Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection (Unannounced)

Delfryn House and Delfryn Lodge

Inspection date: 26, 27 and 28 September 2017

Publication date: 12 February 2018

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

Email: **hiw@wales.gsi.gov.uk**

Fax: **0300 062 8387**
Website: **www.hiw.org.uk**

Digital ISBN 978-1-78859-445-5

Contents

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

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection of Delfryn House and Delfryn Lodge on 26, 27 and 28 September 2017.

Our team, for the inspection comprised of a HIW inspector, two clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and a lay reviewer. The inspection was led by a HIW inspection manager.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with the Act.

HIW explored how the service complied with the Care Standards Act 2000, requirements of the Independent Health Care (Wales) Regulations 2011 and met the National Minimum Standards (NMS) for Independent Health Care Services in Wales. Where appropriate, HIW also consider how services comply with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Further details about how we conduct independent mental health service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, we found evidence that the service provided safe and effective care. There was a focus on least restrictive care to aid recovery and supported patients to maintain and develop skills.

Staff were positive about the support and leadership that they received.

We found that there was good management overview of the service and comprehensive policies and procedures in place to support safe delivery of care.

We found that improvements were required in respect of some aspects of the service and in particular the administration of the Mental Health Act and medication management.

This is what we found the service did well:

- Person centred care
- Patient involvement in planning and delivery of care
- Good staff interaction with patients
- Good health promotion, protection and improvement information and initiatives
- Good staff support and supervision
- Good management processes and overview

This is what we recommend the service could improve:

- Menu planning
- Cleanliness of bedrooms
- Medication management
- Mental Heath Act administration

- Additional staff training and resources to support Mental Health Act administration process.
- Remove lock from all external fire escape door

We identified regulatory breaches during this inspection. Further details can be found in Appendix B. Whilst this has not resulted in the issue of a non compliance notice, there is an expectation that the registered provider takes meaningful action to address these matters, as a failure to do so could result in non-compliance with regulations.

3. What we found

Background of the service

CAS Behavioural Health Ltd is registered to provide independent hospital services at Delfryn House and Lodge, Argoed Hall Lane, Mold, Flintshire, CH7 6FQ.

Care is provided for up to fifty eight patients within three separate units:-

- Delfryn House which is a male rehabilitation unit accommodating up to twenty eight patients
- Delfryn lodge which is a female rehabilitation unit accommodating up to twenty four patients
- Rhyd Alun which is a female rehabilitation unit accommodating up to six patients.

Delfryn House was first registered with HIW in December 2005 and the Lodge in 2010.

The service employs a staff team which includes a hospital director (who was also the registered manager), deputy director, two heads of care, twenty registered nurses, sixty two support workers, six therapy co-ordinators, six administrative/reception staff and seventeen catering, housekeeping and maintenance staff. The multi-disciplinary team includes two Responsible Clinicians[1], two assistant psychologists and three occupational therapists. Bank staff were also available to provide cover when necessary.

At the time of the inspection, there was a total of fifty one patients accommodated at the hospital. Twenty seven patients were accommodated in Delfryn House, twenty one of whom were detained under the Mental Health Act.

[1] The Responsible Clinician has overall responsibility for care and treatment for service users being assessed and treated under the Mental Health Act.

Twenty two patients were accommodated in Delfryn Lodge, all of whom were detained under the Mental Health Act and two patients accommodated in Rhyd Alun, one of whom was detained under the Mental Health Act.

Patients are accommodated at the hospital for an average stay of 18 to 20 months.

We did not view the accommodation within Rhyd Alun during this inspection.

The opportunity was taken during this inspection to confirm that the requirements highlighted during the inspection of the hospital undertaken by HIW in September 2015 had been addressed. It is positive to note that all of the requirements made had been addressed and that the improvements made, had been sustained.

Quality of patient experience

We spoke with patients,, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Throughout our inspection, we observed staff treating patients with respect and dignity.

We received positive feedback about the care and treatment patients were receiving.

Both Delfryn House and Delfryn Lodge were suitable for the patient group and were generally clean and maintained to a high standard.

Health promotion, protection and improvement

There was a range of health promotion, protection and improvement information and initiatives available to the patients at Delfryn House and Lodge which assisted in maintaining and improving patients' wellbeing.

