Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report – Focussed (Unannounced)

Hillview Hospital

Inspection date: 9 and 10 May 2023

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In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

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

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Following concerns identified with this service regarding the number and reporting of incidents, and the safe and effective care of the patients, HIW completed an unannounced independent mental health inspection at Hillview Hospital on 9 and 10 May 2023. The inspection did not use HIW's full methodology and only focussed on areas that affected safe and effective care and leadership and governance.

Elysium Healthcare served notice on the contract for the provision of children and adolescent mental health services (CAHMS) at Hillview Hospital on 3 January 2023 and gave more than the contractual requirement of 28 days, with an end date to 30 March 2023. There were four young patients in the hospital at the time of the inspection.

Our team for the inspection comprised of two HIW Healthcare Inspectors and one clinical peer reviewers (who concentrated on patient care notes). The inspection was led by a HIW Senior Healthcare Inspector.

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

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Staff provided as much privacy and dignity as their care plans allowed.

The building work at the setting did not appear to affect the care of patients on the remaining ward.

Delivery of Safe and Effective Care

Overall summary:
The environment was generally well maintained internally, with no major work required in the ward area used by patients and no trip hazards. However, the fire exit route shown required staff and patients to re-enter the premises before safely exiting the premises, from the rear first floor bedrooms. The exterior garden areas and walkways appeared unkempt.

We were satisfied that the safeguarding process was now well managed.

Care plans were considered to be generally of a good standard with some areas for improvement required.

Due to the loss of specialist staff at the location the provision of safe and effective care could be improved.

Non-compliance notice:
The following areas that required a non-compliance notice to be issued, were noted:

- Number of specialist staff had left the hospital due to the provider having issued a notice to end the contract
- Programme of events not being completed
- Lack of opportunities for fresh air for patients
- Not meeting the care needs of the patients.

This is what we recommend the service can improve

- Confirm re-entry to building on fire risk assessment
- Further work required to improve the care notes and plans.

This is what the service did well:

- Internal environment generally well maintained

- Safeguarding process has improved
- Staff working collaboratively
- Care plans generally of a good standard.

Quality of Management and Leadership

Overall summary:
Senior management at the setting engaged well with the inspection team and other staff within the hospital.

The management of the complaints process ensured that complaints were managed in a timely manner.

There were a number of qualified agency staff at the hospital and the setting ensured there was evidence to support the management of these staff.

Following our previous inspections in November 2021 and August 2022, Hillview Hospital was designated as a Service of Concern in line with HIW's Escalation and Enforcement process for independent healthcare services. This was due to the number and severity of the issues we identified. We saw that issues remained in several areas that affected safe and effective care and the number and recording of incidents. As a result of these concerns, HIW took the decision to issue an Urgent Notice of Decision to suspend the registration of Hillview Hospital. This took effect on Friday 12 May 2023. This arrangement will remain in place until such a time that HIW is satisfied that the risks to individuals have been addressed.

Non-compliance notice:
The following areas that required a non-compliance notice to be issued were noted:

- Length of time and management of restraints with seven instances of restraints lasting over 60 minutes
- Lack of immediate life support trained staff.

This is what we recommend the service can improve

- Updating the statement of purpose and registration certificates in a timely manner
- Mandatory training compliance.

This is what the service did well:

- Regular conference calls to manage the patients at the hospital
- Management of the complaints
- Ensuring there was evidence to support the recruitment of agency staff.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Dignity and respect
Patients had their own bedrooms that they could personalise, depending on the risk assessment with photos and mementos. We were also told that patients did not require support with their personal care.

Whilst doors to the patients' bedrooms had a viewing panel, as patients were on enhanced observations, including being at arm's reach, doors would not be closed. As a result, patients' privacy was very limited, but we were told that as much dignity as possible would be given to the patients, as described in the individual's care plan. The senior staff we spoke with stated that whilst the observation paperwork was good, linking this to care plans may not be as good, to ensure that the actions carried out were consistent with these plans.

During our limited visits to the ward, we observed that staff did not appear to be interacting with the patients. The nurse on duty, did inform the patients in the common room at the time about who we were. Staff appeared to be despondent.

