Independent Mental Health Service Inspection (Unannounced)

St David's Independent Hospital, Mental Health Care (St David's) Limited

Inspection date: 4, 5, 6 March 2019

Publication date: 10 June 2019

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Digital ISBN 978-1-83876-485-2

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

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 mental health inspection of St David's Independent Hospital on 4, 5, 6 March 2019.

Our team, for the inspection comprised of two HIW inspectors, one of whom acted as the lay reviewer and three clinical peer reviewers (one of whom was the nominated Mental Health Act 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

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

Staff were positive about the support that they received and the training opportunities made available.

We found that there was improving 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.

This is what we found the service did well:

- Quality of environment
- Person centred approach to provision of care and patient engagement
- Medication management and audit
- Mental Health Act administration
- Cohesive team working
- Management overview, governance, auditing and reporting
- Staff training and support and supervision.

This is what we recommend the service could improve:

- Medication dispensing
- Review patients' snack policy
- Activities and outings
- Monitoring of staffing levels

- Some aspects of file management
- Restraint reduction plans
- Keep safeguarding referrals on individual patient files.

We identified regulatory breaches during this inspection regarding staffing levels and record keeping. 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

St David's Independent Hospital is located in the village of Carrog near Corwen in Denbighshire, North Wales. St David's Independent Hospital is an open rehabilitation, learning disability hospital owned by Mental Health Care (St David's) Limited.

The setting is a male only unit with 15 beds. There were 13 patients accommodated at the time of the inspection.

The service employs a staff team which includes the recently appointed hospital manager, a psychiatrist (the responsible clinician for the patients at St David's Hospital), a practice nurse, two senior nurses, a consultant clinical psychologist and assistant, a senior social worker, an occupational therapist, occupational therapy assistants, speech and language therapist, registered mental health and learning disability nurses, health care support workers, administrative, catering, maintenance and housekeeping staff.

The service was registered on 19 October 2013.

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.

We saw staff treating patients with respect whilst providing them with individualised rehabilitation care. We saw that staff upheld patients' rights and supported them to be as independent as possible.

All patients had individualised activity plans that reflected a range of appropriate rehabilitation and recreational activities. Coed Bach, the day centre at St David's Hospital, provided facilities for patient therapies and activities.

Health promotion, protection and improvement

We found that arrangements were in place to support patients to adopt and improve their health, wellbeing and independence.

Through speaking with staff and patients and looking at patients' care records, we found that care was planned to include the input of doctors, nurses and therapeutic staff. The care provided aimed to support patients through rehabilitation and to improve their health and wellbeing.

Patients we spoke with told us that the staff team were kind and provided encouragement and motivation to help them through their rehabilitation.

A number of health promotion leaflets and details of support organisations were available within the reception and main corridor areas of the hospital.

Smoking was not allowed within the hospital. However, smoking was permitted within the designated area outside of the building.

We saw patients taking part in various activities such as group work, cooking and going for outings in the company of staff members. Patients were seen to interact well with the staff on duty during the course of the inspection. However, some of the patients we spoke to told us that outings and activities are sometimes cancelled at short notice due to unavailability of staff.

The hospital was secured from unauthorised access by locked doors. However, patients were able to go outside, unaccompanied, or in the company of staff members, as directed by individual detention support requirements and risk assessments.

Improvement needed

The provider must continue to monitor staffing levels to ensure that outings and activities are not cancelled at short notice.

Dignity and respect

We found that patients at the hospital were treated with dignity and respect by the staff and this was also reflected in patients' care documentation.

The hospital provided care, treatment and support to male patients only. Patients had their own bedrooms which provided a high level of privacy. Nine of the bedrooms had en-suite facilities and there were communal bathroom facilities for those patients without an en-suite. Patients were able to personalise their rooms and had sufficient storage for their possessions. Patients could lock their bedrooms from the inside and had their own electronic key card to access their rooms. The staff could over-ride the locks if required.

Patients had access to two lounges and two dining rooms. These had been refurbished to a high standard with appropriate fixtures, fittings and furniture for the patient group. Books, radios, and televisions were available within the lounges.