Patients were able to access GP, dental services and other health professionals as required. Patients' records also provided evidence of detailed and appropriate physical assessments and monitoring.

Smoking was not allowed within any of the units. However, smoking was permitted in the enclosed garden areas associated with Delfryn House and Delfryn Lodge. The enclosed garden areas were accessible to patients, under staff supervision where required, up to 12.00pm on weekdays and 1.00am on weekends.

Patients within both units had use of an activity room and a small gym containing a variety of exercise equipment. We were told by staff that patients were assessed before using gym equipment to ensure that it was safe for them to do so. However, we found that one patient, who had a diagnosed medical condition, had not been assessed before using the gym equipment.

The hospital employed a team of occupational therapists and therapy co-ordinators. The therapy co-ordinators who spoke with us at Delfryn House were very enthusiastic about heir roles and were keen to tell us about the

activities they had planned in conjunction with patients both within the hospital and in the local community. Patients were seen to interact well with the therapy co-ordinators and were eager to involve themselves in activities.

Patients had access to small quiet lounges as well as a large communal lounge within both units. Books, radios, and televisions were available. Patients also had access to a computer room which they could use in line with individual care plans and risk assessments. Physiotherapy and occupational therapy staff had developed exercise programmes for individuals appropriate to their needs. Therapy co-ordinators supported the patients with crafts and other activities which we saw patients participating in, during our visit. However, patients in Delfryn Lodge told us that the availability of activities was limited on weekends, and that on occasions, planned activities were cancelled at short notice and without explanation.

The units were secured from unauthorised access by locked doors and an intercom system.

In each unit office there was a patient status board[2] displaying confidential information regarding each patient being cared for on the ward. The boards were designed in such a way that confidential information could be covered when the boards were not in use. This meant that the staff team were making every effort to protect patient confidentiality.

Improvement needed

All patients must be formally assessed before using gym equipment to ensure that it is safe for them to do so.

[2] A board that provides staff with a quick reference to essential information about the individual patients being cared for on the ward.

Dignity and respect

We observed staff on both units interacting and engaging with patients appropriately and treating patients with dignity and respect.

We heard staff speaking with patients in calm tones throughout our inspection. There was evidence that staff addressed patients by their preferred name. We observed staff supporting patients at mealtimes by offering alternative choices and ensuring food was suitable for their needs.

Patients told us that they were generally treated with dignity and respect by staff and that staff listed to them and took time to explain aspects of their care.

Patients had This is Me booklets in place which were completed with family involvement. The information contained included basic information about the patient, their previous career, interests, hobbies, likes, dislikes and family members.

All patients had their own bedrooms with en-suite facilities. The bedrooms offered adequate storage and patients were able to personalise their room with pictures and posters. Patients could also lock their bedrooms and patients told us that staff generally respected their privacy and dignity.

Facilities were available for patients to spend time with family and friends; visitor rooms being located on both units.

Payphones were available on both units and these were found to be in working order at the time of the inspection. Patients were also able to use their own mobile phones to maintain contact with family and friends.

Patient information and consent

The hospital had a written statement of purpose which was made available to patients and their relatives/carers.

Notice boards were situated just outside the main entrance to each ward. The information displayed was current and included advocacy and visiting time information.

On the wards, we observed advocacy posters which provided contact details about how to access the service.

Heath promotion information was seen displayed throughout both units together with information about healthy eating.

Communicating effectively

Through our observations of staff-patient interactions it was evident that staff ensured that they communicated with patients effectively. Staff took time to undertake discussions using words and language suitable to the individual patient. Where patients remained unclear or misunderstood, staff would patiently clarify what they had said. These actions were observed during our inspection.

Patients attended multidisciplinary team meetings (MDT) and where appropriate, worked with their key nurses to review and develop their care and treatment plans.

Staff told us that, where applicable, patient care and treatment plans were made available to patients and/or their carers to help them understand their care.

Care planning and provision

There was a clear focus on rehabilitation with individualised patient care that was supported by least restrictive practices, both in care planning and ward or hospital practices.