We checked five days rotas of staff on the ward and noted that the majority of staff on duty were female, which was important as all the patients were female.

We were given a tour of the new ward, which was being redeveloped at the time of the inspection. The building work did not affect the care of the patients and there were no means for any interactions between the builders with the patients.

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety
The internal environment appeared to be well maintained. However, on day one, the path to the outside area, with a trampoline, picnic bench and table was covered in leaves, which appeared to have been there for some time. This area, accessible from the first floor bedrooms, was also a fire exit route, with steps to a lower level, which were also covered with damp leaves. By the second day the leaves had been cleared and the route to the trampoline, picnic area and fire exit was safer to use.

We were told that all staff had working alarms and there were sufficient alarms to cover the two shifts. Ligature cutters were seen and readily available.

Senior staff described the new system in place relating to dealing with incidents and Therapeutic Management of Violence & Aggression (TMVA) tutors and instructors attended the setting. There would be immediate debriefs given to patients and staff following the incidents. These debriefs included asking if anything could have been done better, were patients experiencing pain and if so a body map would be completed. This information would be discussed the next day at the morning meeting. The instructors would then visit the patient involved to confirm they were ok following the restraint.

We were provided with information by senior staff in regard to the internal process for incident recording and reporting. The process appeared sufficient. Data from incidents is recorded and analysed for common themes and trends, management stated that the main theme related to “headbanging”. Additionally, there were instances of swallowing foreign objects, due to inadequate observations being carried out by staff members.

We were told that all incidents would be discussed at handovers, multi-disciplinary team (MDT) meetings, management meetings and governance meetings. Lessons learned from incidents would be shared through the same channels, as well as supervisions and all staff emails.

A copy of the fire risk assessment was provided, dated 26 May 2022. This stated that there were sufficient and appropriate means of internal and external escape routes. We were told by the health and safety manager that fire escape routes were discussed with staff during the induction training. The escape route from the upstairs bedrooms, passed the trampoline and picnic area, down the stairs, then

involved re-entering the building either into a corridor near the front reception or into the downstairs ward communal room.

The registered provider needs to ensure that staff are fully briefed on the risks to patients of not ensuring observations are carried out as required.

We recommend that the registered provider confirms this is an acceptable fire exit route in light of the need to re-enter the building. Additionally, whilst we were told that staff were aware of this escape route, the route should be better signposted, to avoid any doubt.

Safeguarding children and safeguarding vulnerable adults
Safeguarding procedures were available to staff on the intranet, including in the form of a flow chart as well as on display at the setting and in the ward office. Senior staff we spoke with said that staff were aware of the need to call the on-call manager if there was a safeguarding issue.

We also saw notices for patients and carers on how to raise a safeguarding concern and patients also had access to an advocate. Following incidents, patients were asked if they wished to raise a safeguarding concern or to call the police and this would be facilitated, with the patients supported through the process.

Senior staff described how safeguarding concerns would be managed through a safeguarding tracker and also at MDT meetings. They stated that currently the setting were over reporting on safeguarding due to concerns that issues had not been previously reported in a timely manner. Senior staff had oversight of safeguarding concerns as all issues were directed to the Welsh regional lead as well as support from the Group Head of Safeguarding. Completed investigations would also be reviewed by the regional lead and the operational director for Wales and the South.

Lessons learned would be shared with staff through similar means as described above for incidents.

We also spoke to the safeguarding lead and were assured that the process in the setting was now being well managed. We were provided with a copy of the safeguarding report for February 2023, which listed nine incidences with a brief commentary.

Safe and clinically effective care
Senior staff stated that staff had enough time to deliver care to patients safely, as there were only four patients at the hospital at the time of the inspection. Whilst

staff had sufficient time for one-to-one meetings with patients, the documentation on care notes was not completed as well as on observation notes.

Staff had access to National Institute for Health and Care Excellence (NICE) guidance and there were copies of the code of practice available both in the mental health act administrators' office and on the ward.

Senior staff stated that team working could be better, stating that the occupational therapy assistants were "fantastic". Staff were attempting to work collaboratively on the ward round, including by online methods.