We heard staff speaking with patients in calm tones throughout our inspection. We observed staff being respectful toward patients including prompt and appropriate interaction in an attempt to prevent patient behaviours escalating.

Patient information and consent

We found that patients were provided with information and had opportunities to discuss their treatment options and care with the staff team.

The hospital had a written statement of purpose and service users' guide which was made available to patients. Information within the service users' guide was provided in easy to read and pictorial format to aid patient understanding.

Throughout the hospital there were areas where up-to-date patient information was clearly displayed. This included statutory information along with information

on operation of the hospital and activities that were being undertaken in the hospital and community.

Patients were provided information in written format and there was evidence that staff discussed the information recorded in their individual notes. Where required, the hospital was able to provide written information in Welsh or other languages. We noted that patients' individual occupational therapy planners were both written and pictorial which assisted patient understanding.

Through looking at patients' care records and speaking to staff and patients, we found that arrangements were in place for patients to discuss any aspect of their care during their stay. Patients we spoke with confirmed that they had opportunities to speak to staff about their care.

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.

Patients, if they chose to do so, attended multi-disciplinary team meetings (MDT) and where appropriate, worked with their key nurses to review and develop their care and treatment plans.

For individual meetings, patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. Patients' families and carers were also included in some individual meetings.

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

We found that the hospital had an established care pathway in place that included arrangements for the referral, admission, assessment, care provision and discharge of patients.

We had sight of the care files of all 13 patients, to include individual Care and Treatment Plans where these were available, and found that they were generally well maintained. We looked at three sets of statutory detention documentation in detail, and found that they were very well maintained. Entries were comprehensive, with evidence of the use of recognised assessment tools to monitor mental and physical health. We saw that care plans were person

centred with support provided in a structured way to enable patients to achieve individual goals.

Despite the detailed documentation, as with our previous inspection in January 2016, patients' files were difficult to navigate. The index at the front of patient care files was difficult to follow, with some notes filed in incorrect sections and some clinical notes were not in date order. Some information was duplicated or outdated. This meant that finding the relevant information was time consuming, which would hinder staff trying to learn about individual patients and how to care for them.

For easy reference, we suggested that the patients' one page profile be kept at the front of care files, along with basic information about the patient's care needs,

The care pathway was outlined within the statement of purpose and patients' guide. The hospital accepted patients living within the local health board locality and from neighbouring 'out of county' areas in England. An established care pathway was described from the point of a patients' referral to the hospital through to discharge.

Each patient had their own individual weekly activity planner. This included individual and group sessions, based within the hospital and the community (when required authorisation was in place).

Activities were varied and focused on recovery. These included Living Skills Day[1], mindfulness[2], arts and crafts, shop and cook and dialectic behavioural therapy[3] (DBT.

[1] Living Skills Day – a patient works with their key worker to undertake a variety of daily living skills to maintain or develop their ability.

[2] Mindfulness – a mental wellbeing activity where the person focuses on the present moment, their own thoughts and feelings, and to the world around them.

[3] Dialectical behaviour therapy (DBT) – a therapy designed to help people suffering from mood disorders as well as those who need to change patterns of behaviour that are not helpful, such as self-harm, suicidal ideation, and substance abuse.

Activity participation was monitored and audited. We observed staff actively encouraging patients to participate in their planned activities. Where patients declined, we observed staff offering alternatives and this was noted in the patient record. There was an audit of activity participation which would feed in to future activity planning.

The majority of patient activities in St David's Hospital take place within the day centre known as Coed Bach. Coed Bach is a standalone building within the grounds of St David's Hospital. It comprised of an occupational therapy kitchen, a sensory room and three large rooms that were used for arts and crafts, wood work, and group activities and therapies.

The occupational therapy kitchen had recently been refurbished to a high standard. Patients had individual cupboards within which to store their own food and drinks.

Throughout the inspection, we saw patients being encouraged to cook their own meals and help themselves to hot and cold drinks.

