Independent Mental Health Service Inspection (Unannounced)

Delfryn Lodge - Cygnet

Behavioural Health Limited

Inspection date: 22 – 24 March 2021

Publication date: 25 June 2021

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

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

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-80195-556-0

Contents

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 Lodge on the evening of 22 March and following days of 23 and 24 March 2021.

The following sites and wards were visited during this inspection:

- Delfryn Lodge

Our team, for the inspection comprised of two HIW inspectors and two 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 Act.

The purpose of this inspection was to gain assurance on whether sufficient attention is being given by the registered provider on the following areas:

- Patient Care
- Infection prevention and control
- Safeguarding
- Staffing
- Governance and leadership

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 staff interacting with patients respectfully throughout the inspection.

Staff were positive about the support and leadership they received.

Patients had good access to education, psychology, occupational therapy and community activities.

Improvements are required in some areas of medicines management and mandatory training compliance.

This is what we found the service did well:

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

This is what we recommend the service could improve:

- Some areas of medicines management required improvements
- Completion and monitoring of mandatory training and staff appraisals.

There were no areas of non-compliance identified at this inspection that presented an immediate risk to patient safety.

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 inspection specifically focussed on Delfryn Lodge, this was due to the Coronavirus pandemic (COVID -19) and the need to reduce the number of people attending the hospital to minimise any risk to patients and staff in other areas of the hospital.

The service employs a staff team which includes a Hospital Director, a newly appointed Registered Manager, a team of registered mental health nurses, and also a multi-disciplinary team members which include consultant forensic psychiatrists, clinical psychologists and occupational therapists.

The day to day operation of the hospital was supported by dedicated teams of administration staff, maintenance team and catering and domestic 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.

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 in Delfryn Lodge, to aid patients' rehabilitation.

Health promotion, protection and improvement

Delfryn Lodge had a range of well-maintained facilities to support the provision of therapies and activities. These facilities included a sensory therapy room, 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 and a beauty therapy room where patients could receive beauty treatments. 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 were very enthusiastic about their roles and were keen to tell us about the activities they had planned in conjunction with patients and explained how activities had to be adapted and changed due to the coronavirus pandemic (COVID–19). 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 healthcare assessments and monitoring.

Smoking was not allowed within the hospital buildings, however patients did have access to designated smoking areas located in the garden.

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.

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.

Hospital policies and the staff practices we observed contributed to maintaining patients' dignity and enhancing individualised care at the hospital. There were regular ward meetings to review and discuss practices to minimise the restrictions on patients in Delfryn Lodge based on individual patient's risks.

It was also positive to note that staff had documented and understood individual patient preferences for interventions to manage their challenging behaviours. Through our conversations with patients and staff we were informed that, where possible, these advanced preferences were followed which helped maintain patients' dignity and wellbeing.

The registered provider’s statement of purpose also described how hospital staff would support patients in ways which would maintain their privacy and dignity.

Delfryn Lodge had suitable rooms for patients to meet ward staff and other healthcare professionals in private.

There were suitable arrangements for telephone access in Delfryn Lodge so that patients were able to make and receive calls in private. Depending on individual risk assessment, patients were able to have access to their mobile phone. Patients signed a mobile phone contract with the registered provider to agree to terms of use to confirm that the mobile phone would not be misused and to allow staff to monitor mobile phone use and content.

At the time of our inspection no visitors were allowed at the hospital due to Welsh Government restrictions associated with the Coronavirus (COVID-19) legislation. However patients could maintain contact with family and friends through virtual technology. We were told that Wi-Fi access within the hospital had been an issue however this had since been resolved and patients were able to access the newly improved Wi-Fi system.

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.

All patients we spoke with, stated that they felt safe and able to speak with a staff member should they need to. Patients told us they were happy at the hospital and that staff were kind and helpful. There was clear mutual respect and strong relational security between staff and patients.

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

There were a number of meetings that involved patients and staff, these included formal individual care planning meetings and group community meetings. We attended a number of clinical meetings and it was evident that discussions focused on what was best for the individual patient.