There was a business continuity plan in place, that was last modified in 2022. There were also clear arrangements in place for escalating issues to senior managers which staff were aware of, including an on-call managers' rota.

The service issued a notice to terminate the contract for the service provision at Hillview Hospital with an end date of 31 March 2023. As a result of the incidents reported we had concerns about the level of provision offered by the service since that date and the impact on the quality of care. The CAHMS expertise on site had been reduced, there was no longer an educator employed at the setting, neither was there an occupational therapist (OT). Additionally, the consultant psychologist was on maternity leave and had not been replaced. There were occupational therapy assistants and assistant psychologists on site, we were also told that the Elysium head of education had set up the patients with online education access but the patients were not engaging with this. We noted that the post of consultant psychologist had been advertised but remained vacant and we saw evidence that the hospital were trying to fill the OT vacancy.

We checked the care plans and care notes of two of the four patients, spoke with members of staff, visited the ward on two occasions, viewed the outside areas and information provided. The information provided included, two differing programmes of events for the patients, community meeting minutes and care plans for the patients.

The care notes viewed showed that neither of the two patients checked had taken any section 17 leave. However, we were provided with leave applications which showed numerous section 17 leave applications for three of the patients in March and April 2023 and five leave applications for the fourth patient at the setting. For two of the patients, there were not any leave applications for May 2023. We were also told that the patients had not been out into the garden area and therefore for at least two of the patients, they had not had any fresh air apart from limited leave as a matter of course.

These issues were dealt with under HIW's non-compliance notice process. These are referred to in Appendix B of this report.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision
We checked the care treatment planning for two of the four patients at the hospital. Generally, we found the notes and care plans were good, with detailed evidence based information including involvement of families and patient. We saw that the positive behaviours support plan was very detailed and all patients had risk assessments and risk plans. One care treatment plan was considered to be very detailed including skills to move on called "Recovery Outcomes Plans". The notes taken on the ward were contemporaneous but did not refer back to the plans to see how the plan was being evaluated.

We also saw evidence of continuing health monitoring such as height and weight. There was also clear indication about what happened if paediatric early warning scores (PEWS) were exceeded.

It was clear that families were involved in the MDT. However, the involvement of external agencies could be better evidenced on the care plans. We saw evidence on the plans that, for example, psychology staff offered a dialectical behaviour therapy (DBT) group to one patient, which was not taken and occupational therapist offered group therapy but this was also refused. There was evidence that qualified staff were trying to engage with the patients.

It was also positive to note that the care notes showed that mental health rights were being read to patients consistently, in accordance with section 132 of the Mental Health Act 1983 (revised 2007).

From the review of care notes, it was difficult to see on one comprehensive plan an assessment of care. These would be included in a minimum of three plans e.g. psychology, psychologist and care assessments notes. Therefore, to find out the overall plan there was a need to view the various care plans. Additionally, we did not note an initial assessment of the patient on the care notes.

The care notes did not include any evidence of section 17 actual leave records and therefore did not reflect when the patients went out on leave

The registered provider is to review care plans to ensure that there is one clear comprehensive care plan for each patient.

The registered provider is to ensure that all section 17 leave is recorded on care notes.

We also noted the following areas where the care plans could be improved or there were omissions:

- Whether copies of reviews were sent to the patients' general practitioner, referrer or commissioner

- Medication prescribed was included in the care notes, but there was no evidence of whether there had been any side effects or reasons as to why medication had been changed

- For both patients checked there was a change in diagnosis with no evidence of formal diagnosis to support this

- There was no information on the patients religious and ethnic needs, also no evidence of whether social aspects of the patients' needs had been evidenced

- No entry relating to the patients' sexuality (how they want to be addressed and wishes) and associated issues to give a holistic approach to the patient

- Whilst the care plans were good as regards to what to do in the event of an incident, there was no reference back to the care plans following the incidents

- Not all information from the previous system had been migrated to the new system

- The recording of information in the care notes was also not consistent, for example some care plans were found under risk assessments, whereas some risk assessments were found in the care plans

- The MDT meeting minutes were incomplete regarding who attended and their role

- There was no evidence of the education that had been offered.