The Sensory Room was furnished with soft relaxing furniture and a few pieces of optical equipment. We spoke with the Occupational Therapist who told us that she was due to attend further training which would help her to develop this facility.

Improvement needed

Review patient care files in order to make them easier to navigate.

Equality, diversity and human rights

Staff at the hospital recognised their responsibilities around equality, diversity and human rights.

The hospital provided care and treatment to male adult patients. This was in accordance with the conditions of its registration with HIW. The statement of purpose clearly described the circumstances where the hospital would not be able to provide services to patients.

We found that patients were afforded choice in their day to day routines according to their assessed needs and wishes.

The main hospital building was not deemed suitable for people with mobility problems as the accommodation is set out over two floors which are accessed by a stair case. This is made clear in the statement of purpose.

Citizen engagement and feedback

The hospital had arrangements in place for patients to provided feedback on their experiences of using the service.

We found that a quality monitoring visit had been undertaken to the service within the last six months as required by the regulations. We saw that the views of staff and patients had been sought and a written report produced, which included an action plan to make improvements.

There was a complaints policy and procedure in place. The policy provided a structure for dealing with all patients' complaints. Information about making a complaint was provided in easy to read/pictorial format within the patients' guide.

There was a patient satisfaction questionnaire available in easy read/pictorial format for patients to complete.

Delivery of safe and effective care

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

We found that systems were in place to keep patients safe and to provide care that was effective.

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.

Clinical treatment was led by a psychiatric consultant and we found effective multi-disciplinary team working

The statutory documentation in relation to both the Mental Health Act and the Mental Health (Welsh) Measure were completed to a high standard and compliant with their associated legislation. However, as with our previous inspection, patient files were difficult to navigate due to the quantity of information, some of which was duplicated or outdated.

Managing risk and health and safety

The hospital and day centre have undergone extensive refurbishment which has been carried out to a high standard.

There were comprehensive policies and procedures in place to manage risk and to ensure the safety of patients, staff and visitors.

No obvious health and safety risks were highlighted during our tour of the hospital and day centre.

We recommended that the layout of the main reception area be reviewed in order to provide a secure area for visitors to wait and sign in before entering the main corridor.

All staff had a personal alarm that could be used in an emergency. There were also nurse call alarms in bedrooms.

There were garden areas that patients could use either independently or with staff support. There was also a designated, outdoor smoking area which patients could use.

All areas of the hospital and day centre viewed during the inspection were found to be clean, tidy and well maintained.

Improvement needed

Review the layout of the main reception area in order to provide a secure area for visitors to wait and sign in before entering the main corridor.

Infection prevention and control (IPC) and decontamination

There were comprehensive policies and procedures in place to manage the risk of infection. Infection control audits were being undertaken on a regular basis.

There was a weekly cleaning rota and a monthly deep clean rota in place. The housekeeping staff work in partnership with care and support staff to encourage patients' engagement with keeping their own bedrooms and communal areas tidy and maintaining clean environments.

The housekeeping staff told us that they have the correct equipment and sufficient supplies for cleaning.

Nutrition

An evidence based screening tool was used to assess patients' dietary needs on admission. Patients were weighed on admission and body mass index (BMI) and malnutrition universal screening tools (MUST), were used to confirm whether their weight was appropriate in relation to their height.

Meals were prepared in the main kitchen located within the hospital with patients offered choices at mealtimes. As previously mentioned, patients were also encouraged to prepare meals and snacks within the day centre kitchen. Patients were very positive about the meals provided.

Patients chose their meals from the six-week menu plan that provided a balanced diet. In addition, we were told that alternative meals were available in response to individual cultural requirements or preferences.

Where patients had Section 17 Leave[4] authorisation, they could also undertake food shopping as part of their community focused rehabilitation activities.

Patients were given advice on healthy eating and meal preparation.

There was a patient snack policy in place which limited the availability of snacks and drinks with high sugar content to certain amounts and during specific times of the day. This policy applied to all the patients accommodated regardless of individual abilities to make reasonable decisions and regardless of dietary intake and weight. We recommend that the snack policy be reviewed and be based on individual care needs and assessment.

Improvement needed

Review the snack policy.

