Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Heatherwood Court

Inspection dates: 12, 13 June 2024 and 23, 24 September 2024

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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:

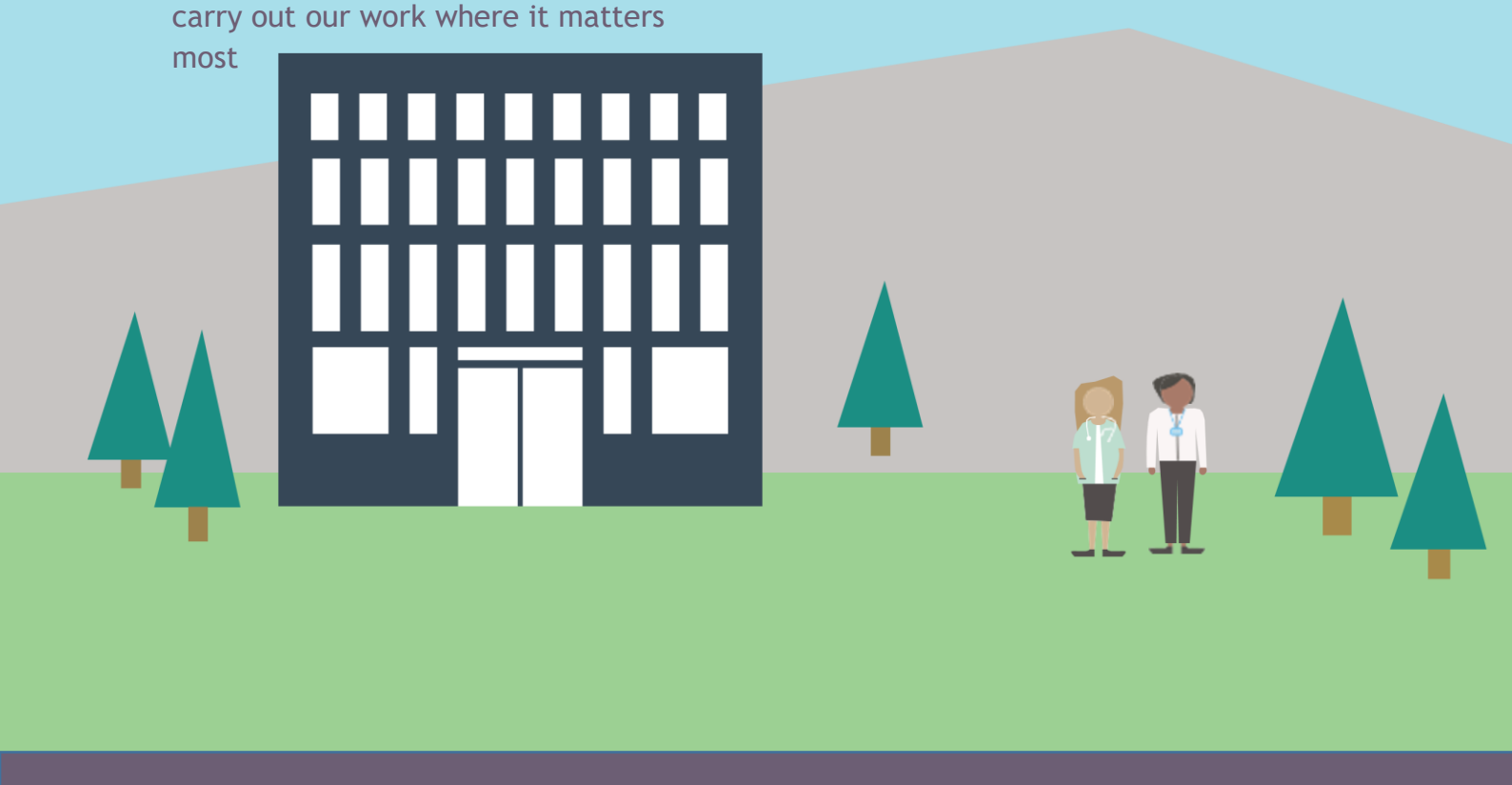
- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and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

HIW undertook two unannounced inspections at Heatherwood Court in response to incidents that had occurred at the hospital.

The first inspection was undertaken on the evening of 12 June 2024 and in the daytime of 13 June 2024 by a team comprised of two HIW healthcare inspectors and one clinical peer reviewer.

The second inspection was undertaken on the evening of 23 September 2024 and in the daytime of 24 September 2024 by a team comprised of three HIW healthcare inspectors and one clinical peer reviewer.

The following hospital units (wards) were reviewed during each inspection:

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

The hospital was being managed by Iris Care Group at the time of both inspections.

Note the inspection findings relate to the point in time that the inspections were undertaken. The inspections did not use HIW's full methodology and only focussed on areas that affected safe and effective care and the quality of management and leadership.

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

2. Summary of inspection

Overall summary:

Heatherwood Court was designated as a Service of Concern on 24 May 2024. This was due to several incidents that had occurred at the hospital where patients had come to harm, or could have been harmed, despite being under enhanced observations. HIW subsequently undertook two unannounced inspections at Heatherwood Court to seek assurance on how the service was operating and to directly observe the provision of care being provided to patients.

Following our first inspection in June 2024, we were not assured that the processes and procedures in place at the hospital were sufficiently managing the risk of some patients coming to harm while being under enhanced observations. There did not appear to be a sufficiently robust governance process to ensure decisions taken in relation to allocating staff to enhanced observations were informed and made in the best interests of the patients. This is because:

- Staff handover meetings we attended were disorganised, with some staff members arriving late and therefore missing key information in relation to the current risks of each patient
- One staff member producing the staff shift schedule did not appear to know the names of all the agency staff members on shift
- Two references were made during the inspection of patients taking advantage of being allocated 'unfamiliar staff' which allowed them to attempt to self-harm. We were therefore concerned that staff members were not always being allocated to patients they knew or had built a therapeutic rapport with
- We found some inconsistencies between the information provided to staff during the handover meetings and the information recorded on documentation such as individual patient grab sheets and staff schedules
- We saw two instances of staff members not adhering to the required level of enhanced observations for their patient
- We noted generally that staff members did not appear to be fully engaging with patients positively and therapeutically
- We saw examples of staff members undertaking enhanced observations on patients for three and five hours in a row without receiving extended or regular breaks other than their standard recognised break
- The patient documentation we reviewed appeared to be generic, and appeared identical in places, with no descriptions of individual interventions tailored to each patient. Some care plans were not being updated at the

same time as they were being reviewed, which meant they did not contain the correct current level of enhanced observation for the patient.

Our concerns following this inspection were dealt with under our non-compliance process. Details of the concerns for patient's safety and the immediate improvements and remedial action taken by the service are provided throughout the report and in Appendix B.

HIW received written assurances and supporting evidence from the service to demonstrate the improvements that had been implemented in response to our concerns. The service remained a Service of Concern while we reviewed the evidence and allowed time for the changes to become embedded.

We undertook our second inspection at the hospital in September 2024. It was positive to see the progress that had been made since our first inspection. It was clear that the actions taken by the service had led to a more organised approach towards managing risk and making more informed decisions in the best interests of the patients. We found that:

- Staff handover meetings were more organised, staff members arrived for each meeting on time, and the meetings contained clear descriptions of current risks for each patient
- Each staff shift schedule had details included at the top by each staff member to indicate their gender and length of time worked at the hospital. This helped ensure only staff members with experience of the patients at the hospital were being allocated to undertake enhanced observations.
- Staff members appeared more engaged with patients when undertaking enhanced observations, which meant there appeared to be an improved and more relaxed atmosphere on the units
- There were no instances of staff members undertaking excessive hours of enhanced observations on patients
- The care plans and risk assessments were more personalised. There was an improved joined up approach visible in terms of capturing current patient risks through the risk assessments and other documentation such as grab sheets and safety and support plans.

As part of HIW's escalation and enforcement process, we continued to engage with the service following our second inspection. We subsequently received appropriate assurance on the actions taken by the service to reduce the risk to patient safety, and the hospital was de-escalated from a Service of Concern on 08 November 2024.

3. What we found

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety
HIW attended the staff handover meetings for the Caernarfon, Cardigan and Caerphilly units on the evening of our first inspection on 12 June 2024 to observe the governance in place for patients on enhanced observations. Having attended these meetings, we could not be assured that the processes were sufficiently managing the risk of some patients coming to harm while enhanced observations were being undertaken. This is because:

- We observed four members of staff arriving late to the handover meetings which meant they had missed the discussion and overview of the risks in relation to several patients. Three of the four members of staff left the meeting without receiving an additional update on the patients they had missed, or without reading the staff handover briefing sheet
- During the handover meeting on Caernarfon Unit, we noted that no details were provided to staff on the current rationale for patients presenting with increased risks as determined by their 'Amber' Dynamic Appraisal of Situational Awareness or 'High' Deliberate Self Harm scores
- We saw examples of inconsistencies between the information provided to staff during the handover meetings and the information recorded on documentation such as individual patient grab sheets and staff schedules.

Our concerns were dealt with under our non-compliance 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. These included:

- Meetings were held with agency providers to highlight concerns over lateness of some staff members. Any further examples of agency lateness were to be escalated and addressed with the relevant agency
- Meetings were held with staff members to reinforce the need to follow the guidance and template during each handover meeting and to reinforce the need to ensure changes in patient information are consistently recorded on the relevant patient documentation

- Twice daily checks of staff handovers were carried out by senior staff members to ensure appropriate patient information was being communicated as required
- Staff members were reminded of their roles and responsibilities during supervision sessions and the Nurses Supernumerary agenda was amended to include a triangulation of key documentation to provide additional oversight.

During our second inspection at the hospital, we again attended the staff handover meetings for the Caernarfon, Cardigan and Caerphilly units on the evening of 23 September 2024. It was positive to observe that each handover meeting was much improved since our previous attendance. Each meeting was more structured, with a clear description of current risks for each patient, including discussions on Dynamic Appraisal of Situational Awareness and Deliberate Self Harm scores. Staff members arrived for each meeting on time, and staff appeared engaged and asked clarifying questions when required. It was also positive to find that the information provided to staff during the handover meetings was also accurately reflected in the information recorded on the individual patient grab sheets and staff schedules.

Safe and clinically effective care
During our evening inspection at the hospital on 12 June 2024 we had concerns in relation to the undertaking and management of enhanced observations for patients. This is because:

- On two occasions we observed instances where staff members were not adhering to the required level of enhanced observations for their patient
- We observed instances where staff members did not appear to be engaging with patients positively or in a therapeutic manner, particularly when on ‘within arms-length’ enhanced observations
- We saw examples of staff members undertaking enhanced observations on patients for three and five hours in a row without receiving extended or regular breaks other than their standard recognised break. This was in breach of the hospital policy which requires that “An individual member of staff does not undertake a continuous period of observation above the general level for longer than two hours.”

Our concerns were dealt with under our non-compliance process. Remedial actions taken by the service included:

- The introduction of a management rota to ensure oversight on morning and evening handovers, and to review how staff are conducting enhanced observations and monitor positive engagements between staff and patients

- The multidisciplinary team (MDT) undertook a review of all patients on enhanced observations to ensure clear rationale for any prolonged periods of observation was recorded within the MDT minutes for each patient
- The staff shift schedules for each unit were amended to support the units to adhere to the hospital Levels of Observation policy.

During our second inspection at the hospital, it was positive to note an improvement in this regard. We did not see any instances of staff members not adhering to the required level of enhanced observations for their patient. We felt staff members were more engaged with patients when undertaking enhanced observations, which meant there appeared to be an improved and more relaxed atmosphere on the units. We reviewed the staff shift schedules and did not see any instances of staff members undertaking excessive hours of enhanced observations on patients.

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

During our first inspection we undertook a review of five patient records. We primarily focussed on reviewing the care plans and risk assessments in place for the five patients. We identified several areas that required improvement:

- The five care plans and risk assessments we reviewed were not individualised. For example, we noted that some sections of the care plans were identical for each patient, and did not contain any specific details about the individual circumstances, objectives or goals for each patient
- Observation care plans were not always being updated at the same time as they were being reviewed. For example, one observation care plan had not been updated since 31 August 2023. This meant that the observation care plans did not accurately reflect the current level of enhanced observation for the patient
- We saw several examples of observation care plans being reviewed by support workers or senior support workers rather than registered nurses
- The risk assessments contained a good level of detail for historical risk behaviours but did not adequately describe the current risks for each patient. For example, one patient's risk assessment contained a tally of the number of incidents over the past three months, but there were no details provided of the nature of the incidents to provide context to staff members
- Some sections of the risk assessments, which described the interventions to take for each patient, were not individualised, and were identical for all five patients.

These issues were dealt with under our non-compliance process. Actions taken by the service in response to our concerns included:

- All primary nurses were given designated supernumerary time to ensure their clinical files (including care plans) were thoroughly reviewed, individualised, and evaluated
- Nurses were given the responsibility to complete reviews of key documentation in future
- The MDT team were given time to review the risk assessments to ensure sufficient details were included on current risks for each patient.

During our second inspection at the hospital, we were informed that the hospital had recently uploaded paper documentation to a new electronic system. We reviewed the new system and it was clear that work had been undertaken to improve the documentation. We saw evidence of more personalised care plans and risk assessments. There was an improved joined up approach visible in terms of capturing current patient risks through the risk assessments and other documentation such as grab sheets and safety and support plans. The information contained within such documentation was detailed and comprehensive. We did note a few instances where further work was required to remove generic phrases. The service informed us that a review of the documentation with patients to ensure they became more personalised was an ongoing project.

During our review of the new electronic system, we noted that the date of birth for one patient had been recorded incorrectly. We advised the service to undertake additional checks to ensure that all the key information held on the new electronic system was accurate.