The registered provider needs to ensure that additional information is included in the care notes to make them comprehensive and easier to navigate.

Quality of Management and Leadership

Governance and accountability framework
The latest available statement of purpose (SoP) was dated September 2022 and did not reflect the current arrangements at the setting, including the name of the registered manager. We were told this was currently under review, due to changes at the setting.

The statement of purpose should be updated as changes are made at the setting.

Additionally, the registration with HIW was not up to date, as this listed the previous interim hospital director, not the current hospital director. We were told this was because the setting were looking to move to a new type of service, where the conditions of service would be different, once the patients at the hospital had been transferred to other suitable locations. However, the registration should be kept up to date to ensure the setting was properly registered in accordance with the Care Standards Act 2000 and the Independent Health Care (Wales) Regulations 2011.

The registration of the hospital needs to be kept up to date and accurate.

There were currently four patients at the setting. These patients were all commissioned from England. There were regular weekly conference calls with various groups including the commissioners, NHS England and Elysium, to discuss the future of the patients. The setting were confident that all the patients would be moved to other suitable placements by the end of May.

There had been a recent unannounced visit, during the first week of May, made in accordance with regulation 28 of the Independent Health Care (Wales) Regulations 2011. The previous six monthly visit was made in November 2022.

We were told that senior managers visited the hospital regularly and engaged with staff. Senior staff were also visible and knew the staff and patients at the hospital.

We reviewed the provider policies and procedures available to the setting and noted that some of these were out of date. We saw evidence that the provider was updating these.

The employer needs to ensure that up to date policies and procedures are regularly reviewed in a timely manner and are available to the setting.

On our visits to the ward, we did not see any engagement between health care support staff and patients.

It was clear from the copy of the activities programme obtained that this programme was not being implemented regarding education and garden access. We were also provided with a different activity plan that we were told was under review.

The community meeting minutes provided, which included staff and patients, over the period 10 February 2023 and 14 April 2023 had action points carried forward relating to the computers not working. The minutes stated that “whilst young people are given schoolwork / courses to do online, they cannot carry out due to lack of computer equipment”.

As a result of the evidence that we have gathered, we believe that the service is not meeting the care needs of the service users in line with the requirements of its registration, and that this is having a detrimental impact on the wellbeing of the patients.

These issues were dealt with under HIW’s non-compliance notice process. These are referred to in Appendix B of this report.

The registration certificate required three registered mental health nurses (RMNs) to be always on duty. A variation to the conditions had been submitted to reduce this number to two in view of the low number of patients.

The new system of electronic reporting was described. The hospital has recently moved onto a new system for recording care notes. Whilst the previous system was still available to view, not all the information had been migrated onto the new system for reporting purposes.

We were provided with a report for the period 6 March 2023 to 9 May 2023, this stated that there had been 436 incidents, with 383 of these requiring physical interventions with 641 various holds being used.

The majority of these (60%) lasted less than 10 mins. However, there were seven incidents that lasted longer than 60 minutes, with the longest being 166 minutes.

We were provided with statistics relating to the number of incidents over the period 6 March 2023 to 9 May 2023. This showed that there were 383 incidents of restraints over this period. Of these, 20% were between 10 and 20 minutes and seven were for over 60 minutes, the longest being 166 minutes. The documentation provided did not give assurance that the periods of restraints were

necessary for these prolonged periods of time and whether they were continuous for this length of time.

All restrictive interventions should be for the shortest time possible and use the least restrictive means to meet the immediate need of the patient.

NICE in its guidelines for violence and aggression states: short-term management in mental health, health and community settings (NG10) published 28 May 2015 stated at section 1.4.29 “Do not routinely use manual restraint for more than 10 minutes”.

There was a need for greater governance around the duration of the restraint, analysis of the number and type of restraint, whether the restraint was necessary, the triggers and build up before the restraint and detailed justification of why the restraint is necessary and for this length of time.