Medicines management

There were arrangements in place for the safe management of mediation. A written policy was available to guide staff on the safe storage, prescription and administration of medicines.

Medication was securely stored and arrangements were in place for the checking and recording of controlled drugs when in use.

We looked at a sample of medication administration records (MARs) and found that they had been completed correctly.

We strongly recommended that the practice of dispensing medication to patients through a hatch in the treatment room be reviewed. This method of

[4] This is a Section of the Mental Health Act (1983) which allows the Responsible Clinician (RC) to grant a detained patient leave of absence from hospital. It is the only legal means by which a detained patient may leave the hospital site.

dispensing medication could be regarded as being institutionalised and should be discouraged.

Improvement needed

Review the practice of dispensing medication to patients through a hatch in the treatment room.

Safeguarding children and safeguarding vulnerable adults

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

We saw examples of completed safeguarding referral forms which included outcomes of discussions with local authority safeguarding leads and action points.

We recommended that completed safeguarding forms be retained on individual patient files rather than on one generic file as was the case during the inspection.

Improvement needed

Keep completed safeguarding forms on individual patient files.

Medical devices, equipment and diagnostic systems

Resuscitation equipment was available for use in the event of a patient emergency (collapse). We saw records demonstrating that staff were checking this equipment on a weekly basis to ensure it was safe to use.

Safe and clinically effective care

We found that care and treatment at the hospital was based upon current, evidence based practice.

Clinical treatment at the unit was led by a consultant psychiatrist. Supportive links with local GP, community teams and the local health board were described and demonstrated.

Staff were trained in Management of Actual or Potential Aggression (MAPA) which is a model of training accredited by the British Institute of Learning

Disabilities (BILD). The training was valid for 12 months and there was a 90% training compliance rate.

Incidents of restraint are recorded on an electronic system but are generally not printed out to be retained on individual patient care files. This can lead the reader of a care file to not have a full understanding of what happened as only a reference number to the electronic entry is included within the daily progress notes. We suggested that this practice be reviewed.

All clinical and support staff receive training on when and how an incident should be reported. Incident reviews were convened every Monday and Friday by the multidisciplinary team. Staff involved in the incident are expected to attend these meetings whenever possible. A Named Nurse coordinates monthly reviews which include reviews of all incidents presented as graphed data with specific focus on the use of restrictive physical intervention. We recommended that individualised restraint reduction plans be put in place for each patient that this relates to that would be informed by this collated data.

Improvement needed

Implement individualised restraint reduction plans.

Information management and communications technology

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

Records management

The patient record systems were well developed and provided generally high quality information on individual patient care. The hospital had a combination of paper and electronic records management system in operation. However, the intention is to move to a solely electronic system in the near future.

The system was comprehensive, accessible and patient orientated.

Mental Health Act Monitoring

We reviewed the statutory detention documents of three of the detained patients being cared for at St David's Hospital in detail. We also reviewed the monitoring and audit procedures that were undertaken by the Mental Health Act administrator.

The statutory detention documentation held at St David's Hospital was well organised and evidenced that the detentions were compliant with the Mental Health Act (the Act). There were strong monitoring, scrutiny and audit procedures to ensure that professionals acted as and when required by the Act.

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

We reviewed three sets of patient records, including two sets of Care and Treatment Plan documentation, in detail. All documentation that we reviewed was generally completed to a high standard.

We found that there were detailed Positive Behavior Support (PBS) plans in place for patients.

There were no Care and Treatment Plans in place for patients supported by placing authorities located in England, as the care planning system in England differs to that in Wales. However, patients supported by placing authorities based in England had individual care plans in place which were based on the domains within the Care and Treatment Plan framework.

Mental Capacity Act and Deprivation of Liberty Safeguards

Only one patient was subject to Deprivation of Liberty Safeguards at the time of the inspection. We found that the correct assessment and referral process had been followed and that the appropriate supporting documentation was available on the patient's file.

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 within the hospital. We saw good team working taking place and staff spoke positively of the support offered by senior 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 and service specific training.

The multidisciplinary team were having a positive effect upon patient care and treatment on the unit.

Governance and accountability framework

There were comprehensive policies and procedures in place to monitor the quality of service provided and to drive forward improvements within the hospital.

Clear lines of delegation, accountability and reporting within the hospital and the wider organisation were described by staff and demonstrated through monitoring and auditing documentation. We saw examples of clinical audits that had been conducted and actions taken in response to findings. These included audits of patients' medication administration records and care records.

In accordance with the regulations, there was a responsible individual in post. The responsible individual had a clinical and wider management role within the organisation. The hospital had been without a registered manager since October 2018. One of the directors of Mental Health Care (St David's) Limited had assumed the role of acting manager in the interim and until a new manager

was appointed. The new manager had been in post for only six days prior to the inspection. We were informed that the newly appointed manager was in the process of completing a formal application to register with HIW.

During the absence of a registered manager, and in support of the acting manager, additional measures had been set in place to ensure that the organisation was sufficiently sighted on the service to ensure that the care and support provided to the patients was not compromised.

It was positive that, throughout the inspection and at the feedback session, the staff at St David's Hospital were receptive to our views, findings and recommendations.

Despite the challenges they faced in order to meet patients' complex, changing needs, our observations and discussions held with staff throughout the inspection clearly demonstrated that they worked effectively as a team. This included multi-disciplinary staff along with auxiliary staff such as the housekeeping, maintenance, catering and administrative staff.

Dealing with concerns and managing incidents

As previously mentioned, there was a complaints policy and procedure in place. The policy provided a structure for dealing with all patients' complaints. Information about making a complaint was provided in easy to read/pictorial format within the patients' guide.

Significant incidents were appropriately documented and escalated through the organisations clinical governance reporting process.

Workforce planning, training and organisational development

Staff reported that the multi-disciplinary team worked in a professional and collaborative way and that individual professional views were valued and considered as part of the multi-disciplinary care.

We reviewed staff training and noted that there was a mandatory programme in place for all staff. Systems were in place to monitor completion rates and regular review of the information by the management team ensured staff remained up to date. Staff told us they could access additional and relevant training.

Inspection of a sample of five 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 management team. Staff told us that the management team were approachable and visible and that

an open door approach was adopted. In addition, regular staff meetings were taking place where staff could discuss any issues of interest or concern.

Nurses and health care support workers worked 12 hour shifts from 8am to 8pm and 8pm to 8am, with other multi-disciplinary team members present throughout the day. The hospital also used a twilight shift where staff members would be present from the afternoon until midnight to assist with patients' evening routines.

Staffing levels during our visit were appropriate for the patient group. However, some staff raised concerns that there were times when there were insufficient staffing levels, particularly if there was a need to undertake enhanced patient observations. Some staff also told us that they were not always able to take scheduled breaks due to workload demands. The provider must continue to review and adjust staffing levels in order to ensure that staff are able to take regular breaks whilst maintaining adequate cover to meet patient needs.

We were told that the reliance on bank and agency staff had reduced of late with a number of new staff recently recruited. Every effort was being made to ensure that the same bank or agency staff were being used to cover shifts in order to ensure continuation of care.

The recruitment of permanent staff was ongoing with further staff interviews scheduled.

Compliance with mandatory and service specific training was good. We reviewed the training matrix and we could see high completion rates (90%+ in most areas).

Improvement needed

Review and adjust staffing levels in order to ensure that staff are able to take regular breaks whilst maintaining adequate cover to meet patient needs.

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. This process was managed by the organisation's central human resources team.

Newly appointed staff undertook a period of induction under the supervision of the lead nurse.

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, measurable, 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
No immediate concerns were identified during this inspection.			

