvement			
The registered provider must ensure that all fixtures and fittings are safe and appropriate for the patient group	10. Dignity and respect	Heatherwood Court staff complete a daily environmental check on each shift which identifies any new or outstanding environmental issues. Unit Managers collate all the relevant information on a daily basis and ensure	Nurse in Charge to ensure environmental checks are carried out Unit Manager to	Daily / ongoing Daily / ongoing

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		that any maintenance requests for repairs or replacement furniture is submitted immediately via our electronic maintenance request system. Additionally, if there are any immediate maintenance issues raised, HWC has a 24 hour on call system in place to ensure that any identified environmental risks or shortfalls can be addressed immediately.	check daily paperwork packs on a daily basis and report any environmental issues via the electronic maintenance reporting system. All on call staff responsible for reporting environmental concerns as they arise and utilising the on-call maintenance system to address any urgent safety issues. General Manager to complete a weekly	Daily / ongoing Weekly/ongoing

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that agency staff maintain the care standards expected and displayed by permanent staff members		The Registered Manager and Clinical Lead Manager have met with the preferred provider for agency staff to discuss their recruitment, induction and training standards. To ensure compliance with this requirement the following is in place in Heatherwood Court in relation to all agency shifts: • All agencies require to provide a record of all their allocated staff training and evidence of DBS check prior to staff working in HWC	environmental audit of the hospital to identify any outstanding environmental issues and escalate accordingly Registered Manager / Clinical Lead Manager to coordinate Unit Managers / Hospital Administrator	Monthly meetings Prior to allocation of staff Daily Daily

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		• Agency "passports" are audited by the Hospital Administrator daily. • All agency staff are required to have a full unit induction on their first shift and subsequently every 10 days following their first shift • This is audited by the Hospital Administrator who pro-actively checks the staffing lists daily and sends reminder emails to those in charge of the shift to ensure the required inductions/re-inductions are completed in the required timescale • HWC has introduced a daily competency checklist for all Unit Managers to utilise. The checklist is used as a tool to interact with all staff on shift to ascertain verbally that they are fully aware of their role and responsibilities. This is specifically targeted at new staff and more directly at the	Hospital Administrator Unit Managers / Hospital Administrator Hospital Administrator / Nurse in Charge of relevant shift Unit Managers	Daily Daily

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		agency staff on shift as an additional tool to ensure they are working to the same standards as the regular staff. • Additionally to this daily competency tool, there is a 3-weekly audit carried out by the manager performing the role of "bronze on call". This audit tool is used across the whole hospital and is directed at those agency staff who are new to the hospital. • Specific Therapeutic boundary and security training is also provided on the 3rd Monday of every month. HWC has invited the agencies to send their staff to these sessions and have had approximately 12 staff attend since December. • HWC have also invited agency recruiters to attend the HWC interview process to further understand the requirements that	Bronze on Call Manager Security Lead Nurse to provide the training. Clinical Lead Manager to liaise with relevant agencies for attendees	3 times weekly Monthly training (3rd Monday of each month) Monthly meetings

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		HWC look for in their own recruitment of staff.		
The registered provider must ensure that Healthcare Inspectorate Wales contact information is available on patient notice boards on all wards.	9. Patient information and consent	A basic HIW information poster has now been provided for all units. In addition, the patient handbook and complaints process has been fully updated with all the relevant HIW contact details. Part of the "bronze on call" audit has been adapted to ensure that the on-call manager also checks that all relevant information posters are being displayed as per the regulatory requirements.	Unit Managers to ensure this information is maintained and displayed	3 times weekly as part of the bronze on call audit process
	18. Communicating effectively			
The registered provider must ensure that the therapy services for patients are accessible to suit the patients needs	8. Care planning and provision	There has been a re-structure within the OT department to promote the use of the Hub and ensure that a full schedule of activities is offered. This has included the Activity Co-Ordinator working 9am-5pm to support	Senior OT/ Clinical Lead Manager	Monthly updates in Local Governance

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		patients' to meaningfully structure their time and have a set schedule of activities on offer. These are accessible to suit the patients' needs as a survey has been put out to collate patients views on the activities and facilities available at the Hub. Following this survey, changes were made to further meet patients' needs and interests within the Hub. Alongside this change the OT department has expanded to include x2 additional OT Technicians to further meet the needs of the patients' and ensure that client-centred OT interventions are facilitated in a timely manner. The Health and Wellness Coach has also began working some evenings to promote engagement and meet the needs of the patients' around scheduled therapy sessions		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	2. Equality, diversity and human rights			
	5. Citizen engagement and feedback			
Delivery of safe and effective care				
The registered provider must ensure all staff adhere to the night time observation process and conduct the appropriate level of observation for each patient as identified in the individual care plan.	22. Managing risk and health and safety 12. Environment 4. Emergency Planning Arrangements	Addition made to the Standardised observation care plans to ensure details are clear in regards to the expectations of staff performing the relevant observations at night Additional text added to ensure clarity: By night and when patients are in their bedroom, staff are to be able to clearly observe the patients face, neck and hands with evidence of breathing and movement. Should this view be restricted staff to enter the room as per	Registered Manager	Ongoing – began 22nd Nov to continue until further notice

