Independent Mental Health Service Inspection (Unannounced)

Delfryn House and Delfryn Lodge

Inspection date: 30 September and 1, 2 October 2019

Publication date: 2 January 2020

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Digital ISBN 978-1-83933-783-3

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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 independent mental health inspection of Delfryn House, Delfryn Lodge and Rhyd Alyn on the evening of 30 September and following days of 1 and 2 October 2019.

The following sites and wards were visited during this inspection:

- Delfryn House
- Delfryn Lodge
- Rhyd Alyn

Our team, for the inspection comprised of two HIW inspectors, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) The inspection was led by one of the HIW inspection managers.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with 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 a dedicated staff team that were committed to providing a high standard of care to patients. We observed that staff interacted with patients respectfully throughout the inspection.

There was a clear focus on least restrictive care to aid recovery and support for patients to maintain and develop skills.

Patients we spoke to told us they were happy and receiving good care at the hospital.

Overall, we found that the service provided safe and effective care. However, we found that improvements were required in the administration of the Mental Health Act, and more robust checks and audits were required on first aid kits and expiry dates of items stored in the clinic room.

This is what we found the service did well:

- Staff interacted and engaged with patients respectfully
- Patients were provided with a good range of therapies and activities
- Good team working and motivated staff
- Established governance arrangements that provided safe and clinically effective care
- Safe and effective medicines management.

This is what we recommend the service could improve:

- Mental Health Act administration
- Additional staff training and resources to support Mental Health Act administration process
- Make sure regular checks and audits are undertaken on first aid kits and expiry dates for medicines / medical items.

We identified regulatory breaches during this inspection:-

- Some items in the first aid kits at Delfryn Lodge were out of date

- Some items within the clinical room at Delfryn Lodge were out of date.

Further details can be found in Appendix A. 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

Cygnet Behavioural Health Limited is registered to provide an independent hospital service 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 Alyn 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, a team of registered mental health nurses and support staff. The day to day operation of the hospital was supported by dedicated teams of administration staff.

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.

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

We observed staff interacting and engaging with patients appropriately, and we observed staff treating patients with dignity and respect.

Patients we spoke to told us they were happy and receiving good care at the hospital.

There were a range of suitable activities and therapies available throughout the hospital, and within the community, to aid patients' rehabilitation.

Health promotion, protection and improvement

The hospital had a range of well-maintained facilities to support the provision of therapies and activities. These facilities included a sensory therapy room in Delfryn Lodge, patients also had access to snooker tables, television rooms, and occupational therapy rooms. The therapy rooms provided patients with a number of useful resources, such as board games and arts and crafts. Patients also had access to gym equipment in both Delfryn Lodge and Delfryn House. A personal trainer attended at the hospital on Thursdays to provide training advice, and a gym induction course was available for patients who had not previously used the gym equipment.

A beauty therapy room was available for patients in Delfryn Lodge to attend and receive beauty treatments, some patients were also undertaking training courses in beauty therapy provided by the beauty therapist.

Patients had access to a computer room which they could use in line with individual care plans and risk assessments. 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 their 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. The occupational therapists created bespoke activities based on the individual patient's interests.

This made sure that all patients had the opportunity to participate in activities they enjoyed and were interested in.

Patients had open access to the kitchen area and were encouraged to plan and prepare their own meals with support from staff. This gave patients the opportunity to have an input on what they ate on a daily basis.

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. Staff had access to three designated hospital vehicles which enabled staff to facilitate patients' activities and medical appointments in the community.

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

Dignity and respect

We noted that all employees; ward staff, senior management and administration staff, interacted and engaged with patients appropriately and treated patients with dignity and respect. The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients. We observed staff taking time to speak with patients and address any needs or concerns the patients raised, this demonstrated that staff had responsive and caring attitudes towards the patients.

In each unit office there was a patient status at a glance board[1] 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.

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

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

Each patient had their own bedroom which they could access throughout the day. The bedrooms provided patients with a high standard of privacy and dignity.

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. During the course of our inspection we saw many examples of staff knocking on patients doors before entering the bedrooms.

Facilities were available for patients to spend time with family and friends; visitor rooms were available on all sites of the hospital. Patients were also able to use their own mobile phones to maintain contact with family and friends, in addition to having access to the office phones if required.

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

Patient information and consent

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 saw 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. However there was insufficient information available on smoking cessation. There was a lack of information about the role of HIW and how to contact HIW should any patients or visitors wish to raise any concerns or complaints.

Improvement needed

The registered provider must make sure smoking cessation advice is displayed on hospital wards.

The registered provider must display information about Healthcare Inspectorate Wales and how to contact us.