Appendix B – Improvement plan

Service: Mental Health Care (St David's) Limited

Ward/unit(s): St David's Hospital

Date of inspection: 4, 5, 6 March 2019

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				
The provider must continue to monitor staffing levels to ensure that outings and activities are not cancelled at short notice.	Regulation 15. (1) (a) Regulation 20. (1) (a) 3. Health promotion, protection and improvement	There is a continuous review of safe staffing practice taking place. There is a Company-wide Nursing Development Group where this is being reviewed. Safe staffing levels are reviewed on a daily and weekly basis forecasting staff levels and resource management for the week ahead. A more responsive schedule of outings and activities is under consultation. Hospital management and MDT will keep the schedule under ongoing review. A daily planner (involving Patients) instead of	Kenny Gordon Registered Manager	Initial stage of review completed. Internal review by 25.6.2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		the current weekly planner is being brought in. A record of any activities which could not be facilitated has been added to the daily Ward Report Record which the Registered Manager will keep under review to monitor any shortcomings.		
Review patient care files in order to make them easier to navigate.	8. Care planning and provision	The files are already under review through internal and external audit to ensure easier navigation.	Jill Broom Senior Nurse Kenny Gordon Registered Manager	25.06.2019
Delivery of safe and effective care				
Review the layout of the main reception area in order to provide a secure area for visitors to wait and sign in before entering the main corridor.	Regulation 47. (1) (c) 22. Managing risk and health and safety 12. Environment 4. Emergency Planning	It is currently being reviewed at Board level and solutions considered to adapt the environment appropriately.	Dr Anthony Dean Responsible Individual Kenny Gordon Registered Manager Mike Pearce, Head of Estates	24.7.2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	Arrangements			
Review the snack policy.	Regulation 15. (9) (a) and (b) 14. Nutrition	MHC UK Ltd has never formally adopted a "Snack Policy" at Executive Board level. A local procedure was implemented at St David's to address historical concerns. This local Snack Procedure has been discontinued with immediate effect. The Hospital Social Worker has now met with all Patients about their preferences and individualised person centred snack plans are now in place. A copy of the plan has been affixed to the top of the Patient's snack box where dysphagia is a risk. Patients can access their snacks at a time of their choosing.	Kenny Gordon Registered Manager Dr Jon Nash Consultant Psychiatrist Wendy Goulbourn Senior Social Worker	25.6.2019
Review the practice of dispensing medication to patients through a hatch in the treatment room.	Regulation 18. (1) (a) 15. Medicines management	The hatch within the stable door has been disabled as an immediate response so this practice has ceased. A completely new Clinic door will have the hatch permanently removed by Estates Department.	Kenny Gordon, Registered Manager Mike Pearce Head of Estates	Achieved By 25.5.2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Keep completed safeguarding forms on individual patient files.	11. Safeguarding children and safeguarding vulnerable adults	Any new Safeguarding papers will be filed on individual Patient files once sent to Denbighshire Safeguarding Board. Papers will be redacted where other Patient's details are included, to ensure GDPR compliance. (This will be raised as an agenda item at the Company wide GDPR Committee meeting).	Wendy Goulbourn Senior Social Worker	2.5.2019
Implement individualised restraint reduction plans.	Regulation 16. (2) (a) and (b) 7. Safe and clinically effective care	Going forward the data collected from incidents of restraint by Named Nurses will be given to the twice weekly Incident Review Meeting so that individualised restraint plans are reviewed, Restraint reduction is currently being considered in the MHC Evidence Based Treatment Pathways Committee (EBTP) to identify tools in line with the recommendations from the Restraint Reduction Network.	Named Practitioner/ Nurse(s) (Registered) who collate the data. Dr John Sorensen Consultant Clinical Psychologist/Head of EBTP	25.6.2019. 25.07.2019
Quality of management and leadership				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Review and adjust staffing levels in order to ensure that staff are able to take regular breaks whilst maintaining adequate cover to meet patient needs.	Regulation 20. (1) (a) 25. Workforce planning, training and organisational development	There is a continuous review of safe staffing practice taking place. There is a Company-wide Nursing Development Group where this is being reviewed. Safe staffing levels are reviewed on a daily and weekly basis forecasting staff levels and resource management for the week ahead.	Kenny Gordon Registered Manager	Having completed an initial review following HIW visit, further review by 25.6.2019

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): Kenny Gordon

Job role: Registered Manager (Application Pending)

Date: 25/04/19