Independent Mental Health Service Inspection (Unannounced)

Heatherwood Court

Caernarfon, Caerphilly, Cardigan and Chepstow Units

Ludlow Street Healthcare

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Contents

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

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

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection of Heatherwood Court on the evening of 24 June 2019 and the following days of the 25 and 26 June. The following sites and wards were visited during this inspection:

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

Our team, for the inspection comprised of three HIW inspectors, 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

There was a clear focus on least restrictive care to aid recovery and support for patients to maintain and develop skills.

Established governance arrangements were in place that aided staff to provide safe and clinically effective care. However, improvements are required in medicine management, the completion of clinical documentation and the implementation of the Mental Health Act.

This is what we found the service did well:

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

This is what we recommend the service could improve:

- Medicine Management
- Completion of clinical documentation
- Implementation of the Mental Health Act
- Stability of workforce.

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

3. What we found

Background of the service

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

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

- Caernarfon Unit – an 11 bed controlled access/egress (locked rehabilitation) environment for persons requiring care and treatment for a mental disorder. Treatment may be offered to persons who have a diagnosis of Personality Disorders, or those whose needs arise from enduring mental illnesses.
- Caerphilly Unit – a 12 bed low secure environment for persons requiring care and treatment for a mental disorder. It will cater for the needs of people with a mental disorder who may require intensive treatment over longer periods.
- Cardigan Unit – a 12 bed low secure environment for persons requiring care and treatment for a mental disorder. Treatment may be offered to persons who have a diagnosis of Personality Disorders, or those whose needs arise from enduring mental illnesses.
- Chepstow Unit – a 12 bed low secure environment for persons requiring care and treatment for a mental disorder. Treatment may be offered to persons who have a diagnosis of Personality Disorders, or those whose needs arise from enduring mental illnesses.

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

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

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

The service was first registered on 20 December 2007.

Quality of patient experience

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

We observed that staff interacted and engaged with patients appropriately and treated patients with dignity and respect. However, some patients raised their concerns about inconsistent staffing and the difficulty in building therapeutic relationships.

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

Health promotion, protection and improvement

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

Heatherwood Court had a wide range of well-maintained facilities to support the provision of therapies and activities on each ward and within the hospital's therapy and activity building, the Hub.

The Hub facilities included the Social Hub with a café and shop which were both operated by a selection of patients. There was a games room with a pool table, table tennis table and darts board. There was also woodwork room and an area for learning bike maintenance skills and a gym to undertake physical exercise.

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.

The hospital had just introduced the Recovery College. This provides opportunity for patients to develop skills which can include nationally recognised qualifications. These skills and qualification can assist patient in gaining employment.

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

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

Dignity and respect

We observed that all staff interacted and engaged with patients appropriately and treated patients with dignity and respect. We heard staff speaking with patients in calm tones throughout our inspection. We observed staff being respectful toward patients, including knocking on doors before entering bedrooms.

During our discussions with patients, some expressed their dissatisfaction with staff, stating it was difficult to build a therapeutic relationship due to staff moving between wards and the use of agency staff members. Our discussions with management provided assurance that efforts were made to stabilise the workforce at the hospital to help provide consistency of staffing to aid therapeutic relationships and that the quality of agency staff members was monitored.

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.

Bedrooms were not en-suite however there were sufficient toilets and showers available on each unit. These areas appeared clean and tidy and appropriate for the patient group.

Each ward had suitable rooms for patients to meet ward staff and other healthcare professionals in private. There was also a visiting room, in the hospital reception area, available for patients to meet with visitors, including younger family members.

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

Patient information and consent

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

The information on display included patient activities, statutory information, information on the Mental Health Act and advocacy provision, how to raise a complaint, however information about Healthcare Inspectorate Wales and how to contact us were not displayed.

Improvement needed

The registered provider must display information about Healthcare Inspectorate Wales and how to contact us.

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. As stated earlier, some patients raised their concerns about agency staff and that they had difficulty in understanding them or that the agency staff did not listen.

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

The hospital also held a monthly meeting where patient representatives from each of the wards 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

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

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

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

Equality, diversity and human rights

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

Mental Health Act detention papers had been completed correctly to detain patients at the hospital. However, the registered provider must implement improvements to the application of the Act to fulfil its statutory duties under the Act and as set out in the Mental Health Act Code of Practice for Wales 2016. These are detailed later in the report.

Citizen engagement and feedback

There were regular patient meetings to allow for patients to provide feedback on the provision of care at the hospital. The hospital also undertook patient surveys which enabled the service to develop using the feedback provided.