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		observation policy/videos.		
		Email advising this addition sent to all staff	Registered Manager	Complete
		Additional information added to the existing unit induction paperwork to inform all agency staff	Registered Manager	Complete
		Additional measures to ensure all staff are fully aware of how to perform enhanced observation duties:		
		Email update sent to all staff from the nominated Registered Manager to advise of the concerns raised in this improvement notice and the proposed actions to be taken.	Registered Manager	Complete
		Unit Managers to meet with staff face to face with all their team members as part of a newly implemented daily audit process. This process will involve all	Unit Managers	From 30th Nov onwards. Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Unit Managers interacting directly with all staff on shift to ensure the following is discussed and documented accordingly: • All staff to confirm they are fully aware of the observation policy and where to find it for reference. • All staff to confirm verbally and subsequently sign the daily audit tool to confirm they fully understand what is expected of them in the performance of enhanced observations. • All Unit Managers to ensure all staff involved in enhanced observations are observed completing all necessary checks and documentation as per the policy. This will then be documented accordingly within the daily Unit Manager audit tool paperwork. • Unit Managers to identify training issues as they arise as part of the		daily for all units / split between day shifts and night shifts dependent on the Unit Managers shift pattern.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must address the ward office on Chepstow ward which is cramped and cluttered with no view of the ward or patients		daily process and ensure any training requirements are recorded and met as they arise. • All Unit Managers are to additionally ensure that all their staff team have understanding and compliance with the enhanced observation policy as a standing objective in all PDRs. Ensure hard copy of observation policy is in each nursing office Email policy and reminder to staff that the policy is also accessible via Staffnet The office has recently been moved to allow for the provision of more patient space in the quiet room on this ward. The bronze on call audit tool has been amended to include the assessment of	Registered Manager / Ops Director	All staff PDRs in place by 31st Jan 19 Completed 30th Nov 18 Completed 28th Nov 18 Ongoing

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		the office areas for accessibility. The structure of the building and current layout limits the possibilities for change. However, to address the limited view from the office, feasibility plans are being looked at to replace the current hatch with a window. Additionally there would then be a viewing mirror placed in the corridor to allow for sight up and down the corridor.		
	13. Infection prevention and control (IPC) and decontamination			
	14. Nutrition			
The registered provider must ensure staff sign drug sheets when drugs are being administered. The registered provider must ensure medication trolleys and the drugs liable to misuse cupboard are locked when the treatment room is	15. Medicines management	Immediate supervisions provided for the nurse's identified during the inspection. Immediate suspension from medication duties whilst awaiting formal reassessment training from the Clinical Lead Manager	Clinical Lead Manager to coordinate all relevant reassessment training going	Both nurse's reassessed on 27th Nov 18 .

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
unoccupied. The registered provider must ensure that single use medical items are disposed of after each use. The registered provider must ensure that a hard copy of the medicines management policy is available in all treatment rooms. The registered provider must ensure that staff adopt appropriate non-touch techniques when administering medication The registered provider must ensure there is an accurate recording of controlled drugs stock in each treatment room.		Communication sent to the whole nursing team to advise of the concerns raised in this assurance notice. All nurses advised of what had been identified and the proposed actions to address recurrence. Medication management training and medication competency reassessments arranged for the whole nursing team Unit Managers have met with their own nursing staff face to face as part of a newly implemented daily audit process. This process now involves all Unit Managers interacting directly with all those responsible for medication duties to ensure the following is discussed and documented accordingly: • Confirmation of re-assessment for medication competency	forward	Completed 23 Nov 18 Whole nursing team reassessed by end of December 18. Additional assessment training completed by Ashtons in January 19 Re-assessment training to

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
				take place 3 monthly for all nursing staff
		• Random spot checks throughout the shift to ensure best practice is being adhered to. • Immediate identification of issues and concerns • Fully documented audit tool to evidence this process is in place and being adhered to.	Unit Managers (as part of the daily competency check process)	Ongoing from 26th Nov Random checks 3 times weekly from 30th Nov
		The Clinical Lead Manager will instigate random management checks of medication rooms to ensure best practice is being adhered to.	Clinical Lead Manager	Weekly

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	11. Safeguarding children and safeguarding vulnerable adults			
	17. Blood management			
	16. Medical devices, equipment and diagnostic systems			
	7. Safe and clinically effective care			
	6. Participating in quality improvement activities 21. Research, Development and Innovation			
	19. Information			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	management and communications technology			
The registered provider must ensure that unmet needs are documented for all patients	20. Records management	The Senior Management Team met to discuss this action. The following has been implemented: • Addition made to the basic MDT template to ensure that unmet needs are clearly discussed and where applicable documented appropriately • Same addition made for the CPA template	The RC to ensure completion in all relevant meetings	Immediate and ongoing
Quality of management and leadership				
The registered provider must ensure that senior staff on site have available to them all necessary information the covering numbers of patients and their needs as well as the number of staff available should this be required in an emergency.	1 Governance and accountability framework	All those who provide "Senior on Site" duties have received an update in regards to their role and responsibilities. This included the following update to the process for ensuring that both patient and staff information is updated daily and available in a central location:	Clinical Lead Manager to add to Unit Manager supervision process to cascade to all nursing staff	Immediate / ongoing

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		• All patient lists (inclusive of section, Unit, Admission date etc) is sent daily to the Reception Team Leader by the Medical Secretary. • The daily staffing list, inclusive of total staff on each Unit and numbers on enhanced observations are sent to the Reception Team Leader daily. • The Reception Team Leader collates the information into one hard copy file which is then stored on Reception for the Senior on Site to access.	Medical Secretary Hospital Administrator Reception Team Leader	Daily Daily Daily
	23 Dealing with concerns and managing incidents			
	25. Workforce planning, training and organisational			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	development			
	24. Workforce recruitment and employment practices			

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): Andy Keen

Job role: Interim Registered Manager

Date: 5TH February 2019