As a result of these findings HIW could not be assured that the welfare and safety of patients was being maintained, or that adequate arrangements were in place to protect patients against the risk of restraint being unlawful or otherwise excessive. The young people in the service subject to restraints of this length and number may not be able to maintain their dignity. Additionally, restraints in any position can lead to compression of the chest, compromised breathing along with additional risk factors which may increase the likelihood of an adverse outcome. These interventions should be avoided wherever possible and time limited if used in an emergency.

These issues were dealt with under HIW’s non-compliance notice process. These are referred to in Appendix B of this report.

We had a detailed discussion with management at the hospital regarding this area and gained a level of assurance that lessons were learned from the restraints and that each incident was adequately analysed to ensure that the patient was safely restrained using best practice following national guidelines such as NICE. We requested further analysis for the restraints recorded and this initially did not include sufficient detail in the analysis of the type of hold used. It was also unclear which patient this referred too.

Following a meeting with the staff involved in the data collection, further details on the seven restraints above 60 minutes was requested. However, there was a lack of reassurance that, prior to the incidents of restraint, triggers and other de-escalation techniques had been implemented.

The registered person is to ensure that the governance of restraints are appropriately reported and investigated.

The registered person is to ensure that the restraints are analysed to identify any themes, whether the restraint could have been avoided and whether the restraint used was appropriate.

We were provided with staff meeting minutes for the three months, February to April 2023. These showed that staff were uneasy about the changes to the site, the comments included, having to work at other sites, shift pattern changes and numbers of patients. Some of the comments related to rumours and the minutes showed that senior staff tried to allay the fears of the staff. Other discussions included reminders to staff about completion of care notes and annual leave requests.

Dealing with concerns and managing incidents
We reviewed the complaints policies and this contained the necessary content, including time frames and responsibilities. There was also information displayed at the hospital for patients and carers, on how to make a complaint and on the advocacy services available. We were told all patients had advocates in place.

The complaints process was also described. There had been five complaints during 2023 including two complaints from staff. The two complaints from April were both ongoing, for one an extension letter had been sent to the parent and the other was open awaiting a reply from the complainant. We were told that both informal and formal complaints were listed. Staff were also able to make a complaint through the same process.

There were organisational policies in place to ensure all incidents were reported, investigated and managed appropriately, with clear lines of accountability. There was also training in place on reporting and recording. There were logs to monitor the incidents, including whether 24/72 hour reports were required and if there was a serious untoward incident that required further investigating. These would be discussed daily, depending on the incident this may also lead to a regulation 30/31 report as required by the Independent Health Care (Wales) Regulations 2011.

From information supplied by the concerns team in HIW, the setting was reporting incidents as required to HIW. Although there may have been issues around the timely reporting of safeguarding incidents and this was being investigated by the hospital.

Workforce planning, training and organisational development

There was an induction process in place for new staff and a shorter version was completed for agency staff.

Overall compliance, based on information supplied, showed that there was 72.5% compliance with the Elysium training requirements. This percentage varied from 91% for fire safety to 33% for immediate life support (ILS) (three out of nine members of staff).

Individual staff compliance varied from 100% for six members of staff, to 7%. However, we were shown the regional training plan for May and June 2023 where a number of courses were being run to update staff compliance with their mandatory training. This included clinical note writing, safeguarding and management of movement, violence and aggression.

The hospital needs to continue to work on ensuring full compliance with mandatory training.

We viewed the hospital compliance with annual appraisals of staff. Whilst we were told that there was a plan in place to improve compliance the current completion of annual appraisals was only 20%

The hospital needs to continue to work on ensuring full compliance with annual appraisals of staff.

We checked the training records available on file, dated 31 January 2023, as supplied by the agency for two qualified agency staff and noted that there were gaps in the training records for two of the agency RMNs checked. This included out of date training in infection control and safeguarding for one of the nurses and no entries for the other nurse for medication administration and positive behaviour management. There was no entry on the record relating to ILS.

The staff at the hospital had requested further information on 31 March 2023, but nothing had been received. A further update was requested during the inspection and the subsequent information received showed for both nurses that they had not completed ILS training.

Failure to provide adequately qualified staff could result in a patient not receiving timely intervention in the event of a resuscitation emergency. Therefore, we could not be assured that the resuscitation arrangements in place at the hospital ensured the welfare and safety of patients.