We reviewed a sample of care files and found that they were generally maintained to a good standard. Entries were comprehensive, with evidence of the use of recognised assessment tools to monitor mental and physical health. We saw evidence that monthly multidisciplinary reviews were being undertaken with patients fully involved in the process. We also saw that care plans were person centred with support provided in a structured way to enable patients to achieve individual goals.

Equality, diversity and human rights

Staff practices were aligned to established hospital policies and systems ensured that patients' equality, diversity and rights were maintained.

We found that the quality of legal documentation to detain patients under the Mental Health Act was variable and not compliant with the legislation in every case. This was brought to the attention of the Mental Health Act Administrators working at the hospital and the senior Mental Health Act Administrator for the company. This is referred to in more detail within the Mental Health Act Monitoring section of this report.

We saw that patients had access to the Independent Mental Health Advocacy (IMHA) service and the Independent Mental Capacity Advocacy (IMCA) service, when required.

Citizen engagement and feedback

There were regular patient meetings to allow patients to provide feedback on the provision of care at the hospital. Information was also available to inform relatives and carers about how to provide feedback.

There was a complaints policy and procedure in place. The policy provided a structure for dealing with all patients' complaints for services.

A sample of complaints records were looked at during the inspection to ensure completeness and compliance with the complaints policy. Complaints were predominantly managed via an electronic based method of logging and recording, with paper based files providing greater detail. The complaints process and associated actions were overseen by the hospital director.

The hospital had a system in place to obtain patient feedback and any identified learning from feedback would be shared with staff during staff meetings or through regular staff bulletins.

Advocacy services were available to provide independent advice for any patient who wished to raise any concerns.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

The hospital environment was generally well maintained and equipped with suitable furniture, fixtures and fittings for the patient group.

There were established processes and audits in place to manage risk, health and safety and infection control. This enabled staff to continue to provide safe and clinically effective care. However, some improvements were required in relation to medicines management.

Patients' Care and Treatment Plans, where available, reflected the domains of The Mental Health (Wales) Measure 2010[3] and were regularly reviewed.

Legal documentation to detain patients under the Mental Health Act required attention to ensure compliance with the requirements of the legislation and the Mental Health Act Code of Practice.

Managing risk and health and safety

The hospital had processes in place to manage and review risks and maintain the health and safety of patients, staff and visitors. The hospital provided

[3] The Mental Health (Wales) Measure 2010 is a law passed by the National Assembly for Wales and, as such, has the same legal status in Wales as other Mental Health Acts. However, whilst the 1983 and 2007 Mental Health Acts are largely about compulsory powers, and admission to or discharge from hospital, the 2010 Measure is all about the support that should be available for people with mental health problems in Wales wherever they may be living.

individualised patient care that was supported by least restrictive practices, both in care planning and hospital practices.

Staff were able to report environmental issues to the hospital estate team who maintained a log of issues and work required and completed.

We were informed that there was a responsive hospital estates team and quick referrals to contractors when required. Throughout the inspection, we saw the estates team responding and undertaking maintenance work to rectify environmental issues.

We found that a fire escape door within Delfryn Lodge to be locked and that it required a staff member with a key to open it. We discussed this with the hospital director who informed us that this was done in order to reduce the risk of patients leaving the hospital without authorisation by forcing the door open. We were also informed that the hospital's fire safety procedure specified the requirement for dedicated staff to unlock the door in the event of a fire. We discussed the matter further with the organisation's estates manager who arranged for the fire door to be unlocked. The estates manager also stated that arrangements would be made to fit stronger magnetic catch in order to prevent unauthorised egress.

We also found that egress into the enclosed garden in Delfryn Lodge was compromised due to a small bush growing directly in front of the fire exit door. This was brought to the attention of the hospital director and estates manager and immediate action was taken to remove the bush.

We also noticed that some of the light diffusers in Delfryn Lodge required cleaning due to an accumulation of dead flies.

There were security procedures in place to minimise the risk of restricted items being brought on to the units. This was to ensure the safety of patients and staff.

Staff wore personal alarms which they could use to call for assistance if required. There were also nurse call points around the units and within patient bedrooms so that patients could summon assistance if required.

The furniture, fixtures and fittings at the hospital were appropriate for the patient group. There were up-to-date ligature point risk assessments in place. These identified potential ligature points and what action had been taken to remove or manage these.

There was an established electronic system in place for recording, reviewing and monitoring patient safety incidents. Incidents were entered on to the system that included the names of patient(s) and staff involved, a description, location, time and length of the incident. Any use of restraint was documented, including who was involved and the body positions of each person involved in the restraint. Incident reports were automatically linked to the individual patient's electronic care notes which ensured that these were up-to-date.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner by a member of the clinical team involved in the individual patient's care and an employee responsible for hospital health and safety.

Regular incident reports were produced and reviewed at hospital and organisation level so that the occurrence of incidents could be reviewed and analysed. Additional reports could be produced as required to look at specific areas of service. The incident reporting system and reporting schedules ensured that incidents were recorded, reviewed and monitored to assist with the provision of safe care.

The hospital had a business continuity plan in place that included the service's responses to such things as adverse weather, utility failures and outbreak of infectious disease.

Improvement needed

The key operated lock must be removed from the fire exit door within Delfryn Lodge and the hospital fire safety policy amended to reflect this.

The light diffusers in Delfryn Lodge require cleaning.

Infection prevention and control (IPC) and decontamination

Dedicated housekeeping staff were employed at the service. All communal areas of the hospital were clean, tidy and clutter free and there was access to hand washing and drying facilities throughout the hospital. Staff had access to Personal Protection Equipment (PPE) when required.

Cleaning equipment was stored and organised appropriately. Generally, throughout the inspection, we observed both Delfryn House and Delfryn Lodge to be visibly clean and clutter free. However, we noted that, a small number of bedrooms needed cleaning. We were told by staff that the patients

accommodated in the bedrooms concerned, were expected to attend to the cleaning as part of their care plans. However, when patients refuse or are unable to undertake cleaning tasks, then staff should assist.

Laundry facilities were well equipped, laundry rooms and linen cupboards were well organised across both units.

Improvement needed

Measures must be put in place to maintain the cleanliness of bedrooms when patients refuse or are unable to undertake cleaning tasks as part of their care plans.

Nutrition

Staff told us that patients were encouraged to maintain a healthy lifestyle. Nutritional information was displayed within both Delfryn House and Lodge. Patients' dietary needs were discussed with them and recorded within their care files. Four meals were provided daily including breakfast, lunch, tea and supper. Snacks and drinks are available at all times and we observed patients receiving these during our visit. Patients were encouraged and assisted to prepare their own meals making use of the kitchen areas within both units. Patients were generally positive about the meals provided. However, a small number of the patients in Delfryn Lodge commented that the menus could sometimes be repetitive and that there was very little choice for those preferring a vegetarian diet.

In addition to the meals prepared within the hospital, patients were also able to order take-away deliveries and, if they had appropriate leave, go out to the local shop to purchase food items.

There was a vending machine located in the corridor within Delfryn Lodge. However, this was not in use at the time of the inspection.

Improvement needed

Menus should be reviewed in order to ensure that a variety of meals are made available to patients.

Medicines management

Medication was stored securely with cupboards and medication fridges and trolleys were locked and secure. There was regular pharmacy input and audits undertaken that assisted the management, prescribing and administration of medication at the hospital.

There was evidence that there were regular temperature checks of the medication fridge to ensure that medication was stored at the manufacturer's advised temperature.

There were appropriate arrangements for the storage of Controlled Drugs and Drugs Liable to Misuse Controlled.

The hospital had policies and procedures in place for the safe management and storage of medication. However, we found that not all were adhering to these policies and procedures. We therefore highlighted the need for the following to be addressed:

- Staff need to make sure that they are using the correct codes on the medication administration record (MAR) charts when medication is refused or not given
- We found that not all 'consent to treatment' forms (CO2) listed all medication prescribed to the patient
- Medication prescribed for patients no longer accommodated at the hospital must be disposed of
- Instructions on MAR charts must be legible in order to reduce the risk of errors being made when administering medication
- Patients' blood pressure, pulse oxygen saturation levels must be monitored and an up to date electrocardiogram (ECG) obtained when Haloperidol and Lorazepam are given to patients as rapid tranquilizers
- Physical health checks must be undertaken consistently as indicated within patients' care plans e.g daily basis
- The information on the white board in the nurses' station, containing information as to who requires regular physical health checks must be updated to reflect the current patient group

- Steps must be taken to ensure that staff are clear about medication administration obligations reflected on the 'consent to treatment' forms
- Steps must be taken to ensure that staff are clear on the correct pathway to follow for hyper/hypo glycaemic episodes
- Controlled drugs must be checked on a daily basis

Improvement needed

Medication management practices must be reviewed in order to address the issues identified above.