Communicating effectively

Through our observations of staff-patient interactions, it was evident that staff made sure they communicated appropriately and effectively with patients. Staff took time to undertake discussions using words and language suitable to each individual patient. Where patients remained unclear, or what they were trying to communicate was misunderstood, staff would patiently attempt to clarify what they had said.

We frequently observed patients approaching a variety of staff from the multidisciplinary team, and it was praiseworthy to see staff take time out to speak to the patients irrespective of other commitments staff may have been dealing with at the time. The hospital director was also observed talking to the patients who responded well to her, evidencing that the hospital director spent time getting to know the patients on an individual basis, it was clear to see that the hospital director was a familiar and friendly face to the patients.

We attended a number of clinical meetings and it was evident that discussions focused on what was best for the individual patient. Where the patient was present at the meeting all staff engaged respectfully and listened to the patient's views and provided the patient with clear reasons for the decisions taken. It was reassuring to see and hear professional discussions and debates taking place during meetings when individual risk assessments were being discussed. This demonstrated that every member of staff contributed to the intelligence and information process, and all staff views were considered and discussed when making an important decision on a patient's level of risk and needs.

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 hospital practices.

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. Through our findings there was clear evidence of multidisciplinary involvement in the care plans, this helped support the hospital in being able to deliver comprehensive care to the patients.

Equality, diversity and human rights

Staff practices aligned to established hospital policies and systems ensured that patients' equality, diversity and rights were maintained. We saw that patients had access to the Independent Mental Health Advocacy (IMHA) service and the Independent Mental Capacity Advocacy (IMCA) service, when required.

Mental Health Act detention papers had been completed correctly to detain patients at the hospital. However, the registered provider must implement improvements to the application of the Act to fulfil its statutory duties under the Act and as set out in the Mental Health Act Code of Practice for Wales 2016. This was brought to the attention of the Mental Health Act Administrators working at the hospital and senior management. This is referred to in more detail within the Mental Health Act Monitoring section of this report.

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 complaint 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. The complaints process and associated actions were overseen by the hospital director.

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 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, medicines management and infection control. This enabled staff to continue to provide safe and clinically effective care.

However, improvements are required on the implementation of the Mental Health Act and audit checks on the first aid kits and items within the clinical area in Delfryn Lodge.

Managing risk and health and safety

The hospital had established processes in place to manage and review risks and to maintain health and safety at the hospital. This enabled staff to continue to provide safe and clinically effective care.

Access to the hospital building was direct from the car park level which provided appropriate access for persons with mobility difficulties. The hospital entrance was secured to prevent unauthorised access. The hospital provided individualised patient care that was supported by least restrictive practices, both in care planning and hospital practices.

The hospital's estate team were part of the daily staff handover meetings, this meant that any maintenance would be discussed during the meeting and estates would be in a position to deal with any issues in an efficient and effective way. Throughout the inspection, we saw the estates team responding and undertaking maintenance work to rectify environmental issues.

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 were weekly audits of resuscitation equipment, staff had

documented when these had occurred to ensure that the equipment was present and in date.

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. We found evidence that individual patients had individualised restraint reduction plans in place which identified the least restrictive options for risk management. Staff confirmed that they undertake MAPA[2] training which emphasises de-escalation and using physical restraint as a last resort.

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. Incident reports were also discussed at morning meetings between the multidisciplinary teams.

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.

Infection prevention and control (IPC) and decontamination

Dedicated housekeeping staff were employed at the service. All communal areas of the hospital were visibly clean, tidy and clutter free. There was access to hand

[2] MAPA (Management of Actual or Potential Aggression) is a behaviour management system that teaches skills for assessing, managing, and responding to risk behaviour. The focus is on verbal de-escalation, prevention, and early intervention. Safe physical intervention options are also taught, to be used only as a last resort.

washing and drying facilities throughout the hospital. Staff had access to Personal Protection Equipment (PPE) when required.

A comprehensive system of regular audit in respect of infection control was in place. Daily audits were completed and filed accordingly. Staff confirmed that cleaning schedules were in place to promote regular and effective cleaning of the hospital and they were aware of their responsibilities around infection prevention and control.

Cleaning equipment was stored and organised appropriately. There were hospital laundry facilities available so that patients could undertake their own laundry with appropriate level of support from staff based on individual needs. However we noted that clean mop heads were being stored amongst patients' clean laundry, this is not a hygienic solution and the hospital needs to identify an alternative storage space for clean mops to be stored.

Improvement needed

The registered provider must make sure that alternative and appropriate storage is found for clean mops.

Nutrition

Staff told us that patients were encouraged to maintain a healthy lifestyle. Nutritional information was displayed across the hospital. Patients' dietary needs were discussed with them and recorded within their care files.

The hospital provided patients with a range of meals. In addition, as part of patient rehabilitation, staff supported patients to plan and prepare their own meals or communal meals for patients and staff at the hospital. This equipped patients with cooking skills and additional skills in menu preparation and food shopping.

A good selection of fresh fruit was located in the communal area which was freely available to all patients. We observed patients accessing the patient kitchen facilities throughout the inspection and patients confirmed to us that they were able to use the kitchen to prepare food whenever they wanted to.

Medicines management

Medication was stored within cupboards and medication fridges that were locked and secure. All cupboards were locked, however we noted that the controlled drug keys were held on the same bunch of keys as the clinic room keys. This meant that if the bunch of keys were misplaced there would be a risk that both

the clinic and controlled drugs cupboards could be accessed. Therefore the registered manager needs to make sure controlled drug keys are kept separate from clinic room keys.

The clinical area was free from clutter and well organised, and medication files were laid out in an organised manner which were easy to navigate and find information. The medical files also included the necessary capacity assessments. They have adopted the Cygnet medication file which has an index page which includes, photo identification, Mental Health Act consent to treatment certificates, and major tranquiliser monitoring. However we identified that the Cygnet medication file index was in some of the files but the contents were incomplete or inconsistent this could affect a safe and complete level of clinical governance of individual patient care

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. However, upon reviewing dates on a sample of items in the clinical room there were some items found to be out of date, namely:

- 3 open pots of Ketostix
- Sterile dressing
- 1 x Multistix expiring end of October 2019.

We raised this with staff during the inspection as the out of date items may pose a risk to patient safety.

There was regular pharmacy input and audits undertaken that assisted the management, prescribing, and administration of medication at the hospital, and a process was in place if emergency orders were required.

We observed staff discussing medication with patients and found that these discussions with the patients had been documented and recorded in the patients care and treatment plans.

Improvement needed

The registered provider must review their processes around the controlled drugs keys and clinical keys being stored on the same bunch.

The registered provider must make sure that all medical items stored in the clinical room are in date.

Safeguarding children and safeguarding vulnerable adults

There were established processes in place to ensure that the hospital safeguarded vulnerable adults and children, with referrals to external agencies as and when required. During discussions with the hospital director she clearly demonstrated her knowledge on what constituted a safeguarding referral, and from documents we inspected it was evident to see that the hospital director had worked hard to develop and maintain a good working relationship with the police and local authority.

This collaborative approach is key to effective safeguarding processes and demonstrated that the hospital placed a strong emphasis on safeguarding their patients. This was further supported by training records we examined. Staff completion rates of mandatory safeguarding training were high, and in addition, all staff files contained a matrix which had been developed to identify any training gaps around knowledge and understanding of safeguarding issues. If any gaps were identified then additional safeguarding training would be provided.

Medical devices, equipment and diagnostic systems

Weekly audits of resuscitation equipment were taking place and staff documented when these had occurred to ensure that the equipment was present and in date. However, we found that some items within the first aid kits in Delfryn Lodge were out of date. The emergency resuscitation equipment was not 'tamper sealed' as required and there were two tracheal tubes which are not part of the Cygnet audit check list, this can lead to confusion in emergency situations. In addition these were out-of-date and required to be replaced. This was brought to the attention of the nurse in charge who took immediate steps to replace the out of date items as this may have posed a risk to patient safety.

There were a number of ligature cutters located within all units in case of an emergency. During staff discussions it was evident that all staff were aware of the locations of ligature cutters. There were up-to-date safety audits in place, including ligature point risk assessments.

Improvement needed

The registered provider must make sure that the first aid kits are stocked appropriately and checks are undertaken to make sure all items are in date.

Safe and clinically effective care

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

Clinical governance arrangements for the hospital fed through to Cygnet central governance arrangements, which facilitated a two way process of monitoring and learning.

Participating in quality improvement activities.

Links with local colleges, leisure centres, and community initiatives ensured that patients had access to courses and activities, enabling patients to participate in meaningful activities during their time at the hospital and when they are also on unescorted leave. The hospital worked collaboratively with Cyfle Cymru which helped to support patients in applying for job opportunities and voluntary work.

As previously highlighted in the safeguarding portion of this report, It was really positive to see that the hospital director and the local police had developed a strong working relationship, which included monthly meetings and a mutually agreed hospital protocol which was available to staff when any incidents occurred which may warrant police attendance.

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.

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 three patients in the hospital.

The statutory documentation reviewed verified that the patients were legally detained. We saw that some improvements had been made with regards to Mental Health Act monitoring since our last inspection. However through reviewing the patients' records we identified that further improvements are necessary to achieve full compliance:

- We would strongly advise that the hospital use Welsh Government patient leaflets for reading patients their rights under the act
- There was no evidence on the leave forms that section 17 leave[3] had been risk assessed
- All expired section 17 leave forms were not clearly marked as no longer required
- Documents were not being scrutinised for accuracy and completeness and must be checked to ensure they do not fail to comply with the procedural requirements of the Act in respect of application for detention
- No evidence within patient records to confirm that patients had been made aware of HIW's role.

Improvement needed

The following areas of improvement are required :-

- The registered provider must use Welsh Government patient leaflets for reading patients their rights under the act
- The registered provider must make sure that all expired section 17 leave forms are clearly marked as no longer required

[3]Section 17 leave allows the detained patient leave from hospital

- The registered provider must make sure that patients records contain information on the role of HIW
- The registered provider must make sure that detention papers are medically scrutinised before admission.

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

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

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. The patient records we viewed were both electronic and paper files which were well organised and easy to navigate.

There was comprehensive needs and risk assessments completed throughout the patient admission which directly linked to the plan of care and risk management strategies implemented on the unit. There was clear evidence of multidisciplinary involvement in the care plans which reflected the domains of the Mental Health Measure Wales. However we did note that the unmet needs of the patients were not recorded and evidenced in the notes we viewed. It is important that unmet needs are documented so that these can be regularly reviewed by the multidisciplinary team to look at options for meeting those needs.

The hospital utilised the start model[4] for risk assessment which offered both comprehensive risk history and more dynamic daily and weekly reviews. We observed staff discussing and debating the risk assessments during the morning meetings we attended and it was reassuring to witness meaningful discussions around individual patients risk assessments.

[4] Start is used to assess risk behaviours that change fairly quickly. Start also looks at strengths as well as considering areas of need.

Improvement needed

The registered provider must make sure that unmet needs are evidenced and documented within patient care plans.

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.

We saw good management and leadership at the hospital which was supported by the Cygnet organisational structure. We observed a committed staff team who had a good understanding of the needs of the patients at the hospital.

Mandatory training completion rates were high and staff were able to access additional course to further their personal development.

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

Governance and accountability framework

We found that there were well defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit and its established governance structure which enabled key/nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

There was dedicated and passionate leadership displayed by the hospital director who was supported by committed multidisciplinary teams. We found that staff were committed to providing 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. It was positive that, throughout the inspection, the staff at the hospital were receptive to our views, findings and recommendations.

Dealing with concerns and managing incidents

There was a complaints policy and procedure in place at the hospital. The policy provides a structure for dealing with all patients' complaints for services within the hospital.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the system that included the

name of patient(s) and staff involved, a description, location, time and length of the incident. This provided staff with appropriate data to identify trends and patterns of behaviour.

It was also positive to note that the hospital director would meet with patients as and when the patient requested in order to discuss any concerns or issues the patients may have.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and reviewed at hospital and organisation level so that the occurrence of incidents could be reviewed and analysed.

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. It was also pleasing to see that all occupational therapists from the wider Cygnet group would meet up at regional level and discuss lessons learnt and share ideas and resources in order to improve and enhance the patient experience.

Workforce planning, training and organisational development

We reviewed the mandatory training and clinical supervision statistics for staff at the hospital and found that completion rates were high. There was a programme of training so that staff would receive timely updates. The electronic records provided the senior managers with details of the course completion rates and individual staff compliance details. Some staff were trained in some 'train the trainer' which enabled the trainers to provide onsite training to staff. All staff had regular professional development meetings with senior management and we saw evidence of meaningful and relevant professional development discussions and plans which were documented in individual staff records.

Staff told us that the hospital management team were approachable and visible and during interviews with staff they told us they had confidence to speak with management if they needed to raise issues or concerns. In addition, regular staff meetings were taking place which provided staff with opportunities to have discussions and share information amongst the teams.

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. It was positive to see that the hospital did not rely on the use of agency staff, meaning that there was continuity and consistency of staff around patient care. The hospital had also developed community links with the local universities

which had resulted in student nurses attending the hospital for student placements, which often resulted in the students returning to work at the hospital.

Staff told us they could access additional and relevant training when approved by their line manager which was recorded on the training spreadsheets that we saw. It was positive to see that external training opportunities were given to staff which enabled staff to gain additional qualifications. The clinical lead was currently undertaking a research project in developing further approaches to aggressive behaviours which was supported and funded by the hospital.