These issues were dealt with under HIW's non-compliance notice process. These are referred to in Appendix B of this report.

Workforce recruitment and employment practices
The 12 RMNs staff at the setting working in the wards were agency staff, we were told they had been booked for some time on a long term contract, to ensure familiarity with the patient group and continuity of care.

We viewed the evidence provided for two agency RMN staff. There was sufficient information on the paperwork provided to show that they had a valid, disclosure barring service certificate, were on the nursing and midwifery council register and were appropriately recruited.

There was a wellbeing service available to staff.

4. Next steps

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

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

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
The path to the outside area, with a trampoline, picnic bench and table was covered in leaves, which appeared to have been there for some time. This area, accessible from the first floor bedrooms, was also a fire exit route, with steps to a lower level.	Patients may not be using the outside area due to the potential slip hazards. Egress of staff and patients in the event of a fire may be compromised.	This was evident to the deputy hospital director during the tour of the building.	The access to the outside areas, including the fire exit route was cleared by maintenance staff.

Appendix B – Immediate improvement plan

Service: Hillview Hospital – Focussed Inspection

Date of inspection: 9 and 10 May 2023

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

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The registered person is to ensure that the governance of restraints are appropriately reported and investigated including details on: • Triggers and build up to the restraint • Accurate recording of the length of time of restraint • Subsequent analysis and investigation of the restraints to ensure lessons are learnt. The registered person is to ensure that the restraints are analysed to identify any themes, whether the	Independent Health Care (Wales) Regulations 2011, Regulation 15 (1) (a)	Daily log of Incidents has been maintained (established which includes sequence of events and interventions) Daily log Reviewed by Psychology department of incidents for the prior day. Identifying any incidents that require further action, in terms of supporting staff with documentation of incidents, further debriefs of staff patients required Additional daily support and oversight provided on site by an experienced senior nurse from another Elysium site	Registered Person	15/05/2023 And ongoing till discharged from the service 16/05/2023 And ongoing till discharged from the service On site from 17/05/23 up until discharge

restraint could have been avoided and whether the restraint used was appropriate.		with experience in both CAMHS and Secure services. Any incidents requiring further investigation will be allocated an appropriate investigating officer. Lessons learnt will be identified and actioned immediately. Findings and actions will be reported back through governance monthly and weekly SIP meeting Registered person will have oversight of Incident log and review everyday Daily Incident log and review will be shared each day with HIW via Objective Connect Weekly Incident review report will continue to be uploaded onto Objective Connect		Daily until all patients are discharged from the service- End of each working day (Monday – Friday) 19/05/2023 Ongoing till all patients are discharged from service 16/05/2023 and ongoing till discharge form service 22/05/2023 and ongoing till discharge form service Ongoing
The registered person is to ensure that:	Independent Health Care (Wales)	All staff are urged to encourage patients to utilise the outside space, appropriate to risk, and clearly document offer of	Registered person /	16/05/2023

• Patients are offered a period of time outside the internal hospital environment to have some fresh air, on a daily basis, the offer must be recorded on their care notes, together with the results of the offer • The vacant posts of educator, psychologist and occupational therapist are filled urgently to ensure that the educational and therapy needs of the patients are met • The activity plan is agreed and the results of these activities recorded on the care notes • The computers need to be repaired in a timely manner to ensure they are available for the patients • Staff engage with the patients and evidence of that engagement is recorded.	Regulations 2011, Regulation 15(1)(a)	fresh air and patient response in clinical notes - this is highlighted in the ward handover All staff including Occupational therapy assistants will encourage the patients to work on their online education courses, and document patient response to encouragement in clinical notes. Again, added to hand over Computers in the ward IT suite have been attended to and are working All activities will be identified on care notes and monitoring of documentation recorded daily in OTA report reviewed by ward managers or Registered person Occupational Therapy assistant will coordinate daily report identifying all activities and engagement with patient group. Which will be uploaded at end of each day to objective connect	All patient facing staff All Staff IT Tech All staff – monitored by NIC Occupational therapy assistant / Registered person	16/05/2023 15/05/2023 Complete Daily form 16/05/2023 Daily from 22/05/20 – working day Monday – Friday

