Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

New Hall Independent Hospital

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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.

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at New Hall Independent Hospital on the evening of the 24, and two full days on 25 and 26 October 2023.

The following hospital wards were reviewed during this inspection:

- Glaslyn Ward – a four bedded ward
- Adferiad Ward – a six bedded ward

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

During the inspection we engaged with patients where we were able to do so for them to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 8 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

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:
We observed staff communicating with patients in a kind and respectful manner throughout the course of the inspection. This behaviour was observed to be reciprocated by patients to staff throughout the inspection.

There was good access to activities away from and at the setting, which were of therapeutic benefit to patients and based upon their likes and preferences. We confirmed that patients had access to family times where desired and appropriate, and that there were advocacy and representation services in place for patients as required.

This is what the service did well:

- We observed staff communicating with patients in a kind and respectful manner throughout the inspection
- There was good access to therapeutic activities away from and at the setting

Delivery of Safe and Effective Care

Overall summary:

Management and staff at the service demonstrated a well-rounded understanding of the patients. We observed staff responding calmly and appropriately to challenging behaviours, and there was an overall good approach to timely risk formulation.

Processes in relation to location and checking of emergency equipment had improved since the last inspection, with staff aware of how to access this equipment in an emergency. Recently reviewed fire risk assessments had been completed and fire exits were now in appropriate use throughout the setting.

This is what we recommend the service can improve

- The registered manager must ensure that maintenance and housekeeping issues are resolved according to their level of priority and risk
- The registered manager must ensure that [medication] stock reconciliation processes are always adhered to
- The registered manager must ensure that aspects of PBS record keeping is strengthened.

This is what the service did well:

- The setting regularly updated care documentation in relation to risk formulation and challenging behaviours to a good standard
- The setting developed creative ways in support of patients physical needs and accessibility
- Mental Health Act administration processes upheld patient rights, with good management and oversight.

Quality of Management and Leadership

Overall summary:
The setting had strengthened areas which we identified as needing immediate improvement in our last inspection. We found improved governance processes, which enabled timely management responses to risks and incident reporting.

Feedback provided by staff was generally positive. We identified aspects of training which require additional consideration by the setting based on the training needs and priorities of its workforce.

This is what we recommend the service can improve

- The setting must ensure that there is an updated training plan created based on training needs and priorities of its workforce.

This is what the service did well:

- The setting provided staff with the opportunity to high quality reflective sessions
- The setting had been successful in the recruitment of several nursing positions to support continuity of care and patient familiarity.

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

We spoke to patients and observed interactions between staff and patients as part of forming a view on the quality of patient experience.

Health promotion, protection and improvement
We reviewed aspects of physical health care and found good processes in place to meet these needs. Weekly well man clinics were completed by nursing staff and staff had been upskilled to complete various observations and straightforward tests on behalf of the local GP practice, as part of each patient's annual health check. This helped to ensure familiarity of staff with patients to effectively complete the required tests.

We confirmed that patients had accessed other services, such as audiology and dental services, as required. We confirmed that patients would be accompanied by service staff if needing to attend hospital appointments on a routine or emergency basis. Staff confirmed that they contact the health board learning disability liaison team when admissions to hospital are taking place and spoke positively of the support provided by the liaison team in supporting patients through the secondary care process.

Other aspects of wellbeing, such as healthy eating and nutritional monitoring, was encouraged and completed for patients as required.

Both wards had access to therapeutic and activity facilities. These included a gym, rehabilitation kitchen, cinema room and quiet or low stimuli spaces. The hospital benefited from spacious grounds and a minibus for planned activities away from the setting.

When asked how the setting could improve the environment, staff commented that a sensory room would improve the patient experience for patients with autism. The inspection team agreed that this would be a welcome addition based on the criteria and needs of patients accepted by the setting.

Dignity and respect
We observed staff communicating with patients in a kind and respectful manner throughout the course of the inspection. This behaviour was observed to be reciprocated by patients to staff throughout the inspection.

We noted some staff feedback relating to racist language used by patients on occasions to staff. We confirmed that this had been responded to appropriately at the time. We would however encourage the service to explore if activities could be organised to help patients understand the importance of not using language of this nature.