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

Delivery of safe and effective care

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

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

There were established processes and audits in place to manage risk, health and safety, medicine management and infection control. This enabled staff to continue to provide safe and clinically effective care.

However, improvements are required in the safe management on medicine and the implementation of the Mental Health Act.

Managing risk and health and safety

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

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

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

Staff were able to report environmental issues to the hospital estate team who maintained a log of issues and work required and completed. We were informed that hospital estates team were responsive and made referrals to contractors quickly when required. However, within the visitors' room we did discover a small piece of a wall display remaining on the wall following the removal of this item. This could have been removed by a patient to harm themselves or others. This was immediately removed and reported to the hospital administrator who instigated a sweep of the room to ensure that it was clear of any other items.

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

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

We reviewed a sample of incidents from the registered provider's electronic incident recording system and cross referenced with our log of Notifiable Events[1] from the hospital. It was noted that there had been instances of patient self-harm that had not been submitted to as a notifiable event to HIW under Regulation 31 of the Independent Health care (Wales) Regulations 2011[2]. Whilst we acknowledge that 'serious injury' isn't definitively defined within the regulations, within our published guidance[3] we request to be notified of that any incidents of self-harm which result in the patient attending a hospital or where such attendance has been so advised as a consequence of the patient's actions regardless of whether or not the patient attended.

The staff office on Chepstow Unit was small, cramped and throughout the inspection very warm. In addition the carpet was heavily stained and required to be replaced.

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[1] Regulations 30 and 31 of the Independent Health Care (Wales) Regulations 2011 require the registered person to notify HIW about prescribed events (they can be found at Appendix A). The events in question relate to patient safety and whilst there is a legal requirement to notify HIW of their occurrence, it is also expected that the registered person has the necessary policies and procedures in place to reduce the risks of their occurring in the first instance; appropriately manage the situation if and when it occurs; and ensure the occurrence of the identified risk is appropriately managed so as to avoid future occurrences.

[2] http://www.legislation.gov.uk/wsi/2011/734/contents/made

[3] https://hiw.org.uk/sites/default/files/2019-06/160627notifiableeventsguidanceen.pdf

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

Improvement needed

The registered provider must ensure that incidents of self-harm are notified to HIW in line with our published guidance.

The registered provider must improve the conditions of the staff office on Chepstow Unit.

Infection prevention and control (IPC) and decontamination

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

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

Throughout the inspection we observed that overall the hospital to be visibly clean and free from clutter. However, within the clinic room on Cardigan Unit had areas of high level dust and cobwebs.

Cleaning equipment was stored and organised appropriately. The registered provider employed dedicated housekeeping staff for the hospital.

Cleaning schedules were in place to promote regular and effective cleaning of the hospital, and staff were aware of their responsibilities around infection prevention and control.

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

There were suitable arrangements in place for the disposal of waste. Appropriate bins were available to dispose of medical sharp items, these were not over filled.

Improvement needed

The registered provider must ensure that clinic rooms are organised and free from dust and cobwebs.

Nutrition

We found that patients were provided with a choice of meals on a rotational menu. Whilst on the whole there was a variety, some meal options were similar such as evening meal options on one day all being accompanied with chips, with lunch being a choice between sandwiches or jacket potatoes.

During our discussions with patients some shared their dissatisfaction with regards to the meal options. We saw that patients were able to provide feedback on the food and that the chef attended regular meetings with patients to hear their views on the catering provided.

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

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

Improvement needed

The registered provider must ensure that menus provide a suitable range of options to meet the preferences of the patient group at the hospital.

Medicines management

We reviewed medicine management on two wards: Cardigan Unit and Caerphilly Unit. Whilst there were established systems in place to assist in safe and effect management of medicine we identified areas for improvement.

During the first evening of our inspection on Cardigan Unit the medication trolley was not secured to the clinic wall and the medication fridge was left unlocked. The medication trolley was secured and medication fridge locked on Caerphilly Unit.

There was evidence on both wards that there were regular checks of the medication fridge temperatures and the ambient clinic room temperatures to ensure that medication was stored at the manufacturer's advised temperature.

There were appropriate arrangements for the storage and use of Controlled Drugs and Drugs Liable to Misuse, however there were gaps in staff signatures evident on both wards. Staff did report that during the evening medication on the night shift it was difficult to get two signatures because there was typically only one registered nurse per ward on the night shift.

The Medication Administration Records (MAR Charts)[4] reviewed contained the patient's name and their mental health act legal status. On Caerphilly Unit MAR Charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. However, this was not the case on Cardigan Unit where gaps were evident. It was also noted that on occasions the registered nurse had coded the MAR chart as refused, but the reason for the patient not receiving the medication was documented as asleep or not available on the ward. The coding needs to accurately reflect the reason why a patient did not receive their medication.