The registered person is required to ensure that: • Suitably qualified staff, trained in immediate life support, are on duty at all times • Action is taken immediately to ensure that the relevant staff that need to be qualified on immediate life support attend the relevant training • Evidence is available on file to ensure that agency staff are qualified in immediate life support.	Independent Health Care (Wales) Regulations 2011, Regulation 15(1)(b), 15(1)(d) and 20 (1)a	Shift Coordinator liaising with more agencies to source nurses with the relevant in date training. These will be in addition to existing staff numbers when needed. Shifts are now covered with a minimum of one nurse holding ILS certificate, with other staff on shift holding BLS certificates. Where more nurses are available with ILS training they will be included in the shifts, increasing the numbers of trained staff. Profiles of ILS trained nurses will be held on site evidencing their training to be shared with HIW via Objective connect, along with shifts allocated and worked. ILS training course arranged for other nurses to attend on Thursday 25th May, increasing the number of ILS trained nurses available to be on shift.	Registered person / Shift coordinator	15/05/2023 and ongoing till patients are discharged. 22/05/2023 and on going until patients are discharged 25/05/2023

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

Service representative:

Name (print): **Vicki Wheeler**

Job role:	**Hospital Director**
Date:	**18 May 2023**

Appendix C - Improvement plan

Service: Hillview Hospital - Focussed Inspection

Date of inspection: 9 and 10 May 2023

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

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
We recommend that the registered provider confirms the fire exit route to the rear of the building from the upstairs bedroom is an acceptable fire exit route in light of the need to re-enter the building.	Independent Health Care (Wales) Regulations 2011 Regulation 26 (4)	The service inspected is no longer provided at this site and refurbishment is underway however prior to reconfiguration the following improvements will be made: E - Fire - new company sourced in line with Elysium policy will conduct a Fire Risk Assessment and prepare an evacuation plan. This cannot be completed until first phase of Refurbishment of Hospital is complete. This will then require review in line with each phase of Refurbishment completion.	H&S Lead LD PJ - Regional facilities manager E Fire services	To be completed by 31/07/ 2023

Additionally, whilst we were told that staff were aware of this escape route, the route should be better signposted, to avoid any doubt.		E- Fire will present clear signage of evacuation throughout the hospital when evacuation plan complete. This will be evident in line with the completed refurbishment of each phase of refurbishment.		31/07/2023
The registered provider needs to ensure that staff are fully briefed on the risks to patients of not ensuring observations are carried out as required.	Independent Health Care (Wales) Regulations 2011 Regulation 19	There will be a training session formulated to delivered for all staff prior to new service opening, and the admission of any patient in line with the observation and engagement policy. All staff will complete the observation and engagement competency checklist alongside the above training, which will be maintained on file. There will be a clear handover document outlining all patients risk, observation level and detailing any individual need and support requirement, in line with patient admissions. Clarification of understanding of observation levels of each patient will be discussed in supervisions.	Hospital Director (HD) HD Ward manager HD	31/07/2023 31/08/2023 31/07/2023 Ongoing from 01/09/2023

The registered provider is to review care plans to ensure that there is one clear comprehensive care plan for each patient.	Independent Health Care (Wales) Regulations 2011, Regulation 23	There are currently no patients in the service. As patients are admitted there will be a care planning meeting weekly as minimum with input from entire MDT and goals/ outcomes recorded on one document in line with the Welsh Measure. Which may in turn identify more specific intervention focused care plans if/ as required (e.g. meal support plan).	 MDT & patients	06/07/202 01/09/2023
The registered provider is to ensure that all section 17 leave is recorded on care notes.	Independent Health Care (Wales) Regulations 2011, Regulation 23	There are currently no patients in the service. There will be training sessions facilitated for all staff prior to new service opening detailing expectations of documenting in care notes, and the guidelines to facilitating/ supporting Section 17 leave. Ward manager will audit Section 17 recording in care notes at a minimum of weekly via electronic dashboard, following admission of first patient.	 HD Ward manager	06/07/2023 31/08/2023 01/09/2023