All patients had their own bedrooms and en-suite facilities. All patients also had access to additional space, which we confirmed would be retained once admissions to the service increase. We viewed some bedrooms and found these to be personalised, where desired, to provide a homely feel. Where patients had chosen to not personalise their rooms, we confirmed that this was an individual choice.

Patient information and consent
Through our review of patient records, multidisciplinary team entries, and records relating to the Mental Health Act, we confirmed that patients had access to attend meetings and information relating to the provision of their care and treatment. The use of communication aids and tools were used to support patient understanding, for example if changes to medications are made.

Patients had access to advocacy and representation in helping to understand and express their opinions on their care and treatment. We found effective links with local independent mental health advocacy services, but we noted that not all patients actively sought to be involved in their care, with reasons documented.

The involvement of friends or family was encouraged where appropriate and we found that patients had access to time with friends and family either electronically or in person as desired.

Communicating effectively
We observed staff communicating with patients in an individualised and engaging manner according to each patients needs and preferred communication style. This included observed use of verbal, written and pictorial tools as required.

We reviewed material available for patients to help them understand their care and treatment. This information was in an accessible format, and we confirmed that patients had been involved and helped to understand how decisions about their care had been reached.

Access to devices, such as tablets, for video calls with families or for care related meetings were available for patients to use on an individualised and risk assessed basis. We saw evidence to show that the service had liaised with families, friends and professionals to discuss and agree the most appropriate methods of communication.

We noted that in person visits from friends, family and professionals were supported on an individualised basis and that the setting had processes in place to notify families of updates or incidents related to patients.

Equality, diversity and human rights
We reviewed a sample of four patient records in relation to the administration of the Mental Health Act (MHA). All patient records related to the requirements of the MHA were maintained to a high standard, being well organised and easy to navigate.

We found patient rights were upheld and all detentions to be valid in accordance with the Act and Code of Practice. Patients had access to advice, representation and there was evidence on file to demonstrate decision making in this regard. We noted established and effective links with a local independent mental health advocate service.

Citizen engagement and feedback
There were mechanisms in place to capture feedback from patients and their families and friends in relation to their care and experience at the service. We saw examples of patients being given the opportunity to take part in their multidisciplinary team (MDT) meetings. We confirmed patients had taken part in their MDT meetings when they had wanted to and that patients had been offered use of an independent advocate, who attended the service in-person on a regular basis, to assist patients to express their opinions and wishes.

There were several compliments received by the service from family and friends. There were no recent formal complaints logged, but the setting was able to explain how they positively communicate and support patients to resolve any low level concerns that may have, for example issues regarding their planned activities for the day.

Since the last inspection, we noted that the setting had developed a pictorial form for patients to express their opinions and views. Although, the setting noted that none had been completed at the time of the inspection. As the service begins to admit an increased number of patients, they may wish to explore the use of these forms or the establishment of patient groups to ensure that the service is developed through patient feedback.

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety
The environment was accessible to all patients and visitors, and lifts were available on the wards to support patients with mobility needs. We saw suitable equipment on the wards, including bariatric equipment and modified walking aids, to support patients and staff safely and effectively.

Staff had access to alarms and radios, which appeared to be in full working order. Staff raised no concerns in relation to these during the inspection or in questionnaire feedback.

We found fire and environmental risk assessments had recently been completed through external organisations. The actions associated with these risk assessments had been signed off as completed according to the level of risk.

The setting was overall well maintained, and staff spoke positively of the input provide by the maintenance staff. Whilst no notable maintenance issues were identified, we observed a number of smaller issues within the wards which require attention. Examples included broken fire door closers, exposed screws, and missing shower grates. We would advise a walkaround of the setting to identify these issues prior to increased patient numbers.

The registered manager must ensure that maintenance issues are resolved according to their level of priority and risk.

Infection prevention and control (IPC) and decontamination
The setting was overall clean and tidy throughout, including both wards and individual patient bedrooms. However, due to low patient numbers at the time of the inspection, areas of the setting which were not in use or in regular use would benefit from a deep clean and removal of clutter to ensure these spaces are readily available for use again. We would advise a walkaround of the setting to identify areas in need of cleaning, followed by an IPC audit prior to increased patient numbers.

The registered manager must ensure that all areas of the service are clean and free of clutter.