During meetings we attended, we observed staff having meaningful discussions and debates on patient care. This demonstrated that all staff views were considered and taken into account in order to reach the best outcome for the patients 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.

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).

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. Our findings showed 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. Mental Health Act detention papers had been completed correctly to detain patients at the hospital.

Citizen engagement and feedback

There were regular patient meetings and surveys to allow for patients to provide feedback on the provision of care at the hospital.

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 registered manager was already a familiar face to the patients and would meet with patients as and when the patient requested in order to discuss any concerns or issues the patients may have. We were told that the registered manager also spent time on the wards speaking with patients and would also help staff with some tasks on the wards. This demonstrated that the registered manager supported staff and had managerial oversight of how the ward operates.

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.

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 staff were completing clinical processes and documentation as required.

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.

Legal documentation to detain patients under the Mental Health Act was compliant with the requirements of the legislation.

Improvements are required in relation to some areas of medicine management.

Managing risk and health and safety

Delfryn Lodge had processes in place to manage and review risks and maintain health and safety at the hospital. The hospital provided individualised patient care that was supported by least restrictive practices, both in care planning and hospital or ward 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.

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.

During discussions with staff, we were told that staff had noticed that the patient group were becoming more violent and aggressive towards each other. Staff felt that this was because of the COVID-19 lockdown rules and patients being

unable to leave the hospital. The Psychology Department were assisting both staff and patients by establishing a support group around COVID-19. We were told that staff and patients attended this group and early feedback was positive.

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

Infection prevention and control (IPC) and decontamination

A system of regular audit of infection control arrangements was described. This was completed with the aim of identifying areas for improvement so that appropriate action could be taken where necessary. 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.

There were suitable arrangements in place for the disposal of clinical waste. Appropriate bins were available to dispose of medical sharp items, these were not over filled.

We saw evidence to confirm that Delfryn Lodge conducted necessary risk assessments and updated relevant policies and procedures to meet the additional demands of the COVID-19 pandemic. Staff we spoke to were aware of infection control obligations. We also examined COVID-19 documents which had been produced to support staff and ensure that staff remained compliant with policies and procedures.

Anyone entering the hospital had their temperature checked and recorded and hand washing facilities were available for all staff and visitors to use prior to entering the hospital areas.

Delfryn Lodge had areas set aside where if a patient became symptomatic they could be isolated and barrier nursed in their bedroom within a protected area. Additional cleaning schedules were also in place. None of these areas were in use at the time of inspection because there were no symptomatic cases.

Regular communication via meetings, information boards, and emails ensured everyone has up to date advice and guidance on COVID-19.

During our discussions no issues were highlighted in relation to access to Personal Protection Equipment (PPE). PPE including masks and gloves were available at the ward entrance with bins were provided for the disposal of equipment. Staff were wearing masks in communal areas and throughout ward.

Generally we observed the hospital to be visibly clean and free from clutter, however there are some areas of the hospital that required improvements. On the first night of our inspection we noted 3 black bags of rubbish near the stairway corridor of the first floor bedrooms. Patients' belongings were also stored in the I.T. room. These areas and items had been cleared when we arrived for the inspection the following day. We also identified a notice board on the ground floor of Delfryn Lodge which required replacing and some plastering around the framework of a bedroom door on the first floor required re-plastering.

Improvement needed

The registered provider must make sure that:

- Rubbish bags are not stored along the corridors of the first floor
- I.T. room or any other room utilised by patients is not used to store patient belongings
- The broken notice board on the ground floor is fixed or replaced.
- Plastering around the framework of the bedroom door on the first floor is completed.

Nutrition

We found that patients were provided with a choice of meals. We saw that the menu was varied and patients told us that they had a choice of what to eat. Staff told us that patients with specific/special diets were catered for, including vegan, gluten intolerant and religious requirements.

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.

We reviewed care records and confirmed that assessments of patients' eating and drinking needs had been completed. Patient records documented specific

individual dietary needs to maintain sufficient nutrition and fluid consumption, and monitoring documentation we reviewed was completed appropriately.

Medicines management

We reviewed the hospital's clinic arrangements and found that on the whole medicines management was safe and effective. Medication was stored securely with cupboards and medication fridges were locked. There was regular pharmacy input and audit undertaken that assisted the management, prescribing and administration of medication at the hospital. There was also a process in place if emergency medication orders were required.

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

There were appropriate arrangements in place on the ward for the storage and use of Controlled Drugs and Drugs Liable to Misuse. Records viewed evidenced that twice daily checks were conducted with the appropriate nursing signatures certifying that the checks had been carried out. However 3 records we viewed were not countersigned.

In addition, some medication charts did not contain further explanations as to why medication had not been administered. It is important that any refusals of medication are recorded. The Registered Provider must make sure that medication charts are countersigned and non- administrations of medication is recorded accurately.

The Medication Administration Records (MAR Charts)[1] reviewed recorded all patient details on the front and subsequent pages, their Mental Health Act legal status and all consent to treatment forms were also present with the charts.

A Medication Management Policy was available in the clinic, however only three staff had signed this to confirm that they were familiar with the policy. The

[1] A Medication Administration Record is the report that serves as a legal record of the drugs administered to a patient by a health care professional. The Medication Administration Record is a part of a patient's permanent record on their medical chart.

Registered Provider must make sure that all staff have signed this policy to confirm that they understand the policy and are familiar with the content.

It was positive to note from the records we reviewed that we did not see any excessive use of antipsychotic or PRN[2] medication, and when PRN was used the reasons were recorded in patient records.

We observed a number of medication rounds, and saw that staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately.

Improvement needed

The registered provider must ensure that:

- Controlled Drugs and Drugs Liable to Misuse are at all times accurately signed for by staff
- Reasons for non-administration of medication is accurately recorded on medication charts
- All staff sign the Medication Management Policy.

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 registered manager he explained how he had started to develop good working relationships with multi agency partners such as the Police and Local Authority. We were told that meetings were arranged on a monthly basis to discuss issues at the hospital and compile working protocols on Police attendance at the hospital. This collaborative approach is key to effective safeguarding processes and demonstrated that the hospital placed a strong

[2] PRN Medication is administered as and when required as opposed to medication administered at regular times

emphasis on safeguarding their patients and working with others to prevent and minimise harm.

Medical devices, equipment and diagnostic systems

There were regular clinical audits undertaken at the hospital and we saw evidence of regular auditing of resuscitation equipment. Staff had documented when these had occurred to ensure that the equipment was present and in date.

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

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.

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 showed each patient had an individualised restraint reduction plan in place which identified the least restrictive options for risk management.

We noted good evidence of the use of de-escalation techniques and recognition of triggers in the documentation we inspected. Debriefs take place following incidents and this process is used as a learning and reflective practice technique supported by psychology.

For every restraint or verbal de-escalation an incident form is completed; the incident is then discussed at governance meetings and any lessons learnt are shared with staff.

Records we viewed indicated that there had been a reduction in incidents over the past three months. The registered manager told us he would be implementing a new, more robust, method of reviewing incidents through the hospital’s

governance process to establish if there are any re-occurring themes to prevent incidents from escalating.

Participating in quality improvement activities

The Psychologist at the hospital recognised that the COVID-19 pandemic had a huge impact on both staff and patients at the hospital and as a result had set up sessions for patients and staff to have access to different types of therapies. These sessions were solution focussed to help them understand and find coping techniques to deal with the addedd stress and anxiety of the pandemic. This work will also form part of a wider research project.

Information management and communications technology

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

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 from Delfryn Lodge. We identified five separate patient records during the inspection. While the location of the information was clearly recorded (in one file) and records were generally easy to navigate, care should be taken to ensure that the records are kept up to date and that relevant information is always stored in the correct place.

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 on Delfryn Lodge, all records were found to be compliant with the Mental Health Act and Code of Practice. However we did note an admission error on one patient's

record who is no longer a patient at the hospital. It was positive to note that the mental health act administrator picked up on this issue.