The registered provider needs to ensure that additional information is included in the care notes to make them comprehensive and easier to navigate.	Independent Health Care (Wales) Regulations 2011, Regulation 23	There are currently no patients in the service. There will be training sessions facilitated for all staff prior to new service opening detailing expectations of documenting in care notes. Ward manager will audit care notes at a minimum of weekly for quality and confirmation of notes, following admission of first patient.	 HD/ training department Ward manager	06/07/2023 First session completed 29/06/23 Ongoing from 31/08/2023
The registered provider is to ensure that the statement of purpose is regularly updated as changes are made at the setting.	Independent Health Care (Wales) Regulations 2011, Regulation 6, 8 and Schedule 1	Statement of purpose updated to reflect variation and new service. Will be updated in line with any further variations in the future.	HD & RI	22/06/2023
The registration of the hospital needs to keep up to date and accurate.	Independent Health Care (Wales) Regulations 2011, Regulation 11	Application for variation and new registered manager application submitted to HIW.	RI & HD	27/06/2023

The employer needs to ensure that up to date policies and procedures that are regularly reviewed in a timely manner are available to the setting.	Independent Health Care (Wales) Regulations 2011, Regulation 9	Policies remain central to Elysium Healthcare. 2 of the 5 policies provided to HIW have been published on the intranet and are available to all staff, the remaining 3 are currently in review however the existing policies in place until review complete are available on the intranet. Local procedures are being formulated in line with new service requirements and specifications through working groups, these will be ready for implementation in line with training for new service. These will be reviewed in line with changes to service and / or legislation.	Policy department HD/ MDT	01/09/2023 01/09/2023
The registered person is to ensure that the governance of restraints are appropriately reported and investigated.	Independent Health Care (Wales) Regulations 2011, Regulation 16 (2) and 16 (3)	Daily log of Incidents and referral for amended/ addition information commenced and all incidents reviewed by MDT in morning meeting. All Staff will have further training on completion and 'story telling' enabling appropriate identification and sequencing of incidents and any physical intervention required / used.	All staff/ MDT All staff	09/05/2023 01/09/2023

		Ward managers will review any incidents and refer any (back to author) not to standard, with guidance as to completion. Any prolonged restraint over 10 mins will be investigated and reported as required.	Ward manager Ward manager	On going On going
The registered person is to ensure that the restraints are analysed to identify any themes, whether the restraint could have been avoided and whether the restraint used was appropriate.	Independent Health Care (Wales) Regulations 2011, Regulation 16 (2) and 16 (3)	Restraints will be reviewed daily at morning meeting and then further analysed at Ward round, and individual themes identified, and managed in individual in updated reviewed Positive Behaviour Support plans. Any repeated or serious untoward incidents will be investigated and reported to local governance with actions. STMVA instructors will be included in any STMVA care plans required and oversight from Safe and Therapeutic Management of Violence and Aggression Lead for Wales sought. Incidents of restraint will be reviewed in Reducing Restrictive Practice meeting when they resume in line with the opening of the service.	MDT MDT/ STMVA Tutors and Regional Lead HD/DHD/ STMVA instructors ward representative	01/09/2023 01/09/2023 30/09/2023

The registered provider needs to continue to work on ensuring full compliance with mandatory training.	Independent Health Care (Wales) Regulations 2011, Regulation 20 (2) and 47 (1) (d)	Compliance with training is currently at Permanent Staff: 92.8% Compliant. Bank Staff: 47.8% Compliant – bank staff currently not being used, but training will be mandatory prior to use again. Total Compliance: 89.2%. Line managers will have overview and manage their departments training compliance. Training compliance will be reviewed and discussed at local and regional governance.	All staff Line managers Team	05/07/2023 Monthly
The hospital needs to continue to work on ensuring full compliance with annual appraisals of staff.	Independent Health Care (Wales) Regulations 2011, Regulation 20 (2) (a) and 20 (3)	Appraisal compliance currently stands at 35%. Remaining outstanding Appraisals are booked in and will be completed by end of August	All staff All staff/ line managers	06/07/2023 31/08/2023

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

Service representative

Name (print): Vicki Wheeler

Job role: Hospital Director

Date: 11/07/23