Whilst we found cleaning of areas in use was completed to a good standard, we noted that cleaning schedules or checklists were not routinely completed. The

setting should explore the use of checklists to evidence when areas have been cleaned and by whom.

The setting had the ability to provide isolation or barrier nursing as required. Staff described processes that would be followed and confirmed they had access to the necessary personal protective equipment (PPE).

Sharps wastage was stored appropriately and securely in the medication room. There was a protocol in place for staff to follow in the event of a needlestick injury.

There was a laundry room on-site and we were told that either laundry would be completed for patients or patients would be supported to complete their laundry under supervision.

Nutrition
We confirmed that patients with dietary preferences or specific needs were able to provide their views on their menu options, with evidence of staff within the service working together staff to accommodate these needs. There was good evidence of the service working with patients and ensuring that alternative options were made available should patients change their mind.

Clinically, nutrition and hydration needs were assessed, recorded and addressed appropriately. We observed fluid and nutrition charts in place where required, and access to support from a dietician was available. Speech and language therapies input was evident in care plan documentation to appropriately support patient needs.

Medicines management
All medicines were stored appropriately, in either ambient or refrigerated conditions as required, and in secure cupboards through a locked door. Fridge temperature checks were recorded and staff were aware of how to report any temperature anomalies.

On Adferiad Ward, we found an out of date inhaler, and adrenaline being stored outside of the anaphylaxis kit, which could delay timely administration in an emergency.

We escalated this to the service during the course of the inspection and action was taken to immediately rectify this. See Annex A for further details.

We found appropriate processes in place for the recording and signing for drugs liable to misuse.

There was evidence on file of reflective practice tools in use for staff involved in medication error incidents. However, we identified that aspects of stock reconciliation could be strengthened, which the setting was aware of and was in the process of improving.

The registered manager must ensure that medication stock reconciliation processes are always adhered to.

We confirmed that the service helped patients to understand their medication according to their level of capacity. For those patients who require additional support, we saw input from the speech and language therapies team in producing easy read material for new and changes to a patient's medication. Where changes to medication was made, evidence of change and patient involvement was recorded in monthly multidisciplinary team meetings.

We found individual patient medication charts to be completed to a good standard in the sample of records that we reviewed. Each patient had an individualised medication plan, plus an additional care plan for as required medication where required.

There was a clinical procedure in place for the prescribing of antipsychotic or sedation medication. We found no medication being administered outside of recommended clinical limits. Through a review of MDT records, least restrictive practises were applied in the use of medication.

In relation to pain scoring, we found use of traditional numbered scales or emotion based pictorial tools for patients who required additional support to express pain.

We found strengthened arrangements since the last inspection in relation to the storage, access and checking of emergency equipment, including defibrillator and ligature cutters. Equipment was now stored in an appropriate location, with access for all staff. When asked, staff were aware of the location and how to access items in the event of an emergency. Checks of this equipment were now completed on a regular and consistent basis.

Safeguarding children and safeguarding vulnerable adults
There were clear and accessible procedures in place for staff to follow in the event of a safeguarding concern. Staff we spoke with were aware of how to apply this procedure in the context of their roles and the staff training completion rate for safeguarding was good.

We found strengthened governance and oversight mechanisms since our last inspection, which included the acknowledgement and responding to of any

potential safeguarding matters from the previous shift at a daily morning meeting. This was in addition to formal reporting through the settings internal Rivo incident recording system and increased responsiveness in the management review of incidents submitted through the system.

Safe and clinically effective care
We found all patients had care and treatment plans in place. We reviewed a sample of these and found the following positive aspects:

• Care plans were comprehensive and individualised, including an appropriate emphasis on needs, strengths and independence
• Risk assessments were subject to regular review and covered a breadth of risks individualised to each patient
• Care plans were reviewed regularly through a well attended MDT, with patient input where desired
• Care and Treatment Plans were in place for those patients subject to the Mental Health (Wales) Measure 2010

Each patient had a positive behavioural support (PBS) and a crisis intervention plan in place which we found were completed to a good standard, particularly the approach to risk formulation. These contained detailed primary and secondary interventions, reactive strategies, and approaches to nurturing appropriate behaviours for each patient.

