Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
Delfryn House & Lodge
Activity date: **10 August 2020**

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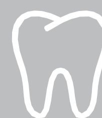

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Delfryn House & Lodge in Mold as part of its programme of assurance work.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Care Standards Act 2000, Independent Health Care (Wales) Regulations 2011 and other relevant regulations. Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks capture a snapshot of the standards of care within healthcare settings. This quality check focussed on four key areas: COVID-19 arrangements; environment; infection prevention and control; and governance. More information on our approach to inspections can be found here.

We spoke to the registered manager on 10 August 2020 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How are you ensuring that the environment is safe and suitable for the needs of patients at this time? What changes, if any, have been made to the physical environment, ward routines and patients' access to leave as a result of COVID-19?
- How is the risk of infection assessed and managed to keep patients, visitors and staff safe?
- Considering the impact of COVID-19, how are you discharging your duty of care against the Mental Health Act and how are patients' rights being safeguarded?
- How are you ensuring that there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed?

COVID-19 arrangements

During the quality check, we considered how the service has responded to the challenges presented by COVID-19; what changes they have made to ensure they can continue to provide a safe, effective and person centred service. We reviewed key policies, including the use of personal protective equipment (PPE).

The following positive evidence was received:

We were told the service had no reported cases of COVID-19 or any other infectious diseases. We saw evidence of policies and procedures to ensure staff have up to date guidance regarding COVID-19 arrangements. Training specific to COVID-19 had also been delivered to all staff.

Documents we reviewed showed that infection control audits completed in June 2020 confirmed scores of 'excellent' across all wards, with the Lodge obtaining 100% compliance.

The hospital manager confirmed weekly audits were completed which include the availability of PPE supplies. Any items required can be obtained within a 24 hour period. We were told that PPE is used by all staff and visitors. PPE items are available for patient use.

We were told the cleaning arrangements for all patient and staff areas had increased to every two hours. Patient mealtimes have been spaced out alongside the removal of some chairs and tables to support social distancing measures.

Posters regarding hand washing and hand sanitiser are available in all wards.

We saw evidence that patient meetings incorporated a COVID-19 update from staff to ensure they remained informed about current guidelines and are able to voice any concerns or ask questions around COVID-19. Staff have received regular emails, which have included links to videos on how to put on and remove PPE. This is in addition to training, written policies, procedures and posters in the hospital. The regular communication has ensured everyone has up to date advice and guidance on COVID-19.

The following areas for improvement were identified:

No areas for improvement were identified.

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments, incident reviews and use of restraint and seclusion. We also questioned the setting on the changes they have made to make sure patients continue to receive the care and treatment according to their needs.

The following positive evidence was received:

We were told of the changes made to the environment as a result of COVID-19 and these

include increasing the cleaning of all patient and staff areas every two hours. There are two mealtime sittings to help manage social distancing. The hospital has access to some large meeting rooms which ensure face to face meetings can take place at safe distances.

Wi-Fi has been installed and extra devices purchased to enable patients to maintain contact with family and friends. Telephone and video calls were used to ensure patients still had access to professional services, including advocacy in relation to their care and treatment. To ensure patients remained in contact with their external services/teams, we were told that virtual meetings were conducted with care coordinators and funders. They were invited to ward reviews and weekly calls to ensure the service has provided relevant updates in relation to patient experiences and service provision throughout lockdown.

Due to lockdown restrictions, patient leave was initially restricted. We were told staff were able to facilitate hospital ground leave for patients to ensure exercise and time away from the ward. This was facilitated in line with patient risks. The registered manager sourced additional garden furniture for around the grounds for patients to access whilst utilising their leave.

The hospital is currently supporting family visits, within the grounds, and a protocol has been devised. Letters have been sent to families to provide updates with regards to visits and the protocol to follow for booking these. PPE is offered to family members for the duration of their visits and a recording sheet for visitors was implemented. As restrictions have been reviewed, staff at Delfryn have been able to review patient leave and can now provide community access/home leave (where applicable).

Following discussions with the hospital manager and a review of submitted documentation it was clear that any patient with an infectious disease would be managed appropriately in line with their policies and procedures.

The following areas for improvement were identified:

No areas for improvement were identified.

Infection prevention and control

During the quality check, we considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments.

The following positive evidence was received:

We reviewed documents which reflected that an infection control policy plus a suite of other supporting policies and procedures to ensure the health of staff, patients and visitors are safeguarded through compliance with relevant legislation and guidance. In addition to

these, a COVID-19 policy plus supplementary procedures have been introduced.

We were told staff have increased cleaning throughout the hospital for all patient and staff areas alongside the implementation of PPE stations upon entering each ward.

We were told of systems and procedures which were in place to identify any staff or patient who may be at risk of developing COVID-19. An introduction to daily temperature checks for patients was commenced in conjunction with each patient having a COVID-19 care plan in line with government guidelines. In addition staff temperatures are taken and documented on a daily basis. Risk assessments have been completed for all staff. Depending on the score, the organisation will determine if the staff member needs to isolate or be removed from patient areas.

The hospital manager told us that training relating to COVID-19 was implemented as part of the on line training system for all staff to complete. The training statistics provided show 85% compliance at the House and 92% at the Lodge. A COVID-19 liaison lead was identified for the service.

We saw documents which reflected that audits are in place to assess and manage the risk of infection. HIW were informed that there has been no cases of COVID-19 but the hospital manager described the processes in place to barrier nurse any patient with an infectious disease.

The following areas for improvement were identified:

No areas for improvement were identified.

Governance

As part of this standard, HIW considered how the setting ensures there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed.

We also questioned the setting about how, in light of the impact of COVID-19, they are continuing to discharge their duty of care against the Mental Health Act and safeguarding patients' rights.

The following positive evidence was received:

We saw evidence of an infection control policy plus a suite of other supporting policies and procedures that ensure the health of staff, patients and visitors are safeguarded through compliance with relevant legislation and guidance. In addition to these, we saw evidence of a COVID-19 policy plus supplementary procedures that have been introduced.

We were told staff have increased cleaning throughout the hospital for all patient and staff areas alongside the implementation of PPE stations upon entering each ward.

The registered manager told us there are systems and procedures in place to identify any staff or patient who may be at risk of developing COVID-19. An introduction to daily temperature checks for patients was commenced in conjunction with each patient having a COVID-19 care plan in line with government guidelines. In addition staff temperatures are taken and documented on a daily basis. Risk assessments have been completed for all staff. Depending on the score, the organisation will determine if the staff member needs to isolate or be removed from patient areas.

Training relating to COVID-19 was implemented as part of the on line training system for all staff to complete. The training statistics provided show 85% compliance at the House and 92% at the Lodge. A COVID-19 liaison lead was identified for the service.

We saw evidence of audits which assess and manage the risk of infection. We were told that there had been no cases of COVID-19 but the hospital manager described the processes in place to barrier nurse any patient with an infectious disease.

The following areas for improvement were identified:

No areas for improvement were identified.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the below:

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
- Ensure required evidence against stated actions is provided to HIW within three months of the Quality Check.

As a result of the findings from this quality check, 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.

Improvement plan

Setting: Delfryn House & Lodge

Date of activity: 10 August 2020

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.
Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	No improvements were identified				
2					
3					
4					

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.

Name:

Date: