Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Health/ Learning Disability Inspection (Unannounced)

Cambian Healthcare Ltd: Delfryn House & Lodge

13 – 15 April 2015

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1. Introduction

Our mental health and learning disability inspections cover both independent hospitals and mental health services provided by the National Health Service (NHS). Inspection visits are a key aspect of our assessment of the quality and safety of mental health and learning disability services in Wales.

During our visits Healthcare Inspectorate Wales (HIW) ensures that the interests of the patients are monitored and settings fulfil their responsibilities by:

- Monitoring the compliance with the Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards
- Complying, as applicable, with the Welsh Government's National Minimum Standards in line with the requirements of the Care Standards Act 2000 and the Independent Health Care (Wales) Regulations 2011.

The focus of HIW's mental health and learning disability inspections is to ensure that individuals accessing such services are:

- Safe
- Cared for in a therapeutic, homely environment
- In receipt of appropriate care and treatment from staff who are appropriately trained
- Encouraged to input into their care and treatment plan
- Supported to be as independent as possible
- Allowed and encouraged to make choice
- Given access to a range of activities that encourage them to reach their full potential
- Able to access independent advocates and are supported to raise concerns and complaints
- Supported to maintain relationships with family and friends where they wish to do so.

2. Methodology

The inspection model HIW uses to deliver the mental health and learning disability inspections includes:

- Comprehensive interviews and discussions with patients, relatives, advocates and a cross section of staff, including the responsible clinician, occupational therapists, psychologists, educationalists and nursing staff
- Interviews with senior staff including board members where possible
- Examination of care documentation including the multi–disciplinary team documentation
- Scrutiny of key policies and procedures
- Observation of the environment
- Scrutiny of the conditions of registration for the independent sector
- Examination of staff files including training records
- Scrutiny of recreational and social activities
- Scrutiny of the documentation for patients detained under the Mental Health Act 1983
- Consideration of the implementation of the Welsh Measure (2010)[1]
- Examination of restraint, complaints, concerns and Protection of Vulnerable Adults referral records
- An overview of the storage, administration, ordering and recording of drugs including controlled drugs
- Consideration of the quality of food

[1] The Measure is primary legislation made by the National Assembly for Wales; amongst other matters it makes provision in relation to assessment, care planning and coordination within secondary mental health services.

- Implementation of Deprivation of Liberty Safeguards (DOLS).

HIW uses a range of expert and lay reviewers for the inspection process, including a reviewer with extensive experience of monitoring compliance with the Mental Health Act 1983. These inspections capture a snapshot of the standards of care patients receive.

3. Context and description of service

Healthcare Inspectorate Wales (HIW) undertook an unannounced Mental Health and Learning Disability visit to Delfryn House and Lodge, Mold on the evening of the 13 April and all day on the 14 and 15 April 2015.

Delfryn House and Lodge is an independent hospital that was first registered in December 2005 and the Lodge in 2010. At the time of our visit, Delfryn House and Lodge was registered to provide care to 58 patients on two wards and a step down facility (Rhyd Alyn). The hospital provides a rehabilitation service for patients with a mental disorder who may also be detained under the provisions of the Mental Health Act (1983). The hospital's registered provider is Cambian Healthcare Ltd.

During our visit we reviewed all areas, reviewing patient records, interviewing patients and staff, reviewing the environment of care and observing staff-patient interactions. The review team comprised of one Mental Health Act Reviewer, two peer reviewers, one lay reviewer and two members of HIW staff.

4. Summary

Our visit to Delfryn House and Lodge highlighted some disappointing issues, including some that had not progressed since our previous visit in May 2014. The biggest concern was the continued inadequate staffing levels, specifically on Delfryn Lodge. We identified occasions when there were significant deficits in numbers and these were confirmed by concerned staff and patients. The impact such inadequate staffing numbers were having upon patient activities and leave was not acceptable and sufficient numbers of staffing are urgently needed to promote the health and safety of all patients and staff.

Despite the staffing levels, the staff and patient interactions we observed during our visit were positive and the staff engagement in the inspection process was duly noted and much appreciated. To note was those members of staff who stayed on duty and came in during our evening visit. In spite of the extreme difficulties with staffing numbers the staff group on the whole remained very committed to the patient group.

The safety of staff and patients had been compromised when a staff member raised an alarm for assistance only for other staff on duty to turn it off and not respond. The dangers of this practice need to be explored and communicated to all staff.

The environment across the House and Lodge continued to be well maintained and clean, with maintenance repairs reported and dealt with swiftly. The facilities available for the patient group were also noted to be comprehensive, if somewhat underutilised, especially the beauty salon on the Lodge. The pro active and supportive advocacy services were noteworthy and the food on the whole was commented favourably upon by patients and staff in terms of quality, variety and presentation.

Issues were identified in the clinic/treatment room on Delfryn Lodge, particularly with the controlled drugs register and inaccurate recording of information, as well as out of stock medications. Internal audits identified issues and these issues were reported month after month highlighting an inactive response to internal governance.

Observational records contained blank lines with no recorded information and as identified in our May 2014 visit, the records were not being signed off by the nurse in charge.

A number of recent admissions to Delfryn Lodge had caused major difficulties in terms of management and this had resulted in detrimental effects upon the patient group. Patients too acute for a rehabilitation service had caused stress for the patient group because of their presentation and the number of staff required to effectively manage those individuals. In addition, the hospital

had experienced a high turnover of Responsible Clinicians over the past four months, causing the patient group to complain of inconsistent medical provision.

Our review of staff files highlighted the continued good work and commitment to maintain relevant employment information which was up to date. In addition, we were pleased to learn the organisation undertakes regular Disclosure Barring Service (DBS) checks on its employees, a practice we found to be noteworthy.

Although improvements were noted regarding staff supervision and appraisal there were still some staff who had not received an appraisal and/or supervision for a considerable period of time and these staff members require an update urgently.

Training had also improved since our visit in May 2014. However as with appraisals and supervision some gaps in mandatory training were unacceptable and these need to be rectified immediately to ensure all staff have the necessary skills and experience for the patient group.

A review of the Statement of Purpose and complaints is required. The statement of purpose was inaccurate regarding bed and staffing numbers and did not cover the Rhyd Alyn facility. The complaints we reviewed did not contain full information to demonstrate what actions taken as a result of any investigatory work. Therefore it was difficult to ascertain the outcome because these were not documented in the final letters to the complainants.

5. Findings

Core Standards

Ward environment

Delfryn House is a 28 bedded male unit which is situated separately to Delfryn Lodge. Delfryn House is a two storey building which is built around a courtyard area.

Delfryn House has its own reception in which staff and visitors sign in and out and are issued with the necessary personal alarms and keys. Within the entrance area there are visitor/meeting rooms as well as staff offices. Locked doors either side of the entrance area leads onto the ward.

Downstairs the hospital provided a number of patient areas and some patient bedrooms. The patient lounge was large with a TV, plenty of seating and a pool and football table. Occupational Therapy had their own room in which therapies and activities would take place. The room had photos and pictures displayed on the walls and a timetable of activities was on display.

A nurse's office, clinic and examination room were situated downstairs as was the dining room and patient kitchen. Patients could access the kitchen to make drinks at any time as long as staff opened the facility and stayed to oversee and lock the kitchen when everyone had finished. The dining area contained tables and chairs and fruit was available for patients to eat.

Patients had access to the courtyard area which had seating, flower beds and smoking facilities.

Upstairs there were patient bedrooms, another lounge, a gym, IT room with three computers, a staff boardroom and a patient kitchen.

The door providing access to the upstairs had been damaged and glass broken. At the time of our visit the door was boarded up and the hospital were waiting for it to be fixed.

Delfryn House was clean and facilities were in good working order.

Delfryn Lodge is a large modern building. Accommodation is over two floors, with the majority of bedrooms on the first floor. There is a lift which is seldom used to gain access to the first floor. At the time of our visit the 24 bedded ward had 21 patients. All bedrooms had a nurse call alarm system, en-suite shower facilities and ample storage for their personal belongings. There was a bath available for those patients wanting this facility.

On entering the ward there is a large foyer with some casual seating and a payphone in a closed room which was out of use at the time of our visit. There were two lounges, one on each floor, with ample seating and large TVs. Both lounges were well decorated however the seating in the upstairs lounge was due for replacement due to damage.

The attractive garden could be accessed from the downstairs lounge and had a large smoking shelter. The garden area was only open for a limited time due to the inadequate height of the fence. The fencing surrounding the garden requires to be raised to allow open access for patients.

The dining room had seating to accommodate 24 people around seven tables. There was a therapy kitchen leading from the dining room in which patients had cupboard space to store their own snacks. Two cookers and fridge freezers were available. Patients items were stored in the fridges and these were labelled and the facilities were clean.

On the first floor there was a sensory room and a large therapy room with a table tennis and pool table, gym equipment, games and arts and crafts materials.

The environment on the Lodge was very clean. Notice boards were displayed on the ward with information about advocates, therapy timetable, healthy living group, solicitors details, how to complain and a therapy jobs board.

Requirements

The payphone on Delfryn Lodge needs to be repaired for patient use.

The fencing surrounding the garden area needs to be heightened to deter patients from absconding.

The furniture in the upstairs lounge on the Lodge requires replacing due to damage.

Safety

It was noted that all staff on duty at the House and Lodge had safety alarms which in the case of an emergency would raise the warning to others. Alarms were also provided to HIW staff to ensure our safety whilst visiting the hospital. Staff and patients did tell us of an occasion at the Lodge whereby a staff member raised an alarm which was ignored. A patient had to assist the member of staff by raising the alert. It is imperative that no alarms are ignored or switched off and the hospital must reinforce the dangers of not responding to alarm calls.

The majority of staff and patients we spoke to commented upon inadequate staffing levels as a big concern. Inadequate numbers of staff was identified in our last visit in May 2014 and the situation had not improved. The problem was worse on the Lodge, however staff at the House did comment that if staff from there go to support staff at the Lodge it can impact upon staffing levels at the House.

Patients told us of the effects of poor staffing levels upon their wellbeing and progress, stating that the staffing situation has prevented regular one to one time with their named nurse and as a result had left some patients contacting the Samaritans. As a result some patients felt rejected and unsafe because of the staffing levels.

A review of staff rotas and other documents identified significant deficits in staffing levels. There were two occasions identified in March 2015 in which shifts were three and two staff short respectively. In addition, we identified staff working part of a shift, going home and then returning to cover a night shift. The continued issue of poor staffing levels is a serious issue and one that is having a major impact upon staff and patient safety. Staffing levels need to be reviewed immediately and numbers improved as a matter of urgency. Following our visit, we issued an immediate concerns letter to Cambian Healthcare regarding our concerns about staffing levels. Cambian Healthcare has responded to the letter and issued HIW with an action plan that we will monitor.

Within the last few months, new admissions to the Lodge had been inappropriate causing major difficulties in terms of management for staff. Patients with complex needs had been admitted and coupled with staff shortages had resulted in patient needs not being met. These concerns were highlighted by staff and the Responsible Individual and Registered Manager needs to ensure that new admissions are appropriate for the hospital. (See last paragraph under General Healthcare section)

Requirements

It is imperative that all alarm calls are taken seriously and answered to ensure the safety of all patients and staff.

Staffing levels require urgent action. The hospital must ensure that every ward has sufficient numbers to provide appropriate care for the patient group.

The multi-disciplinary team

All the staff we spoke to commented positively on the multi disciplinary team (MDT) working. Staff stated that MDT meetings take place on a regular basis

and all disciplines are represented including Psychology, Occupational Therapy, Doctors and Nurses. Staff told us that MDT meetings are collaborative, professional views and opinions from all disciplines are sought and staff felt respected by each other.

Concerns were raised regarding the regular change of medical staff. One patient told us they had seen three Responsible Clinicians (RC) in the past four months and the high turnover has made patients feel unsettled. At the time of our visit a locum RC was in post on the Lodge, however we were informed that recruitment was underway to fill this post permanently. It was felt by staff that a Junior Doctor would be beneficial to support the Consultants and patients, especially in being able to complete all the required paper work.

Daily handover meetings take place on both the House and Lodge, in which handover notes from the previous shift are communicated with the next shift. In addition, staff told us that staff meetings at the House take place every month and that the RC for the House holds informal meetings with staff regarding patients and their care.

Requirement

A review of RC cover is required to ensure the hospital provides consistency for patients.

Privacy and dignity

All patients had their own en-suite bedroom and were able to store their own belongings and put up pictures to personalise their space. Some patients had been risk assessed and had keys to their own rooms, but all patients could lock their own bedrooms. Patients commented that some staff knock the door before entering their bedrooms. It is important all staff respect a patient's privacy and dignity and knock before entering a patients bedroom.

All the patients we spoke to confirmed they had a named nurse that they could meet in private and speak to regarding any issues. However, patients did tell us that they did not feel safe because the staffing numbers had been inadequate and some patients had been quite unwell therefore they felt there was little time given to them.

Patients told us that they can make phone calls in private with their own mobile phones or the payphone. The payphone on the Lodge at the time of our visit was not working (see Ward Environment section). Patients can also use the visitor room to meet family and friends in private.

Patient therapies and activates

The staff we spoke to commented positively on the therapies and activities the registered provider offered. A notice board displayed paid patient jobs, dedicated rooms offered patients activities which included a gym, hair and beauty salon (which was only open once a week), occupational therapy rooms with art and craft material, a kitchen, computer room and a therapy room for relaxation.

At the time of our visit, Occupational Therapy (OT) were in the process of providing their service seven days a week. A company initiative called Project 25 was also underway with the aim of providing each patient with 25 hours protected activity each week. We were told that staff had been trained in this area and 70% of patients were now undertaking the required amount of activities.

OT confirmed that when a new admission arrives at Delfryn, OT interview the patient and completes an interest checklist. Each patient is then provided with a personalised timetable/programme and a standard group timetable was displayed on each ward and this was reviewed and changed every three to four months.

We observed a community team meeting take place at Delfryn House. All staff and patients that were free were able to attend and participate in the meeting. The meeting was chaired by a member of the OT staff and the discussions centred around what activities patients may want to do on the weekend. In addition to discussions around weekend activities, a prize was also presented to a patient for his continued efforts with his community jobs. An announcement was made regarding a fitness month and patients were invited to participate. A personal trainer would also be available for two or three sessions each week to support patients with their goals.

Psychology provided weekly individual theraputic sessions, mindfulness, counselling and were working closely with OT to deliver a group anxiety treatment programme. A health and wellbeing team provided regular programmes and checks on patients including weight management, blood tests, ECG and smoking cessation. Patients requiring access to a GP, dentist, optician or other service were assisted and taken to appointments.

Staff commented that there had been times when patients' care plans were not met because of a lack of staff, however staff at Delfryn House commented that when staffing levels are satisfactory patients are able to get out more and access the community.

Discussions with patients further highlighted the issue that inadequate staffing levels had resulted in limited and/or cancelled activities. However the activities that were offered to the patient group were enjoyed by those we spoke too.

General Healthcare

We reviewed the clinic/treatment room on Delfryn Lodge and identified a number of issues. The controlled drugs register had a number of errors including inaccurate balance checks, a lack of witness signatures, one entry had a date entered and no other details and some lines in the controlled drugs register were left blank and retrospective entries appear to have been made.

The hospital used an external pharmacy to audit their clinics and as a result are provided with a report highlighting their findings. We noted that some areas identified by the external audits had not been actioned, specifically the report dated 1 April 2015. A number of monthly internal medication audits had some of the same issues identified which had rolled over from month to month. The areas highlighted within the reports require immediate action.

We identified and fed back to hospital staff specific patient findings regarding their medication. We identified three patients whereby their medication was unavailable/out of stock for 2 weeks. We identified gaps in administration records whereby it was difficult to ascertain if patients had received their medication or not. In addition, Pro Rata medication was administered to a patient from the hospitals stock whereby the patients record showed it to be prescribed.

There were no dates of opening on some liquid medications and one patient had an allergy to a particular medication, however there was no indication of what the allergy was.

Our review of patient 1:1 observation records highlighted a number of blank lines which had no information recorded on them. In addition, the records were not signed off by the nurse in charge on the day and night shift.

The fluid balance charts for a patient reflected inadequate fluids being provided. It is essential that records and charts are accurately completed to ensure the patient receives the care required.

Delfryn Lodge had admitted three new patients in the last few months that had caused major difficulties in terms of management for staff. These admissions had not been appropriate and impacted on the patients at Delfryn Lodge during this time. It is essential all admissions to the hospital are appropriate and during our feedback we were told that no new admissions would take place without prior consultation with HIW to allow the ward to settle and give

the organisation and manage time to address the significant issues identified within this report. In addition, feedback from the Responsible Individual confirmed that a process with the multi disciplinary team will be put in place to assess any pre admissions.

Requirements

The areas identified regarding the controlled drugs register must be addressed. Specifically the inaccurate balance checks, a lack of witness signatures, one entry had a date entered and no other details and some lines in the controlled drugs register were left blank and retrospective entries made.

All internal and external audits which highlight actions must be addressed and not allowed to roll over continuously.

The specific findings regarding medication issues for individual patients must be addressed.

A review of opened medication must be conducted to ensure dates are clearly visible to identify when the product was opened and when the product may cease to be used.

All records relating to patient care, including observation records and fluid balance charts must be completed in full and signed off by nursing staff to ensure records are accurate and the patients care is comprehensively observed.

All admissions to Delfryn hospital must be appropriate to ensure staff deliver care that is appropriate and in keeping to the hospitals Statement of Purpose and the impact of any admissions is kept to a minimum in terms of the existing patients.

Food and nutrition

The majority of patients and staff we spoke to commented favourably regarding the food served at the hospital, stating choice, quality and portion size were good. We observed staff and patients dining together and commended this practice for its therapeutic value for the patients dining experience.

At the time of our visit, patients could access the kitchens for hot drinks and snacks every hour, cold drinks were accessible at all times. There were discussions taking place to make kitchens on both the Lodge and House open access in the near future. Patients could store their own snacks in a cupboard and/or fridge however some patients told us that items had gone missing.

Some patients and staff told us that vegetarian options and meals were poor and not varied enough. In addition, we were told that the budget for providing diabetic desserts was limited and as a result cakes and puddings were served once a week.

Night staff stated that the food left for them during the shift was inadequate and not enough. Patients told us that a large meal is served at lunchtime and snacks at tea time and for some patients they would prefer to have it the other way around.

Training

We reviewed 10 staff files and noted all files were well laid out and divided into specific sections making it easy to find and locate information. All files reviewed contained evidence that applicants were recruited through fair and open competition with an application form, references, job description, interview notes and contract agreements on file.

It was pleasing to note that Delfryn hospital undertake regular Disclosure Barring Service (DBS) checks for all employees and a system was in place to ensure that all staff with a professional registration was up to date.

A system was in place for staff to receive an annual appraisal, however the statistics provided did show some staff had not received one since 2012. It is essential that all staff receive an annual appraisal and the staff who have not had one since 2012 receive one promptly.

The majority of staff we spoke to said they received regular supervision and the statistics provided did show that staff had received a supervision session between January and April 2015. There were some gaps, specifically for staff based on Delfryn Lodge and these need to be undertaken as a matter of priority.

A comprehensive programme of mandatory training was in place for staff and was delivered via e-learning and classroom style methods. It was pleasing to note that the MVA (Managing Violence and Aggression) training had improved since our last visit in May 2014, however some training for staff had lapsed and required urgent attention. Such areas included Manual Handling training in which the statistics highlighted the majority of staff requiring an immediate update, First Aid and Resuscitation, DEFIB (defibrillation) and Basic Life Support in which across the hospital only one staff member had training in 2014 and one staff member had not received updated training in this area since 2009. An immediate analysis of the training statistics is required to determine the extent to which staff are not up to date in their mandatory training and a plan to be put in place to ensure staff are updated. Staff need regular training to ensure the safety of themselves and patients.

Discussions with staff highlighted the need for specific training in female personality disorders. Training in this area would benefit nursing and care support workers to deliver and develop better ways of working with patients with this diagnosis.

The induction process required improvement and two members of staff reported having received only a half day induction and then allocated a day of observations. The organisation has confirmed that the induction process will change, providing a through induction for new staff including three days of training.

We reviewed 10 complaints and noted that the individual complaint files did not contain full information to demonstrate the actions taken as a result of any investigatory work. Therefore it was difficult to ascertain the outcome because this was not documented in final letters to the complainants.

The Statement of Purpose dated 2 February 2015 was not accurate because it did not include the Rhyd Alyn facility and an incorrect number of beds for Delfryn Lodge was listed.

Many of the patients we spoke to told us of the inconsistencies regarding staff implementing policy which had caused a degree of irritation. Examples cited as being inconsistent were the use of mobile phones, smoking and group outings. It became apparent that some staff were stricter than others in implementing policy and patients were confused by the inconsistencies. It is a requirement that the hospital gather view points from patients regarding this issue and provide clear communications on what patients can and can't do.

Requirements

All staff must receive an annual appraisal with particular emphasis on those staff that have not received one since 2012.

All staff must receive regular supervision and specific attention must be given to those members of staff on Delfryn Lodge who have not received a supervision session for sometime.

An analysis of the statistics for mandatory training is required to determine all members of staff that have expired training and a programme put in place to ensure all staff are up to date.

A robust induction process must be in place for all staff to ensure staff are competent when working on the wards.

All complaints should contain comprehensive information to evidence what steps, actions and outcomes were undertaken to reach the final outcome.

The Statement of Purpose must be updated to accurately reflect the service provisions, including the Rhyd Alyn facility and the number of beds each ward has.

Strategies for improving communication of hospital policies to eliminate the inconsistencies patients are receiving is required.

Application of the Mental Health Act

We reviewed the statutory detention documents of six of the detained patients being cared for on two wards at the hospital at the time of our visit. The following noteworthy issues were identified:

- Good practice in terms of the form for statutory consultee
- A weekly clinic for staff and patients

The following points were identified and needs to be included in your action plan:

- Managing diaries for numerous changes
- Support for newly appointed RCs
- Half of the files we reviewed did not have a record that the patient had applied for a Hospital Manager's Hearing in their notes

Monitoring the Mental Health Measure

We reviewed care and treatment planning documentation for three patients on Delfryn Lodge and identified the following observations:

- There was no evidence that the Mental Health (Wales) Measure 2010 was in place for one patient
- There were long review periods on prescribed care and changing needs/interventions which were not recorded in care plans
- There was a lack of recorded physical base line observations in the care plans reviewed
- There were a lack of a nutritional assessment on the files we reviewed

Requirement

Care plans need to be reviewed and updated to ensure the Measure is in place for all Welsh patients, assessments and records including nutrition and physical base line observations are available and any changing needs and/or interventions for patients are recorded in their care plans.

6. Next Steps

Following on from our inspection and feedback meeting, concerns were raised regarding findings which potentially posed an immediate risk to the safety of patients. A letter was sent to the organisation to seek assurance of the actions being undertaking by the organisation in order to mitigate these risks. An action plan has been received by HIW which we will monitor.

Delfryn Hospital is required to complete an Improvement Plan (Appendix A) to address the key findings from the inspection and submit its Improvement Plan to HIW within two weeks of the publication of this report.

The Improvement Plan should clearly state when and how the findings identified at Delfryn hospital will be addressed, including timescales.

The Improvement Plan, once agreed, will be published on Healthcare Inspectorate Wales website and will be evaluated as part of the on-going mental health/learning disability inspection process.

Mental Health/Learning Disability: Improvement Plan
Organisation: Cambian Healthcare
Hospital: Delfryn Lodge/House
Date of inspection: 13-15th April 2015

Recommendation	Regulation	Action	Responsible Officer	Target date	Comments	Status
1. <u>Patient phone</u> **The Payphone on Delfryn Lodge needs to be repaired for patient use.**	26 (2) (b)	1. New payphone to be ordered for patients.	LB	29.05.15	1. New payphone now in place.	
2. <u>Garden area</u> **The fencing surrounding the garden area needs to be heightened to deter patients from absconding**	26 (2) (a)	2. Staff to be appointed to observe the garden area more frequently to allow patients more frequent access.	LB/ST	Completed	2. The garden area accessibility is not limited because of the height of the fence but due to a range of risks. It is opened for limited amounts of time each day in order to manage a range of risks effectively including absconding and ligature. We will ensure staff are frequently available to observe patients allowing for extra time in the garden area.	
3<u>. Furniture</u> **The furniture in the upstairs lounge on the lodge requires replacing due to damage**	26(2) (b)	3. New furniture to be ordered to replace damaged corner unit.	ST/LB	29.05.15	3. New furniture (1x 3 seater and 1x 2 seater) have been ordered. Awaiting delivery which will be within the next two weeks.	
4.<u>Alarms</u> **It is imperative that all alarm calls are taken seriously and answered to ensure the safety of all patients and staff**	15(1) (b) & 19(1) (a) (b)	4. Response and emergency policy to be reinforced with all staff.	LB	29.05.15	4. HOC to ensure all staff familiarise themselves again with the relevant procedures. Emergency response protocol now drafted and staff have been instructed to familiarise themselves and sign.	

Mental Health/Learning Disability: Improvement Plan
Organisation: Cambian Healthcare
Hospital: Delfryn Lodge/House
Date of inspection: 13-15th April 2015

		4. b Hospital Manager to look into new pager system to possibly replace current alarm system across site.	ST	29.05.15	4. b Agreed system would be appropriate and pagers have now been ordered.	
5. <u>Staffing</u> **Staffing levels require urgent action. The hospital must ensure that every ward has sufficient numbers to provide appropriate care for the patient group**	20 (1) (a) (b)	5. Recruit up to establishment figures for RMN's and Support Worker's.	ST/KW	29.05.15	5. Current vacancy factor at the Lodge is 1 RMN and 0 SW. We are actively recruiting for this post.	
		5. b Sufficient staffing must be provided to promote the health and safety of patients and staff.	NR / ST / LB/MS	Immediate and on-going	5. b Duty rota at Delfryn Lodge is to be audited on a Monday for the retrospective week by corporate Quality Assurance Manager. Outcome of this weekly audit will be communicated to HIW on an on-going weekly basis to evidence this.	
6. <u>RC Appointment</u> **A review of RC cover is requiredto ensure the hospital provides consistency for patients.**	15(1) (a) (b)	6. Substantive RC to be appointed to replace current locum RC	LBu	30.04.15	6. RC appointed. Commenced in post on 01.05.15. Full week's handover received and Assistant Medical Director will continue to visit every Thursday for a further 4 weeks to support induction.	
7.<u>Clinic</u> **The areas identified regarding the controlled drugs register must be**	15 (5) (a) (b)	7. Clinic competencies to be repeated by all nurses.	LB	29.05.15	7. Completed.	

addressed. Specifically the inaccurate balance checks, a lack of witness signatures, one entry had a date entered and no other details and some lines in the controlled drugs register were left blank and retrospective entries made.		7. b Speeds clinic audit to be actioned.	LB/ST	29.04.15	7. b All issues identified now actioned. A further audit will commence 2nd June.	
		7. c New CD book to be ordered.	LB	15.05.15	7. c New CD book now in place.	
		7. d LB to arrange with Speeds Pharmacy for appropriate input to support improvements.	LB/ST	24.04.15	7. d AD from Speeds Pharmacy attended 24.04.15. Pharmacy technician started 11th May to support 1 day a week to help improvement. AD also attended RMN meeting to discuss the outcome of the chart reviews, progress to date and accountability. QAC Regional Manager will also be auditing regularly with next audit to be coordinated with Speeds technician on 29th May.	
7.2 A review of opened medication must be conducted to ensure dates are clearly visible to identify when the product was opened and when the product may cease to be used.	15 (5) (a)	7.2 HOC/RMN'S to review all medication.	LB/RMN's	Immediate & on going	7.2 Completed	
8. <u>Audits</u> **All internal and external audits which highlight actions must be addressed and not allowed to roll over continuously.**	19(1) (a) (b)	8. Weekly audit of clinic to be carried out by QAC manager.	MS	Immediate & on-going	8. Completed.	

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		8.b Regular audit to be organised and completed by Speeds technician	AD	Immediate & on-going	8. b Regular audit process now agreed and implemented. Pharmacy technician started 11th May to help aid improvement. QAC Regional Manager will also audit regularly.	
9. <u>Patient records</u> **The specific findings regarding medication issues for individual patients must be addressed.** **Care plans need to be reviewed and updated to ensure the measure is in place for all welsh patients, assessments and records including nutrition and physical base line observations are available and any changing needs and/or interventions for patients are recorded in their care plans**	15 (5) (a) (b)	9. RC to review all current medication. Physical health files to be introduced and regularly updated. Short term care plans for patients to be introduced.	RC RMN's/RC LB/RMNS	29.05.15 30.04.15	9. Full review now completed. Physical health files are now in place and will be regularly audited. Process now in place with short term care plans initiated as and when required. QAC Regional Manager will also audit regularly.	
9.3 All records relating to patient care, including observation records and fluid balance charts must be completed in full and signed off by nursing staff to ensure records are accurate and the patients care is comprehensively	15 (9) (a) & 23 (1) (a) (i)	9.3 Daily Observation records to continue to be brought to every morning meeting where they are to be signed off by the Head of care and / or hospital Director.	LB/ST	Immediate & on going	9.3 Process in place. Daily observation records now being quality assured on a daily basis by the Hospital Director and Head of Care. Weekly audit will be also be done by QAC Regional Manager.	

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10. <u>PAA/Admissions</u> **All admissions to Delfryn hospital must be appropriate to ensure staff deliver care that is appropriate and in keeping to the hospitals statement of purpose and the impact of any admissions is kept to a minimum in terms of the existing patients.**	9 (1) (c) & 15 (1) (a) (b) (c)	10. Agree a process for Delfryn MDT to assess all referrals to ensure appropriateness of admissions.	NR/ JM / ST	24.04.15	10. New assessment process agreed and in place. Wherever possible a joint assessment will be conducted by a nurse assessor and appropriate representative(s) from the Delfryn MDT. Where not possible an initial nurse assessor assessment will be followed by a Delfryn MDT assessment before a final decision is made.	
11. <u>Statement of Purpose</u> **The statement of purpose must be updated to accurately reflect the service provisions, including the Rhyd Alyn facility and the number of beds each ward has.**	8 (a) (b)	11. Review and update Statement of Purpose with revised accurate staffing figures and submit to HIW for their consideration / approval. Destroy any old copies.	ST/MS	15.05.15	11. Third draft Statement of purpose completed and will be submitted to HIW for consideration with third action plan update.	