We noted that the service was transitioning to a new physical intervention training programme. We saw data which demonstrated a gradual reduction on a month by month basis in the severity and duration of interventions.

Use of interventions were supported by a restraint reduction plan for all patients. Where challenging behaviours presented, we observed staff responding in a way which limited the escalation of this behaviour in a calm and effective manner.

It was positive to find strengthened review of incidents, including those involving any form of intervention. The service acted upon incidents in a timely manner, which included consideration of triggering an incident review meeting, a root cause analysis, and providing staff and patients with the opportunity to debrief. We noted high quality staff reflection sessions provided within the team, which we observed during the inspection.

Records management
We found patient documentation to be overall comprehensive and easy to navigate.

We noted assessments were completed and updated on a regular basis by various members of the MDT. The approach to risk formulation was completed to a good standard, including the updating of care plans and risk assessments based upon acute episodes of changes in a patient's behaviour.

We noted PBS plans to be comprehensive, but that aspects of their record keeping could be strengthened, for example by ensuring plans are correctly dated, and expired plans are clearly indicated as such.

The registered manager must ensure that aspects of PBS record keeping is strengthened.

We identified the use of daily outcome diaries for patients to be a welcome development in support of capturing patient needs, preferences for the day ahead and in providing staff with quality contemporaneous information relevant to each patient.

Mental Health Act Monitoring
We reviewed four files of patients who had been detained under the Mental Health Act and were satisfied that the requirements of the Act and Code of Practice were met.

All records were maintained to a high standard and were easy to navigate. We confirmed that patient rights were upheld, with patients being provided with information about their detention and there was evidence that patients had been helped to understand this. All patients had access to advice and representation where desired and there was evidence on file documenting decision making around this. There were good local links established with the local independent mental health advocate service, with effective and timely access when required.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision
Care and treatment plans were in place for all patients. The plans had been reviewed, were appropriately individualised and contained detailed knowledge of each patient. This included a range of goals, actions and targets for each patient relevant to their interests and in support of their independence.

There were active discharge planning arrangements in situ for patients at the setting. Whilst some patients had been at the setting for lengthy periods of time, staff were able to demonstrate how they had and are working with external partners to support safe, appropriate and sustainable placements for patients. We noted that emphasis was placed on the views of patients when discharge arrangements are considered.

Quality of Management and Leadership

Staff Feedback

We invited staff to complete a HIW staff questionnaire and 8 were completed. Comments are included below where appropriate, but findings may not be representative of the workforce due to the low response rate.

Staff comments included the following:

> "The management are treating everyone equally…"
>
> "There are different people [staff] all working towards the same goal, to take care of patient…"

Governance and accountability framework
The organisational structure appeared suitable to provide managerial and leadership oversight, and to enable the effective flow of information between wards and management. During the inspection, we observed team leaders acting in a supernumerary capacity and those staff were clear on their roles and responsibilities.

In response to the HIW staff survey, all staff agreed the care and the safety of patients is their organisations top priority, with all agreeing that they would be happy with the standard of care provided by this organisation for their friends or family. All but one staff member recommended the organisation as a good place to work.

When asked about senior management, all staff agreed that senior managers are visible and that they are committed to patient care. All but one agreed that communication between senior managers and staff is effective.

In relation to their immediate line manager, all staff agreed that their line manager can be counted on to help with a difficult task at work and that they ask for their opinion before making decisions that affect their work. All but one agreed that clear feedback is provided to them.

We found the Responsible Individual made regular unannounced visits to the service and their reports contained a good level of detail in order for them to be assured of the effectiveness of aspects of running of the service.

Dealing with concerns and managing incidents
We found strengthened arrangements in the management of concerns and incidents by the setting. This included the introduction of new reporting and governance processes, and improved timeliness of management review in response to incident.

The introduction of a daily morning communication meeting reviewed all matters related to incidents, risks and challenging behaviours over the previous 24 hours. This appeared sufficiently detailed to enable timely action by staff.

Actions from this meeting acted as a vehicle for entering incidents onto the settings incident management system, RIVO. We reviewed a sample of these records and found a new daily management review process in place. Once reviewed, we saw decisions in relation to the triggering of other processes, including root cause analysis investigations, safeguarding referrals, or reporting to HIW.