Safeguarding children and safeguarding vulnerable adults

There were established processes in place to ensure that the hospital safeguarded vulnerable adults and children, with referrals being made to external agencies as and when required.

Of the records we reviewed, all relevant patients had a Deprivation of Liberty Safeguards (DOLS) authorisation[4] and were fully compliant with legal frameworks. Assessments completed by best interest assessors[5] were detailed, the decisions made and their rationale were recorded in full and made in a timely manner.

Medical devices, equipment and diagnostic systems

Weekly audits of resuscitation equipment were taking place and staff had documented when these had occurred to ensure that the equipment was

[4] DOLS are a part of the Mental Capacity Act 2005 that provide a means of lawfully depriving someone of their liberty in either a hospital or care home, if it is in their best interests and is the least restrictive way of keeping the person safe from harm.

[5] Best Interests Assessors are needed to ensure that decisions about patients which affect their liberty are taken with reference to their human rights and to safeguard their best interests.

present and in date. However, we found that some of first aid kits within Delfryn Lodge were out of date. This was brought to the attention of the nurse in charge who took immediate steps to replace the kits.

There were a number of ligature cutters located within both units in case of an emergency.

Safe and clinically effective care

Overall, we found governance arrangements in place that helped ensure that staff provided safe and clinically effective care for patients.

Clinical governance activities at the hospital were regularly reported to the organisation's senior management through CAS Behavioural health Ltd group formal monitoring arrangements and any actions or learning in turn communicated to staff.

Participating in quality improvement activities

Through reviewing patient records and speaking to staff, it was evident that the care provided to patients was evidence based and that staff considered a range of care options as a multi-disciplinary team. Staff would also seek the patient's view on the proposed care and where possible incorporate their wishes.

Information management and communications technology

The computerised patient record systems were well developed and provided high quality information on individual patient care.

The system was comprehensive, accessible and patient orientated with the information inputted and maintained goal focused.

There were good electronic systems in place for incident recording, clinical and governance audits, human resources and other hospital systems, which assisted to the management and running of the service.

Some of the patients who spoke with us said that they would benefit from having Wi-Fi access. This is something that the hospital management team should give consideration to, paying due attention to individual patient risk assessment.

Records management

Patient records were electronic and password protected to prevent unauthorised access and breaches in confidentiality.

We reviewed a sample of patient records across both units. It was evident that staff from across the multi-disciplinary teams were writing detailed and regular entries which provided a live document on the patient and their care.

We saw that staff were completing care documentation and risk assessments in full.

Mental Health Act Monitoring

We reviewed the statutory detention documents of two patients across both wards, which included Delfryn House and Delfryn Lodge.

Not all records reviewed were compliant within the requirements of the Mental Health Act and reflective of the Code of Practice to ensure that patients' nominated relatives were given relevant information about the care being provided and rights of appeal.

Medication was provided to patients in line with Section 58[6] of the Mental Health Act, Consent to Treatment. However, there was no record of capacity assessment for medication administration on one of the files viewed. There was no record on one file of the discussions held with the Second Opinion Appointed Doctor [7](SOAD). Nor was there an accurate record of the statutory consultees' discussion.

We also highlighted the need for the following to be addressed:

---

[6] Where sections of the Mental Health Act (MHA) requiring consent and a second opinion (57,58 and 58A) are being applied, before issuing certificates approving treatment, the Second Opinion Appointed Doctor's (SOAD) are required to consult two people (Statutory Consultees), one of whom must be a nurse, the other must not be a nurse or a medical doctor. Both must have been professionally concerned with the patients' medical treatment and neither may be the clinician in charge of the proposed treatment or the Responsible Clinician (RC) responsible for the patients care. Statutory Consultees should ensure they make a record of their consultation with the SOAD and this is placed in the patients notes. It is considered good practice to have a specific form for recording this information and that this is kept together with the SOAD certificates, as well as with the patients MHA documentation.