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12. <u>Policies</u> **Strategies for improving communications of hospital policies to eliminate the inconsistencies patients are receiving is required.**	19 (1) (b)	12. Redistribute patient guide to staff and patients which addresses relevant issues.	LB/ST	15.05.15	12. Completed. Head of care redistributed patient guide amongst all staff and patients and this has also been documented.	
		12.b To bring issue up at the next Clinical Governance meeting	LB/ST	21.05.15	12.b Completed. Patient representative from both the House and Lodge attended the monthly Clinical Governance meeting held on the 25th May.	
		12.c Distribute staff/patient/carer satisfaction surveys at the lodge.	LB/ST/HH/AS	29.05.15	12. c Satisfaction surveys have been distributed to all who agreed to comply.	
13.1 <u>Supervisions/Appraisals</u> **All staff must receive an annual appraisal with particular emphasis on those staff that have not received one since 2012.** **13.2 All staff must receive regular supervision and specific attention must be given to those members of staff on Delfryn Lodge who have not received a supervisions session for some time.**	20 (2) (a**)**	13.1 Hospital manager and head of care to conduct appraisals with all staff	ST/LB	Immediate & on going	13.1 Completed. All staff are up to date including the specific member of staff who had not had one since 2012. QAC Regional Manager will also audit regularly.	
		13.2 Hospital manager to supervise heads of department	ST	Immediate & on going	13.2 Completed	
		13.2b Hospital manager to conduct all RMN supervisions on 1:1 basis within the existing timeframe	ST	08.05.15	13.2b Completed	

		13.2c LB to action supervisions with support staff	LB	15.05.15	13.2c 100% complete.	
		13.2d Regular audit of supervisions and appraisals to be conducted by QAC Regional manager	MS	Immediate & on going	13.2d Process implemented.	
14. <u>Induction/Training</u> **A robust induction process must be in place for all staff to ensure staff are competent when working on the wards.**	20 (1) (a) & 20 (2) (d)	14. All recently appointed staff to receive thorough induction including 3 days of training consisting of policies, induction pack, obs competencies, achieve and breakaway.	ST/LB	29.05.15	14. All newly appointed staff have been provided with a robust induction and have been given all appropriate training.	
14.2 An analysis of the statistics for mandatory training is required to determine all members of staff that have		14.1b All Lodge and selected House staff to receive Personality Disorder training.	JK	29.05.15	14.1b 90% of staff have now completed the training. Further training sessions will commence at the beginning of June to engage any staff previously unavailable to attend. All staff have also been allocated an online PD training module on Achieve to complete and coincide with the	

expired training and a programme put in place to ensure staff are up to date.					training they have already received.	
		14.2 Review training matrix and identify staff who need training updates.	LB/HH	29.05.15	14.2 Completed.	
Mental Health Act						
• Managing diaries for numerous changes	N/A	MHA to set up diary for new RC. To also send all invites out and update outlook calendars.	AS/JM	N/A	Completed. Assistant Medical director will also be visiting Delfryn weekly to provide support.	
• Support for newly appointed RC's	N/A	All paperwork and required log ins to be provided and MHA to support with typing reports.	AS/JM	Immediate & on going	Completed	
• Half of the files we reviewed did not have a record that the patient had applied for Hospital Manager's Hearing in their notes.	N/A	A process has been implemented to evidence if a patient hasn't had either a managers hearing or a tribunal.	AS/JM	Immediate & on going	Completed. .	

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NR- Nick Ruffley – Regional Operations Director
ST- Shani Tanti- Hospital Director
LB- Laura Blythe- Deputy Hospital Director
JK- Julie Knight-Psychologist
KW- Kristy Watters- HR
LBu- Dr Leslie Burton- Medical Director
JMc- Jo McAuliffe –Assessment team Manager
MS- Michelle Stokes- Quality Assurance and Compliance Regional Manager
AD – Alison Duke – Speeds Hospital Pharmacy
AS- Abi Scott- MHA
JM-Jordan Massey MHA Assistant
HH- Administrator

	Completed
	In progress
	Outstanding