We confirmed that this information fed upwards into unit led governance meetings. These meetings had been strengthened with the introduction of lessons learnt and a HIW tracker for the reporting of incidents to us. There appeared to be a good emphasis on incident debriefs and welfare checks for staff or relatives as required.

We reviewed a sample of incidents and found these to correlate with records held by HIW for those incidents meeting HIW regulatory requirements to report.

When asked if their organisation encourages them to report incidents and if their organisation takes action to ensure they do not happen again, all staff agreed. However, all but one staff member agreed that they are treated fairly when reporting incidents and that they are given feedback in response.

Workforce planning, training and organisational development
There were sufficient numbers and skill mix of staff to meet patient needs and observations at the time of the inspection and staff reported no concerns to us regarding staffing levels.

Whilst there was use of agency staffing at the time of the inspection, we confirmed that agency staff were known to the setting, which helped to ensure familiarity with processes and with patients.

There was a low number of vacancies at the setting, and we found that there had been recent successful recruitment of several overseas nurses. We confirmed that

there was a training and induction process underway, and that supervision would be provided for each new member of staff.

We initially found good levels of compliance with mandatory and specialist training. However, due to discrepancies in the way data was recorded, we noted percentage completion rates in several training areas required strengthening.

The setting must ensure that there is an updated training plan created based on training needs and priorities of its workforce.

The registered provider is encouraged to ensure that training data is accurately and consistently recorded across its other regulated sites.

Supervision of registered staff was underway at the time of the inspection and was nearing its completion. All staff who completed a HIW questionnaire told us that they had received supervision or an appraisal within the last 12 months and that they feel they've received appropriate training to undertake their role.

Workforce recruitment and employment practices

We examined a sample of staff files and found them to be maintained to a good standard in respect of pre-employment checks. There was evidence to support on file for each file to confirm that staff were fit to work, appropriately qualified, and professionally registered to work at the setting. We reviewed a sample of professional registration numbers for registered nurses and found no restrictions to practise on staff at the setting.

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
We found an expired inhaler and inappropriate storage of adrenalin outside of the anaphylaxis kit on Adferiad ward	Expired medication may limit their efficacy and items stored outside of the kit may prevent timely administration in an emergency	We highlighted this to the nurse in charge on the ward	New inhaler ordered and adrenalin stored correctly.

Appendix B - Immediate improvement plan

Service:

Date of inspection:

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

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate areas for improvement				

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):

Job role:

Date:

Appendix C - Improvement plan

Service: New Hall

Date of inspection: 24-26 October 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
The registered manager must ensure that maintenance issues are resolved according to their level of priority and risk.	Regulation 26	Incident review meeting highlights maintenance issues that are then e-mailed each day to maintenance.	LH, HM & DR, MHA.	Completed 30/11/2023
The registered manager must ensure that all areas of the service are clean and free of clutter.	Regulation 26	Deep clean of upstairs Adferiad is scheduled prior to any new admissions – storage of items to be organised.	LH, HM, & AB, Maintenance.	Due for completion during January 2024.
The registered manager must ensure that [medication] stock reconciliation processes are always adhered to.	Regulation 15	Medication training by Senior Nurse has been implemented on an individual basis on specific hospital processes. Training session planned for 11 & 25/01/2024.	CM, SSN.	Due for completion 30/01/2024.

		File 1 & 2 Stock reconciliation Medication ordering		
The registered manager must ensure that aspects of PBS record keeping is strengthened.	Regulations 15 / 23	Communication to Psychologist and Psychology Assistant to ensure old versions are removed from files and archived appropriately when replaced with new versions of PBS plans.	LH, HM.	Completed 30/11/2023.
The setting must ensure that there is an updated training plan created based on training needs and priorities of its workforce.	Regulation 21	Training matrix now includes N/A for individuals that do that not require specific training.	VK, Hospital Administrator.	Complete 30/11/2023.
The registered provider is encouraged to ensure that training data is accurately and consistently recorded across its other regulated sites.		Communication passed to executive team. All service training matrixes will follow New Halls KPI.	DW, Head of Support Services.	

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): Linda Hull

Job role: Registered Manager

Date: 05/12/2023