Electronic documents on the ward and paper records were stored securely and held in the Mental Health Act administrator's office. The records we viewed were well organised, easy to navigate and contained detailed and relevant information.

Robust systems of audit were in place for management and auditing of statutory documentation and the Mental Health Act forms a part of the clinical governance meetings.

All staff have Mental Health Act training as part of the induction programme and specific Mental Health training is part of staff mandatory training modules. The Mental Health Act Manager is also member of the All Wales Mental Health Act Managers' Forum.

We saw that some improvements had been made with regards to Mental Health Act monitoring since our last inspection. Section 17[3] leave forms were completed appropriately, risk assessed, and there was evidence of patient involvement.

All patients are provided with information relevant to their section on admission and patients are introduced to the Mental Health Act Manager. In addition the patients' rights are discussed with them on a monthly basis. There was clear compliance with the Second Opinion Appointed Doctor (SOAD) process, for example timescales and administration had improved significantly and this was evidenced through their audit process.

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

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

The first set of care files we reviewed did not contain individual profile information; individual assessment forms and admission forms were incomplete, even though

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

the patient was three weeks into their admission to the hospital. It was also difficult to navigate the patient's notes and find important information.

The second set of care notes we viewed were maintained to a good standard, entries were comprehensive and in both sets of notes recognised assessment tools were used to monitor mental and physical health.

In the second set of notes there were 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 ward. There was clear evidence of multidisciplinary involvement in the care plans which reflected the domains of the Mental Health (Wales) Measure.

Both sets of care plans clearly stated objectives, and review dates. Risk management plans were also personalised and identified potential triggers for patients, enabling staff to identify changes in behaviours.

Management of patients' behaviours were reflected in both care plans and risk management profile, along with staff training to use skills to manage and diffuse difficult situations. Any restraint that occurred during the previous 24 hours was reported and discussed at the daily meeting and then reviewed through the hospital's clinical governance structure.

It was really positive to see that care files clearly demonstrated patient involvement in care discussions which were patient focussed and signed by the patient. Overall the nursing documentation viewed was very good and physical assessments were well completed.

Improvement needed

The registered provider must ensure that:

- Newly admitted patient care notes are fully completed and all relevant risk assessments are completed and up to date.
- Timescales are reviewed for the collection and recording of basic patient datasets, assessments and risk assessments.

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 observed a committed staff team who had a good understanding of the needs of the patients at the hospital.

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

There was dedicated and passionate leadership displayed by the registered manager and hospital director who was supported by committed multidisciplinary team.

However improvements are required in completion of staff appraisals some topics of mandatory training compliance.

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 registered manager who had recently been appointed into post. The hospital director continued to work on-site alongside the registered manager, both were supported by committed multi-disciplinary teams. The team was a cohesive group of leaders and interviews with them demonstrated that they valued and cared for the staff and patients, and were passionate about their roles and responsibilities within the hospital.

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

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

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helps to promote patient safety and continuous improvement of the service provided.

Workforce planning, training and organisational development

The electronic records provided the senior managers with details of the course completion rates and individual staff compliance details.

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.

During interviews with staff, we were told that there were some occasions when staffing could be an issue, particularly when the registered nurse would be away from the ward in meetings. We were told that the hospital had an ongoing recruitment campaign and a preceptorship nurse was starting at the hospital shortly.

Training figures indicated that the training compliance rates show low in some areas. For example the compliance rates for Emergency First Aid and Ligature Rescue Training were 39% and 45% respectively. In addition compliance with staff appraisals was only at 60 %. We have recognised that face to face training has been difficult due to the pandemic, however improvements are still required in these areas.

We found that staff were committed to providing patient care to high standards when we were present on the wards. Staff spoke positively about the leadership and support provided by the heads of care and the registered manager. It was clear to see through the meetings we attended that staff and patient ideas and opinions were valued. A nominated patient representative also attended governance meetings to ensure that the views and opinions of the patient group contributed to the governance processes at the hospital.

Improvement needed

The registered provider must ensure that:

- There is adequate nursing cover on the ward when nurses are off ward attending meetings
- Mandatory training figures are improved
- Staff appraisal figures are improved.