There was a supervision structure in place and staff confirmed that they had regular supervision sessions. Staff also spoke positively about group supervision and reflective practice sessions. Through looking at patient records, specifically when considering the administration process around the mental health act, we would strongly recommend that the hospital director ensures that training provisions are provided to staff.

Improvement needed

The registered provider must make sure that measures are 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

It was evident that there were systems in place to ensure that recruitment followed an open and fair process. Prior to employment staff references were received, Disclosure and Barring Service (DBS) checks were undertaken and professional qualifications checked.

Therefore we were assured that recruitment was undertaken in an open and fair process.

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

The hospital had a clear policy in place for staff to raise any concerns, this was displayed in the staff room area. Occupational health support was also available to staff and staff spoke highly of the welfare support provided by the management team.

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
We found that some items within the first aid kits at Delfryn Lodge were missing and 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 out of date equipment in the first aid kits to be replaced
We also found that some medical items were out of date in the clinical area in Delfryn Lodge	This meant that out of date items may pose a risk to patient's safety.	This was brought to the attention of nurse in charge	Arrangements were made for these items to be disposed of and replaced.

Appendix B – Improvement plan

Service: Cygnet Behavioural Health Limited

Ward/unit(s): Delfryn Lodge , Delfryn House & Rhyd Alyn

Date of inspection: 30 September and 1, 2 October 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 registered provider must make sure smoking cessation advice is displayed on hospital wards.	3. Health promotion, protection and improvement	Smoking cessation is discussed in monthly physical health reviews. We have now put in place posters around the units offering support.	Shani Tanti	Completed
The registered provider must display information about the role of Healthcare Inspectorate Wales and how to contact us for patients and visitors at the hospital.	9. Patient information and consent	Information about HIW is in the patients hospital guide and in receptions.	Shani Tanti	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		When reading the patient's rights additional sheet to be attached giving information.		
Delivery of safe and effective care				
The registered provider must make sure that alternative and appropriate storage is found for clean mops.	13. Infection prevention and control (IPC) and decontamination	Alternative storage has been sought.	Shani Tanti	Completed
The registered provider must review their processes around controlled drugs keys and clinical keys being stored on the same bunch.	15. Medicines management	Reminder has been sent out to all nurses regarding keeping of the keys separate. Monitoring by HOC. When there is only one nurse at night, the keys will be kept in separate pockets.	Shani Tanti Heads of Care/	Completed
The registered provider must make sure that all medical items stored in the clinical area are in date.	15. Medicines management	All items inspected on a weekly walk around by the Heads of Care. This is also monitored by the Deputy and Hospital Directors.	Shani Tanti Suzanne Duff Heads of Care	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must make sure that the first aid kits are stocked appropriately and checks are undertaken to make sure all items are in date.	16. Medical devices, equipment and diagnostic systems	All items inspected on a weekly walk around by the Heads of Care. This is also monitored by the Deputy and Hospital Directors.	Shani Tanti Suzanne Duff Heads of Care	Completed
The registered provider must use Welsh Government patient leaflets for reading patients their rights under the act	Records management	Welsh Government leaflets are now given out when rights are read.	Shani Tanti Mental Health Act Administrators	Completed
The registered provider must make sure that patients records contain information on the role of HIW	Mental Health Act	Additional leaflet devised attached to the Rights forms, providing information on the role of HIW and contact details. The information is also in the Statement of Purpose and in the Patient Guide.	Shani Tanti Mental Health Act Administrators	Completed
The registered provider must make sure that the detention papers are medically scrutinised before admission	Mental Health Act	MHA are requesting medical scrutiny paperwork prior to admission on all new admissions Additional checklist added to current forms.	Shani Tanti MHA Administrators	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must review their administration processes to ensure compliance with the Codes of Practice for Wales (Revised 2016) and provide further training to equip staff with a greater understanding of the Mental Health Act and the Code	Mental Health Act	Staff responsible will attend peer group sessions within the Welsh trusts and the Welsh MHA forums twice a year. Staff have also been offered to work alongside the MHA inspector, this will be arranged in the New Year.	Shani Tanti MHA Administrators	Completed February 2020
The registered provider must make sure that unmet needs are evidenced and documented within patient care plans.	Care Planning	Request has been made to the Data Systems team to add an Unmet Needs section to the on-line careplan system.	Shani Tanti	January 2020
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 out their duties.	Mental Health Act 1983	Staff responsible have attended Peter Edwards Law training on the 7th September. Staff attend HIW away days twice a year.	Shani Tanti MHA Administrators	Completed

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: **12th November 2019**