Quality of Management and Leadership

Governance and accountability framework

During our attendance at the staff handover meetings for the Caernarfon, Cardigan and Caerphilly units on the evening of our first inspection, we observed and considered the decision-making process to allocate staff members to patients to undertake enhanced observations. We were not assured that there was a sufficiently robust governance process to ensure the decisions taken were informed and made in the best interests of the patients. For example:

- Two references were made during the inspection of patients taking advantage of being allocated 'unfamiliar staff' which allowed them to attempt to self-harm. We were therefore concerned that staff members were not always being allocated to patients they knew, or had built a therapeutic rapport with
- Furthermore, one staff member producing the staff shift schedule did not appear to know the names of all the agency staff members on shift. This did not provide us with assurance that the staff members knew the staff member's experience and history of working with the patients they had been allocated to
- Some patients were initially incorrectly allocated male members of staff for their enhanced observations when their care plan specified that female members of staff must undertake their enhanced observations
- There did not appear to be a joined-up approach across the hospital to develop the staff shift schedules for each unit. For example, there was initial confusion during the Cardigan and Caerphilly units handover meeting about who should plan the staff shift schedule, which meant that two members of staff attempted to plan the staff shift schedule at the same time. We also noted two occasions where registered nurses on site at the hospital were scheduled to have their break at the same time. This meant that on one occasion, one registered nurse had oversight of three wards at the same time, and one occasion where one registered nurse had oversight of four wards at the same time.

Our concerns in relation to this process were dealt with under our non-compliance process. Actions taken by the service to improve the process included:

- Training sessions to provide guidance on shift planning were undertaken with staff members
- A quick reference document was created to evidence agency male and female staff members and their length of experience of working at the hospital

- Shift leaders were reminded that any amendments to the staff shift schedules needed to be recorded under version number and saved to evidence the changes
- The Senior on Site protocol was revised following the inspection where it was clarified that break allocation needed to be confirmed by the Senior on Site for all four units to ensure there were no conflicting breaks.
- An additional registered nurse was employed at night to help provide additional support to the existing nurses on site and to help cover their breaks.

During our second inspection at the hospital, we noticed a considerable improvement in the arrangements for allocating staff members to patients to undertake enhanced observations. The staff members leading the staff handovers and planning the shift schedules knew the staff members, and there was no confusion over the production of the schedules. We saw that each schedule had details included at the top by each staff member to indicate their gender and length of time worked at the hospital. This helped ensure only staff members with experience of the patients at the hospital were being allocated to undertake enhanced observations. During the evening inspection we did note that two staff members had been allocated their break at the same time. We raised this with the newly employed additional registered nurse who rectified this immediately.

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
No immediate concerns were resolved during these inspections.			

Appendix B - Immediate improvement plan

Service: Heatherwood Court

Date of inspection: 12-13 June 2024

The table below includes the immediate non-compliance concerns about patient safety identified during our first 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 service must provide further assurance to HIW on how it will ensure the welfare and safety of patients subject to enhanced observations following the issues identified on the unannounced inspection and described in the non-compliance notice.	Regulation 15(1)(a) 15(1)(b)	A detailed report has been produced addressing each issue raised in the non-compliance notice. A summary of the actions from this report has been included below, but the report will need to be consulted for further context in relation to actions already in place and being undertaken and protocols which are already in place, but have been reviewed and amended as a result of the non-compliance notice: 1. Staff consultations in relation to the findings of the non-compliance notice to identify any additional training / support needs over and above what is already in place for ICG and agency staff.	Olivia Ferrari	26 July 2024
		2. Management presence on a more regular and rostered basis at handover of shift (day and night) on all 4 units.	Olivia Ferrari	26 July 2024

		3. Management focused oversight daily of the shift planner (allocation document).	Olivia Ferrari	26 July 2024
		4. Spot visits over a 7-day period (night and days) by Management and the Quality team to review shift management and observation policy adherence.	Olivia Ferrari / Sarah House	26 July 2024
		5. Quality Lead, Hospitals audit template has been amended for ongoing oversight and embedding of the actions.	Sarah House	26 July 2024
		6. Ongoing competence assessments with agency staff to ensure their have full knowledge and sufficient experience of the risks of the patients they are supporting.	Olivia Ferrari	26 July 2024
		7. To continue with daily review of incidents and clinical reviews (as necessary) of incidents of self-harm when on enhanced observations to ensure ongoing learning continues.	Olivia Ferrari	26 July 2024
		8. Ongoing recruitment to fill our vacancy needs.	Olivia Ferrari	26 July 2024

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): **Olivia Ferrari**

Job role: **Hospital Director**

Date: **26 July 2024**

Appendix C - Improvement plan

Service: Heatherwood Court

Date of inspection: 12-13 June 2024 and 23-24 September 2024

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

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	The service is not required to complete an improvement plan.					