MAR Charts did not always include a copy of the most recent Consent to Treatment Certificates that authorised medication (for mental disorder) under the Mental Health Act. In addition, some patients' MAR Charts also had out of date Consent to Treatment Certificates. Therefore registered nurses may not be referring to the correct Consent to Treatment Certificates to confirm that medication had been authorised under the Mental Health Act.

Through our review of care plan documentation it was identified that medication care plans on Cardigan Unit were not up to date, these need to be reviewed and updated.

It was positive to note that "as required" medication was being monitored as part of governance arrangements to oversee the use of medication at the hospital.

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

Improvement needed

The registered provider must ensure that medication trolleys are secured within clinics.

The registered provider must ensure that medication fridges are locked when not in use.

The registered provider must ensure that Controlled Drugs and Drugs Liable to Misuse are appropriately signed for.

The registered provider must ensure that only the most recent Consent to Treatment Certificate(s) is with the MAR Chart.

The registered provider must ensure that medication care plans are up to date.

Safeguarding children and safeguarding vulnerable adults

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

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

Safe and clinically effective care

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

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

Records management

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

However, we identified improvements with the completion of clinical records and care plan documentation within this report, along with the availability of Mental Health Act statutory documentation for ward staff.

Mental Health Act Monitoring

We reviewed the statutory detention documents of two patients across two wards, Caerphilly and Caernarfon. We also reviewed the governance and audit processes that were in place for monitoring the use of the Mental Health Act (the Act) at Heatherwood Court.

We found that copies of the statutory detention documents were not available on the wards, either electronically or as paper records. This means staff would not be able to check the validity of detention for the patients as part of the compilation of health records.

It was also noted that patients were not given the opportunity to receive copies of their section papers, Mental Health Act 1983 Code of Practice for Wales Revised 2016 (the Code) paragraph 4.14.

In addition, copies of Section 17 Leave authorisation forms and, as stated earlier, Consent to Treatment Certificate were not adequately maintained on the wards. Some patient files had documentation that was no longer valid which were not clearly marked as so or removed, therefore they could be mistaken for the current documentation. For one patient the consent to treatment certificate was missing, therefore registered nurses could not refer to it to ensure that the medication that they were administering was authorised under the Act.

One patient's records include a Section 62, authorisation of urgent treatment, dated December 2018 which was still in use, this is an extraordinarily long period after being authorised. This is not an appropriate use of Section 62 which is for immediate and necessary treatment[5]. The Code, paragraph 25.80, directs that

[5] Section 62 (1) (a) which is immediately necessary to save the patient's life; (b) which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or (c) which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or (d) which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.

all treatment should be regularly reviewed, this include treatments authorised under Section 62.

Through our conversations with ward staff, whilst on the whole they knew about the legal documentation, there was a lack of understanding of the rationale of some of the statutory documentation, their responsibilities under the Act and the importance of its use is in upholding the rights of patients.

Improvement needed

The registered provider must ensure that copies of the statutory detention documents are available to ward staff.

The registered provider must ensure that patients are given the opportunity to receive copies of their section papers

The registered provider must consider how to best equip ward staff with a greater understanding of the Mental Health Act and the Code.

The registered provider must ensure that leave forms that are no longer valid are clearly marked as so.

The registered provider must ensure that MAR charts are accompanied by the corresponding consent to treatment certificate(s).

The registered provider must ensure that all treatment are regularly reviewed and Section 62 is used for appropriate circumstances only.

The registered provider must provide staff with further training on the Mental Health Act.

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

We reviewed the care plans of a total of two patient files in detail and supported any findings by referring to additional patient records.

The Care and Treatment Plans reviewed on Caerphilly Unit reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed. Overall individual Care and Treatment Plans drew on a patient's strengths and focused on recovery, rehabilitation and independence.

Care plans were developed with members of the multi-disciplinary teams. To support patient care plans, there were a range of patient assessments to identify

and monitor the provision of patient care, along with risk assessments that set out the identified risks and how to mitigate and manage them.

We reviewed the care plans for a number of patients who were of risk of self-harm and required enhanced observation, including when using the toilets facilities. Whilst the level of observation appeared proportionate to the level of risk, the care plans were brief and could have included more specific details to guide staff. It was also noted that on Cardigan Unit the enhance toilet observations were being undertaken within the toilet neat the entrance to the ward which could impact upon the dignity of the patient. During our inspection feedback the registered provider agreed to consider alternative locations on the ward to undertake enhanced toilet observations.