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.

During interviews with staff it was clear that staff had been adversely affected by the COVID -19 pandemic. The registered provider must ensure that the welfare needs of staff are continually monitored to ensure that staff have access to relevant support through this difficult time. As highlighted in an earlier part of this report the COVID -19 support group will provide additional support for staff and patients.

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 on this inspection.			

Appendix C – Improvement plan

Service: Cygnet Behavioural Health Limited

Ward/unit(s): Delfryn Lodge

Date of inspection: March 22-24 2021

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
Delivery of safe and effective care				
The registered provider must make sure that rubbish bags are not stored along the corridors of the first floor	13. Infection prevention and control (IPC) and decontamination	Communication has gone out to all ward based staff and housekeeping services to ensure that all rubbish is appropriately placed outside in the provided bin. The New Clinical Manager completes a daily walk around to ensure that this is completed. CCTV can be used to monitor if any rubbish is left and the appropriate individual can then be spoken to in	Clinical Manager / Senior Nurses / Ward Staff	Immediately – action complete

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		regards to not following the hospital guidance.		
The registered provider must make sure that the I.T. room or any other room utilised by patients is not used to store patient belongings	13. Infection prevention and control (IPC) and decontamination	Following the Inspection, the Hospital Manager has spoken to the Maintenance Department / Clinical Manager and ward staff to locate additional storage space. New storage cupboards have been purchased and available to appropriately stored patients belonging. As an additional measure, ward staff will be going through the current patient belongings and supporting them to store at their own facilities / families & Friends or identifying which items they no longer want to keep.	Clinical Manager / Senior Nurses / Ward Staff / Maintenance team	Immediately – complete – continue to monitor
The registered provider must make sure that the broken notice board on the ground floor is fixed or replaced	13. Infection prevention and control (IPC) and decontamination	The broken notice board on the ground floor has be raised with Estates and they have fixed the notice board. If there are any further issues with the notice board, a new one will be purchased.	Maintenance team	Immediately - complete

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must make sure that the plastering around the framework of the bedroom door on the first floor is completed	13. Infection prevention and control (IPC) and decontamination	The plastering around the framework of the bedroom on the first floor has be raised with Estates and they have sealed the area. The Clinical Manager (Sian Sorrentino will be taking over in the completion of daily walk around the ward to quality check any areas that needs cleaning and/or repairing.	Maintenance team	Immediately - complete
The registered provider must ensure that Controlled Drugs and Drugs Liable to Misuse are at all times accurately signed for by staff	15. Medicines management	The secondary missing signature has been reviewed and addressed by the Clinical Manager and Speeds Pharmacy. Speeds pharmacy complete a weekly check, including all aspects of medication management and controlled drugs. This is done in partnership with the NIC / Senior Nurse and/or Clinical Manager. This is an additional quality measure to ensure that all medication is appropriately, signed and verified.	Hospital manager / Clinical manager / Nursing staff / Pharmacy	Immediately – complete – to continue to monitor

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that reasons for non-administration of medication is accurately recorded on medication charts	15. Medicines management	To ensure that there are reasons for 'non-administration of medication' is accurately recorded on medication charts. The following processes are in place. • After each shift the nurse in charge checks the medication cards for accuracy. • Speeds pharmacy check the medication cards for accuracy and correct completion. • Specialist Registrar monitors the medication cards for accuracy and to ensure that medication is administered as prescribed. The Clinical manager, spot checks / audits medication cards to ensure that there are no errors / missed signatures.	Clinical manager / Nursing staff / Pharmacy	Immediately – complete – to continue to monitor
The registered provider must ensure that all staff sign the Medication Management Policy	15. Medicines management	The Clinical manager, supported by the Senior Nurses will go through the medication management with all the	Clinical manager / Senior Nurses / Nursing staff	Immediately – complete – to continue to monitor and