[7] The SOAD is a doctor appointed to safeguard the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient.

- Ensure that all hand written records are legible
- Capacity assessments must be undertaken and recorded on individual files
- Section 62 Emergency Treatment Order[8] must be cancelled when a Certificate of Second Opinion (CO3) is in place
- Maintain formal record of Responsible Clinician discussion with the patient
- Ensure that patients are reminded of their rights on a regular basis and maintain a record of this discussions on file
- Ensure that patients are given copies of detention papers
- Ensure that medical recommendations are being appropriately scrutinised
- Ensure that patients' nominated relatives are given relevant information about the care being provided, the Mental Health Act and rights of appeal
- Ensure that there are formal processes set in place to comply with section 37.13 - 4.36 of the Mental Health Act Code of Practice

Improvement needed

Measures must be set in place to ensure that practices within the hospital are compliant with the Mental Health Act requirements and that there is documented evidence to support this.

[8] Action that can be taken under Mental Health Act which is immediately necessary to save the patient's life; or which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.

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

We reviewed the care plans of a total of four patients.

There was evidence that care co-ordinators had been identified for the patients and, where appropriate, family members were involved in care planning arrangements.

We found that Care and Treatment Plans were not available for some of the patients as these had not been forwarded to the hospital by the community mental health teams responsible for drawing them up. We saw evidence to show that staff at the hospital had already requested this information from care co-ordinators and we suggested that further contact be made in an attempt to speed the process up.

Those Care and Treatment Plans which were in place reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed.

Individual Care and Treatment Plans drew on patient's strengths and abilities and focused on their recovery, rehabilitation and independence. Care and Treatment Plans included good physical health monitoring and health promotion. Patient unmet needs were also identified.

To support patient Care and Treatment Plans, there was an extensive range of patient assessments to identify and monitor the provision of patient care, along with risk assessments that set out the identified risks and how to mitigate and manage them.

Improvement needed

Measures must be taken to ensure that every patient has a care and treatment plan in place at the point of admission into the hospital.

Mental Capacity Act and Deprivation of Liberty Safeguards

From the care files viewed, we saw that Deprivation of Liberty Safeguards (DOLS) assessments were undertaken by staff at the hospital as the 'Managing Authority'[9] as required and passed on to the relevant authority as 'Supervising Body'[10] for processing in a timely fashion. There was, however, some delay in the supervising body processing and responding to referrals.

[9] The managing authority is the person or body with management responsibility for the hospital or care home in which a person is, or may become, deprived of their liberty.

[10] The supervisory body is the local authority or local health board that is responsible for considering a deprivation of liberty request received from a managing authority, commissioning the statutory assessments and, where all the assessments agree, authorising deprivation of liberty.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Independent Health Care Regulations and National Minimum Standards.

Through discussions with staff and observations, we concluded that there was good leadership and management across both units. We saw good team working taking place and staff spoke positively of the support offered by senior managers, unit managers and colleagues.

We found that staff were committed to providing patient care to high standards and throughout the inspection were receptive to our views, findings and recommendations.

There were processes in place for staff to receive an annual appraisal and complete mandatory training. We recommended that the mental health act administrators have up to date training in relation to the Mental Health Act, Code of Practice for Wales and Mental Health Measure to ensure current practise is recognised and adhered to.

The multi disciplinary team were having a positive effect upon patient care and treatment on both units.

Governance and accountability framework

We found that there were systems and processes in place to ensure that both units focused on continuously improving its services. This was, in part, achieved through a rolling programme of audit. The results of which are submitted to senior managers so outcomes can be monitored and clinical outcomes discussed regarding the delivery of patient care.

There was dedicated leadership from the heads of care on both Delfryn House and Delfryn lodge, who were supported by committed ward teams, strong multi-disciplinary teams and senior managers who regularly attended both units. We found that staff were striving to provide patient care to high standards.

Staff spoke positively about the leadership and support provided by the heads of care and hospital director. Staff also commented that team-working on the units was very good.

We viewed copies of reports of visits undertaken by senior managers within the organisation as required by Regulation 28 of the Independent Health Care (Wales) Regulations 2011.

It was positive to note that, throughout the inspection, the managers and staff on both units were receptive to our views, findings and recommendations.

Dealing with concerns and managing incidents

As detailed earlier in the report, there were established processes in place for dealing with concerns and managing incidents at the hospital.

It was evident that the registered provider monitored concerns and incidents locally and corporately through regular reporting mechanisms.

We reviewed a sample of records relating to concerns and incidences and found that these had been dealt with in line with the hospital's policies.

Workforce planning, training and organisational development

We observed good team working on both units and across the hospital site. At the time of our visit, there were only a small number of vacancies and staff sickness rates were low. This meant that patients were cared for by a stable staff team.

It was positive to hear the impact and significant benefit that disciplines including psychology, occupational therapy and activities co-ordinators were having on the patient group.

We reviewed staff training and noted that there was a mandatory programme in place for all staff. Systems were in place on each unit to monitor completion rates and regular review of the information by heads of care ensured staff remained up to date. Staff told us they could access additional and relevant training with line manager approval which was recorded on the training spreadsheets that we saw.

Discussions with the mental health act administrators highlighted the need for additional Mental Health Act training to ensure that the staff have up to date knowledge and skills. We also highlighted the need for additional resources to be freed up in order that the staff concerned are able to dedicate sufficient time to the role.

Inspection of a sample of ten staff files showed that individuals received annual, documented appraisals. There was a formal staff supervision system in place in addition to informal day to day overview by the heads of care and hospital director. Staff told us that the hospital management team were approachable and visible and that an open door approach was adopted on both units. In addition, regular staff meetings were taking place where staff could discuss any issues of interest or concern.

Staff spoken with stated that the staffing levels were sufficient given the level of dependency at the time of the inspection. The hospital director informed us that the staff rotas were planned in such a way to ensure that any short notice staff absences were addressed without adversely affecting the level of service provided.

Improvement needed

Measures must be set in place to ensure that the staff with formal responsibility for the administration of the Mental Health Act within the hospital have received appropriate training and have sufficient resources and time to carry out their duties.

Workforce recruitment and employment practices

From the staff files viewed, it was evident that there were formal staff recruitment processes in place. Prior to employment staff references were received, Disclosure and Barring Service (DBS) checks were undertaken and professional qualifications checked.

DBS checks were completed after each three year period of employment and professional registration monitored.

Newly appointed staff undertook a period of induction under the supervision of the heads of care.

4. What next?

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 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.

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a non-compliance notice. The issuing of a non compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

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.

5. How we inspect independent mental health services

Our inspections of independent mental health services are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of independent mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards
- Comply with the Care Standards Act 2000
- Comply with the Independent Health Care (Wales) Regulations 2011
- Meet the National Minimum Standards for Independent Health Care Services in Wales.

We also consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within independent mental health services.

Further detail about how HIW inspects mental health and independent services can be found on our 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 that an external fire exit door was locked on Delfryn Lodge.	This meant that staff members had to physically unlock the door in the event of fire increasing the risk of harm to patients, staff and visitors.	This was brought to the attention of the hospital director and estates manager.	Arrangements were made for the external fire exit door to be unlocked.
We found that there was small bush restricting egress through the external fire exit door to the enclosed garden area within Delfryn Lodge.	This meant that escape through the fire exit was restricted increasing the risk of harm to patients, staff and visitors.	This was brought to the attention of the hospital director and estates manager.	Arrangements were made for the bush to be removed.
We found that some of the fist aid kits within Delfryn Lodge were out of date.	This meant that there was a risk of infection or harm to patients.	This was brought to the attention of the nurse in charge.	Arrangements were made for the first aid kits to be replaced.