The patient records reviewed on Caerphilly Unit contained up to date physical health assessments and monitoring documentations. Where required this included detailed epilepsy care plans. However, on Cardigan Unit the physical health documentation was poorly and inconsistently completed.

The Malnutrition Universal Screening Tool documentation reviewed on Caerphilly Unit evidenced that there was appropriate monitoring and actions taken, including input from dietician, when required.

However, on both Caerphilly Unit and Cardigan Unit, nutrition and fluid input charts were poorly completed. In some cases patient names were entered into the incorrect section or only initials used. There were incomplete and inconsistencies in the details recorded on the charts and no daily or weekly totals. It would be beneficial for staff to record the accurate daily consumption total, to assist with identifying trends between ward rounds.

It was also noted in a sample of cases that insulin dependent patients that were care planned as requiring additional monitoring did not have nutritional content accurately and consistently recorded. This may have an effect on diabetic medication therapeutic benefit and required variations in dose.

There was detailed information displayed within the Cardigan Unit nurses' office regarding diabetes and the signs and symptoms of hypoglycaemia and hyperglycaemia. It was positive to note that staff had signed to confirm that they had read this information, however the last signatory date was September 2018 and a number of staff had commenced working on the ward since that date. There was, for one patient, incomplete records for the recording of diabetes medication.

Improvement needed

The registered provider must ensure that detailed care plans are in place when a patient is under enhanced observation of toilet areas.

The registered provider must ensure that physical health documentation is completed to a good professional standard.

The registered provider must ensure that nutrition and fluid input charts are completed to a good professional standard.

The registered provider must ensure that diabetes medication records are completed in full.

Quality of management and leadership

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

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

Mandatory training completion rates were high and staff were able to access additional course to further their personal development.

Recruitment was undertaken in an open and fair process with appropriate employment checks being carried out prior and regularly during employment.

Governance and accountability framework

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

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

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

Dealing with concerns and managing incidents

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.

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

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and reviewed at hospital and organisation level so that the occurrence of incidents could be reviewed and analysed.

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

Workforce planning, training and organisational development

We reviewed the staffing establishment at Heatherwood Court with that stated within their Statement of Purpose. At the time of the inspection there were 12 registered nurse vacancies, with six of these positions appointed to. The Registered Manager described the hospital's future workforce planning arrangements to fill these positions.

To cover any shortfalls in fulfilling the staffing rota that may occur due to vacancies, the registered provider had a staff bank system in place along with the use of agency staff. Agency registered nurses were typically regular individuals who were familiar with working at the hospital and the patient group. This assisted with the continuity of care for patients. Staff demonstrated their agency staff database that ensured that the agency staff member held the required qualifications, training and inductions to work at the hospital. This linked across all of the registered provider's settings. This database also held a barring list for any agency staff member who not been of the required professional standard so that this was shared between all of the registered provider's settings.

We reviewed the mandatory training statistics for staff at Heatherwood Court and found that completion rates were above 85%. The electronic system provided management with the course and individual staff compliance details.

Staff completed mid-year and annual performance appraisal. There was a supervision structure in place and this was monitored to ensure staff had regular 8 weekly reviews.

Workforce recruitment and employment practices

Staff explained the 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 (DBS) checks were undertaken and professional qualifications checked.

All staff received an induction prior to commencing work on the wards at the hospital. Permanent staff files held a certificate of induction which was issued following the completion of their corporate induction. Agency staff completed an induction at the hospital prior to starting their first shift on a ward and after every 10 days. The completion of the induction was signed off by a member of permanent staff and monitored by hospital administrator.

DBS checks were completed after each three year period of employment and systems were in place to monitor that professional registrations are up to date

4. What next?

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

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

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

The improvement plans should:

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

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect independent mental health services

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

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

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

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

We also consider other professional standards and guidance as applicable.

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

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

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.	Not applicable	Not applicable	Not applicable

Appendix B – Improvement plan

Service: Heatherwood Court

Wards: Caernarfon, Caerphilly, Cardigan and Chepstow

Date of inspection: 22 - 24 June 2019

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

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The registered provider must display information about Healthcare Inspectorate Wales and how to contact us.	9. Patient information and consent	HIW to be contacted so that posters can be made available to the wards. In the interim the hospital will ensure the information on how to contact the HIW is displayed.	RC	09.08.19
Delivery of safe and effective care				
The registered provider must ensure that incidents of self-harm are notified to HIW in line with our published guidance.	22. Managing risk and health and safety	This is now in place and has been completed since the visit.	RC	26.08.19

The registered provider must improve the conditions of the staff office on Chepstow Unit.	22. Managing risk and health and safety 12. Environment	The staff office has been refurbished with a new desk, air conditioning and more floor space.	LB	26.07.19
The registered provider must ensure that clinic rooms are organised and free from dust and cobwebs.	13. Infection prevention and control (IPC) and decontamination	A deep clean has been added to the monthly housekeeping schedule. Nurses will clean on a daily basis. HD and CL will check the clinic room weekly.	DH, RC, LB	31.08.19
The registered provider must ensure that menus provide a suitable range of options to meet the preferences of the patient group at the hospital.	14. Nutrition	The menu options will be a standing agenda item at the 4wards meeting so that feedback can be gathered around the meal preferences and choices. Menus will be amended to meet patient feedback and nutritional goals.	DH, RC, LB	30.09.19
The registered provider must ensure that medication trolleys are secured within clinics.	15. Medicines management	Completed.	LB	31.08.19

The registered provider must ensure that medication fridges are locked when not in use.	15. Medicines management	Locked refrigerators are included on the bronze on call audit daily to check.	RC	20.08.19
The registered provider must ensure that Controlled Drugs and Drugs Liable to Misuse are appropriately signed for.	15. Medicines management	Training has been arranged to support workers so that they can be a second signature on the counting and disposal of CD's and DLM's.	RC	9.08.19
The registered provider must ensure that only the most recent Consent to Treatment Certificate(s) is with the MAR Chart.	15. Medicines management	The medication room will be audited monthly and will include checking to ensure the documentation is correctly filed.	RC	31.08.19
The registered provider must ensure that medication care plans are up to date.	15. Medicines management	This is now audited monthly and was rectified on the day.	RC	06.08.19
The registered provider must ensure that copies of the statutory detention documents are available to ward staff.	Mental Health Act Monitoring	Training will be provided to nurses who are responsible for admitting patients. All documentation is sent to unit managers, current information is put onto the file. An electronic system to share MHA documentation is currently under review.	DH RC	01.09.19

The registered provider must ensure that patients are given the opportunity to receive copies of their section papers	Mental Health Act Monitoring	We will offer the patient a copy of their section papers at their weekly one to one. This will be documented in the patients nursing notes.	RC	13.09.19
The registered provider must consider how to best equip ward staff with a greater understanding of the Mental Health Act and the Code.	Mental Health Act Monitoring	Training around the Mental Health Act will be delivered by the mental health act manager. We will provide clear information around the mental health act.	RC	04.10.19
The registered provider must ensure that leave forms that are no longer valid are clearly marked as so.	Mental Health Act Monitoring	Doctors will ensure documentation is removed or striked through when not valid. Hospital Director and Medical Director will audit leave documentation.	DH, RC, SB	01.10.19
The registered provider must ensure that MAR charts are accompanied by the corresponding consent to treatment certificate(s).	Mental Health Act Monitoring	Completed during visit. Audit is in place to ensure ongoing compliance with this.	RC	06.08.19
The registered provider must ensure that all treatment are regularly reviewed and Section 62 is used for appropriate circumstances only.	Mental Health Act Monitoring	All mental health act documentation will be audited monthly to ensure it is correct and up to date.	DH, RC	01.09.19

The registered provider must provide staff with further training on the Mental Health Act.	Mental Health Act Monitoring	Training will be provided to the team.	RC/DH	04.10.19
The registered provider must ensure that detailed care plans are in place when a patient is under enhanced observation of toilet areas.	Care planning and provision	A care plan will be developed for patients who have supervised toilet access to ensure their dignity is considered.	RC	01.07.19
The registered provider must ensure that physical health documentation is completed to a good professional standard.	Care planning and provision	Care plan audit will be adapted to include the physical health documentation. This audit will then be undertaken monthly.	RC	01.10.19
The registered provider must ensure that nutrition and fluid input charts are completed to a good professional standard.	Care planning and provision	This will be included into the physical health audit tool and audited monthly.	RC	16.08.19
The registered provider must ensure that diabetes medication records are completed in full.	Care planning and provision	Physical health forms will be picked up as part of the physical health audit, this includes records for diet intake and output.	RC	01.07.19

		We continue to have close links with our specialist diabetes nurse who will undertake a full review every three months.		
Quality of management and leadership				
No improvements identified in quality of management and leadership.	Not applicable	Not applicable	Not applicable	Not applicable

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Dean Harries

Job role: Hospital Director

Date: 6 August 2019