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		outstanding and new nurses and ensure that these are signed to confirm they have read and understood the policy.		update new nurses to the ward
The registered provider must ensure that newly admitted patient care notes are fully completed and all relevant risk assessments are completed and up to date	20. Records management	A thorough audit has been completed by the Clinical Manager and Senior Nurse to ensure that all the files are consistent, complete, and up to date and have all the appropriate documentation in. This includes risk assessments, dates completed and a consistent contents page for each patient. Moving forward, following each new admission, the Clinical manager supported by the Senior Nurses and Administration staff will complete a review at week 1, 2 and 4 of new patients care notes. This is to ensure that the file is up to date and has all the appropriate information in and available.	Clinical manager / Senior Nurses / Nursing staff	Immediately – complete – to continue to monitor
The registered provider must ensure that timescales are reviewed for the collection and recording of basic patient datasets, assessments and risk assessments.	20. Records management	As part of the high dependency, clinical model of care, the process for timescales for completion and recording of the	Clinical manager / Senior Nurses / Nursing staff	Immediately – complete – to continue to monitor

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		assessments is outlined. This has been re-circulated around to key professionals. As in point 8 above - *following each new admission, the Clinical manager supported by the Senior Nurses and Administration staff will complete a review at week 1, 2 and 4 of new patients care notes. This is to ensure that the file is up to date and has all the appropriate information in and available.* This will also be monitored during the MDT / CTP / CPA process.		
Quality of management and leadership				
The registered provider must ensure that there is adequate nursing cover on the ward when nurses are off ward attending meetings	25. Workforce planning, training and organisational development	There is a Clinical Manager available 9am – 5pm every Monday to Friday. This will cover the time period when meetings take place. The Hospital Manager is also available during these times. Both the Clinical Manager and/or Hospital Manager have been able, available and willing to either cover the ward or the meeting for the Nursing staff if required.	Hospital manager / Clinical manager / Nursing staff	Immediately – complete – to continue to monitor

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Also, due to staff, there are occasions when there is more than 2 nurses on shift, especially if there is no sickness, annual leave or training on that week.		
The registered provider must ensure that mandatory training figures are improved	25. Workforce planning, training and organisational development	The Mandatory training is a high priority point for the hospital. Key areas such as face to face are now easier to arrange due to a reduction in Covid restrictions. The training stats that we supplied reflected 4 key areas. a) Staff that had received the training b) Staff that had just started and had set dates to complete the training. However, they flag as 'not trained', although still within the time period to complete their training. c) Staff that had not completed their training.	Hospital manager / Clinical manager / Senior Nurses / Admin Department	Immediately – complete – to continue to monitor

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		d) Staff that were not in work, due to LTS, furloughed, maternity/paternity. Unfortunately, this showed a significantly lower training figure than what was reflective of the service. To improve the process, the Hospital Manager has added a Bi-Weekly process to send out training details of all staff that are either out of date or due to go out of date for Mandatory training. This is sent to all Managers / Heads of Departments. This is to ensure that they have the appropriate information and can efficiently and effectively improve the overall training stats for the hospital. This is then reviewed and checked weekly by the Clinical Manager and Hospital Manager, to ensure compliance is reached.		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that staff appraisal figures are improved	25. Workforce planning, training and organisational development	Staff Appraisals is another high priority area for the hospital. A review has taken place, in respects to the following areas to identify staff that need appraisals. e) Staff that had received their Appraisal f) Staff that had just started and will need their appraisal in the future g) Staff that had not received their appraisal. h) Staff that are not in work, due to LTS, furloughed, maternity/paternity. Appraisals will need to be scheduled when they return back. To improve the process, the Hospital Manager has added a Bi-Weekly process (Via the Admin Team) to send out supervision and appraisal of all staff that are either out of date or due to go out of date for their	Hospital manager / Clinical manager / Senior Nurses / Admin Department	Immediately – complete – to continue to monitor

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		appraisal. This is sent to all Managers / Heads of Departments. This is to ensure that they have the appropriate information and can efficiently and effectively improve the overall appraisal percentage for the hospital. This is then reviewed and checked weekly by the Clinical Managers and Hospital Manager, to ensure compliance is reached.		

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): John Bromfield

Job role: Hospital Manager

Date: 14/05/2021