Appendix B – Improvement plan

Service: Delfryn House

Ward/unit(s): Delfryn House and Delfryn Lodge

Date of inspection: 26, 27 and 28 September 2017

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	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
All patients must be formally assessed before using gym equipment to ensure that it is safe for them to do so.	Regulation 15 (1) (b)	All patients now fully assessed for Gym access. Master Folder set up within gym allowing all staff access to relevant risk assessments.	Senior OT	Completed 29th September 2017
Delivery of safe and effective care				
The key operated locks must be removed from all external fire exit doors and the hospital fire safety policy amended to reflect this.	Regulation 26 (4) (b)	Immediate unlocking of door. Electronic magnetic 2 shoot bolt locking	Estates/Maintenance	Completed 16th November

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		system installed. Automatic fire alarm release after 3 minutes.		2017
The light diffusers in Delfryn Lodge require cleaning. Measures must be put in place to maintain the cleanliness of bedrooms when patients refuse or are unable to undertake cleaning tasks as part of their care plans.	Regulation 16 (8) (c) (i)	Monthly Cleaning schedule in situ. Maintenance to check on daily walk around and action on day if identified as requiring attention Management plans added to patients risk assessment deemed as requiring support to maintain room hygiene. To include allocation of a minimal of a weekly deep room clean with the staff support. Senior Support Team to carry out daily room hygiene check and action any requirements to staff on a daily basis. Weekly walk around to be completed with HOC/Maintenance and hotel services.	Maintenance /Housekeeping	Completed 29th September 2017

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Menus should be reviewed in order to ensure that a variety of meals are made available to patients.	Regulation 16 (9) (a) (b)	Patient survey completed following inspection. Menus reviewed. Follow up review of changes made to menus to be completed March 2018. Catering manager to attend patient community meetings on a monthly basis to address any concerns.	Senior OT/Hotel Services	Survey Completed October 2017.
Medication management practices must be reviewed in order to address the issues identified on page 19 of the report.	Regulation15. (5) (a), (b)	10 point MAR chart implemented - HOC to check completion on daily basis. C02/C03s completed. Disposal of discharged patients added to discharge protocol. New physical health folders implemented along with new physical health policy. Regular Audit for Section 62 and consent to treatment implemented to be completed by MHA. Physical health checks put in separate	Head of Cares RC MHA Lead and team Nursing Team	Completed October 2017.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		file instead of on White board– Senior support worker to be allocated as clinic support. Further checks will be made upon MHA documentation during patient's monthly health meeting with the RC.		
Measures must be set in place to ensure that practices within the hospital are compliant with the Mental Health Act requirements and that there is documented evidence to support this.	Mental Health Act 1983	. Ensure that all hand written records are legible - Clarity gained from HIW regards to the SOAD certificate issued and request made for a re-write. HIW responded that they could read the certificate and would not re issue another. 2. Capacity assessments must be undertaken and recorded in individual's files and formal records of RC discussion with patients documented. - All capacity assessments completed New process in place in the House and MHA office to monitor through Monthly Audits.	Nurses Head of Care	September 2017 Remainder fully completed 29th January 2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		3. Section 62 Emergency Treatment Order must be cancelled when a Certificate of Second Opinion is in place. – Identified as an Administration error and rectified. 4. Ensure that patients are reminded of their rights on a regular basis and maintain a record of these discussions on file – Email sent out weekly to nurses of rights due. Section added into morning meeting minute book for nurses to be reminded daily. New forms implemented to reflect requirements. 5. Ensure that patients are given copies of detention papers – All detention paperwork is kept on site and accessible to patients upon request. Patients will now be asked if they require copies of the paperwork upon detention and renewal. 6.Ensure that medical recommendations		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		are being appropriately scrutinised. – Consultants now complete medical scrutiny on new admissions and any patient detained during their stay at Delfryn. 7. Ensure that patients' nominated relatives are given relevant information about the care being provided, the Mental Health Act and rights of appeal - Letter developed and implemented. 8. Ensure that there are formal processes set in place to comply with section 37.13 - 4.36 of the Mental Health Act Code of Practice Medication rights leaflet. - New form implemented to reflect requirements.		
Quality of management and leadership				
Measures must be set in place to ensure that the staff with formal responsibility for the administration of the Mental Health Act within the hospital have received appropriate training and have sufficient resources and time to carry	Regulation 21 (2) (b)	Links information give to MHA team on the day of inspection, same actioned and links with other Welsh CAS hospitals have been made. Email	MHA Lead and team	Completed January 2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
out their duties.		address gained for access to the MHA / HIW forums. First meeting set for March 2018- MHA to attend.		

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): Shani Tanti

Job role: Hospital Director

Date: 30/01/2018