Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Heatherwood Court
Inspection date: 04, 05 and 06 December 2023
Publication date: 03 May 2024

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

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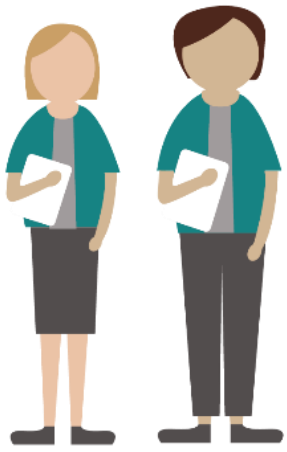
The patients we spoke with were complimentary about the care provided and about their interactions with staff. Patients had their own programme of care that reflected their individual needs and risks.

Suitable protocols were in place to help maintain the health and safety of patients, staff and visitors at the hospital. We found effective processes in place to help ensure that staff at the hospital safeguarded patients appropriately.

However, during the inspection we identified poor standards of cleanliness throughout all wards and the condition of the premises we observed was not reflective of a modern inpatient mental health service.

As a result of our findings, we were not assured that:

- The premises provided a clean, safe and secure environment in line with current legislation and best practice
- The premises were being kept in a good state of repair internally

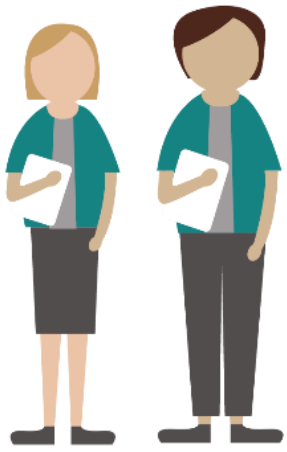


- Patients and staff were being protected from healthcare associated infection through the maintenance of appropriate standards of cleanliness and hygiene
- The service was identifying, assessing and managing risks relating to the health, welfare and safety of patients and others.

We were also not assured that staff had received appropriate training in relation to resuscitation to ensure the welfare and safety of the patient in the event of an emergency.

At the time of the inspection, Heatherwood Court was designated as a Service of Concern in line with HIW's Escalation and Enforcement process for independent healthcare services. Following inspection, it has remained a Service of Concern. HIW will continue to engage with senior management and the provider until it is satisfied with the actions taken to address required improvements.

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



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 Heatherwood Court on 04, 05 and 06 December 2023.

The following hospital wards were reviewed during this inspection:

- Caernarfon – a locked rehabilitation unit with 11 single gender beds
- Cardigan – a low secure unit with 12 single gender beds
- Chepstow - a low secure unit with 12 single gender beds

At the time of the inspection the hospital was being managed by Iris Care Group.

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

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

A full report, which is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients can be found on our website.

Quality of Patient Experience

Overall Summary

Staff interacted and engaged with patients appropriately and with dignity and respect. Patients could engage and provide feedback about their care in a number of ways. Staff had undertaken equality, diversity and inclusion training to help recognise the importance of treating all patients fairly. Information was available to inform patients of their rights under the Mental Health Act. Patients had weekly access to a mental health advocate who provided information and support with any issues they may have regarding their care.

It was disappointing to find that the Social Hub, which included facilities such as a café and shop, was no longer in operation. We have asked the service to consider the feasibility of reinstating the Social Hub to provide an opportunity for patients to engage and relax with each other when appropriate.

Where the service could improve

- Patients must be provided with access to a dentist and other health services when required.

What we found this service did well

- Patients were asked to complete outcome measures, and summary reports produced by staff contained recommendations to help improve patient experience and their wellbeing.

Delivery of Safe and Effective Care

Overall Summary

Staff were committed to providing safe and effective care. The dietary needs of patients had been assessed on admission and specific dietary requirements had been identified and acted upon where necessary. The statutory documentation we saw verified that the patients were appropriately legally detained. The care and treatment plans we reviewed were generally being maintained in line with the Mental Health (Wales) Measure 2010.

The service had recently implemented an electronic Medication Administration Record system which had helped to reduce the number of medication errors occurring at the hospital. We saw that some patients were having their medication administered through a hatch in the clinic room door. We have asked the service to review the way medication is administered to fully protect the safety, privacy and confidentiality of patients.

Immediate Assurances

During the inspection we identified poor standards of cleanliness throughout all wards and the condition of the premises we observed was not reflective of a modern inpatient mental health service. Cleaning schedules we were provided with had numerous gaps which indicated that the required cleaning tasks were not always being undertaken. We were concerned that recent audit reports and environmental checklists undertaken by hospital staff had not identified the same issues.

We were also not assured that staff had received appropriate training in relation to resuscitation to ensure the welfare and safety of the patient in the event of an emergency.

Our concerns were dealt with under our immediate assurance process. This meant that we wrote to the service immediately following the inspection issuing a non-compliance notice requiring that urgent remedial actions were taken.

Where the service could improve

- Medication fridges must be locked when not in use and the daily medication fridge temperature checklist must be completed to ensure that medication is being stored at the manufacturer's advised temperature

- Consent to treatment certificates must always state the correct type and dosage of medication that has been prescribed to patients
- The service must provide assurance to HIW that patients have received a capacity assessment
- Care and treatment plans must be developed, maintained and reviewed in line with the Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010.

What we found this service did well

- The environment of each ward was accessible for patients with mobility difficulties
- Kitchen staff attended the weekly community meetings to enable patients to raise any issues and to have input in the menus and suggest changes.

Quality of Management and Leadership

Overall Summary

Audit activities and monitoring systems helped to ensure the hospital focussed on improving its service. Staffing levels appeared appropriate to maintain patient safety within the wards at the time of our inspection. The majority of staff said they would recommend the unit as a place to work and that they would be happy with the standard of care provided by the unit for themselves or their friends and family. However, some staff members provided feedback indicating that there was a poor working environment at the hospital. We have asked the service to engage with staff to further understand their views and provide assurance to HIW on what actions it will take to address the concerns raised.

Where the service could improve

- The service must continue to recruit more permanent staff to reduce the feeling among some staff that they do not have enough time to give patients the care they need
- Staff members must receive their annual performance development reviews with evidence provided to HIW on current compliance rates.

What we found this service did well

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

We asked staff in the questionnaires what could be done to improve the service. Comments included the following:

"I believe the commitment from the staff team to support extremely complex patients is second to none. They constantly go over and above in ensuring that our patients' needs are met."

"Improvement with certain members of the MDT working together. Some members of the MDT come across as not taking patients interests into consideration and believing that their role is more important than other members of the MDT."

Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the appendices of the full inspection report.

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

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