Independent Mental Health Service Inspection (Unannounced)

Aderyn

Elysium Healthcare

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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 Aderyn on the evening of 31 January 2022, and following days of 01 and 02 February 2022.

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.

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. Staff interacted with patients respectfully throughout the inspection.

Safe and therapeutic responses were in place to manage challenging behaviour and promote the safety and wellbeing of patients.

Patient care plans were of a good standard, and patients had good access to occupational therapy and community activities.

We found that improvements were required to aspects of the service, including the overall appearance and the cleanliness of some areas of the hospital.

This is what we found the service did well:

- Staff treated patients with dignity and respect
- Patients could provide feedback to staff about their care in a number of ways
- Established governance arrangements were in place that provided oversight to aid improvement
- Patient records were well maintained and easy to navigate
- The statutory documentation we saw verified that the patients were legally detained.

This is what we recommend the service could improve:

- Changes in the physical health of patients must be monitored and identified promptly
- More information should be provided to patients in relation to healthy living, and how to contact HIW
- The living environment and cleanliness of the hospital site must be improved

- A review of the current attack alarm system is required to ensure it fully protects the safety of staff and visitors
- Staff must work with patients to help them check for out of date food in the occupational therapy kitchen
- Medical equipment must be checked and calibrated when required
- The service must work with relevant mental health service providers to ensure all patients are appointed with a care coordinator.

3. What we found

Background of the service

Aderyn is registered to provide an independent mental health hospital at Penperlleni, Pontypool, NP4 0AH.

The service was first registered in October 2006, and provides a rehabilitation service to a maximum of 19 patients. Aderyn is a male only hospital, and consists of a 17 bedded main building, and a separate flat located in the grounds of the hospital, which provides step-down accommodation for two patients preparing for discharge. At the time of inspection, there were 16 patients in the main building, and two patients in the flat.

The service employs a staff team which includes a hospital director, ward manager, and a team of registered nurses and healthcare support workers. The multi-disciplinary team includes a consultant psychiatrist, psychologist, occupational therapist and a social worker. The hospital is supported by a team of administrative, catering, domestic and maintenance staff.

At the time of the inspection, the hospital was being managed by Elysium Healthcare.

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 treating patients with dignity and respect.

Patients had access to a range of suitable activities and therapies at the hospital, and within the community, to aid their rehabilitation.

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

Health promotion, protection and improvement

During the inspection we saw evidence that physical assessments had been undertaken on patients upon their admission. We were told that a physical health nurse attends the hospital twice a week to monitor and assess patients throughout their stay. However, we noted during our review of patient records that some physical health care plans had not been kept up to date with required checks, for example, the recording of latest National Early Warning Scores[1] (NEWS). We understand that some patients decline such checks, but ongoing monitoring is important to promptly identify changes in the health of patients. The service should also consider increasing the physical health nurse resource to allow an appropriate amount of time to undertake these important physical health care checks.

Patients were able to access health professionals as required, and a GP clinic is held on site every week. An occupational therapist and therapy support

[1] National Early Warning Score (NEWS) is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

worker supported patients to engage in a wide range of group and individualised activities to support and maintain their health and wellbeing.

Staff told us that outside activities such as football, bowls and walks, are scheduled for patients to participate in. Within the gardens there was a horticultural area which included a poly-tunnel for patients to grow fruit and vegetables. However, we saw that there was damage to the poly-tunnel and that it was being used to store inappropriate items such as large wooden pallets.

Many patients regularly use leave from hospital to engage in activities in the community. During the inspection we saw patients visiting the local shops, and staff used the minibus available at the hospital to take some patients to Merthyr for a day trip.

In the conservatory area of the main building there was a pool table and gym equipment for patients to use. We were informed that plans were being developed to install a separate gym within the hospital grounds. This would be a positive step, as some patients we spoke with told us that they wanted strength and weight training equipment to be made available to use at the hospital.

Patients had access to a smoking area within the courtyard adjacent to the main building. We were informed that an action plan was currently being developed to make the hospital smoke-free from 01 September 2022. Smoking cessation leads have been identified at the hospital as part of the action plan to encourage and support patients to stop smoking ahead of the change coming into force.

Improvement needed

The registered provider must ensure that ongoing physical health checks on patients are undertaken as required to ensure any changes in the health of patients is identified promptly.

The registered provider must improve the upkeep of the poly-tunnel in the horticultural area.

Dignity and respect

Throughout the inspection we observed staff treating patients appropriately and with dignity and respect. The staff we spoke with demonstrated a good level of understanding of the patients they were caring for. Staff showed a responsive

and caring attitude by taking the time to speak with patients to understand their needs or any concerns patients raised.

Each patient had their own en-suite bedroom, which provided a good standard of privacy and dignity. Patients were able to store possessions and personalise their rooms with pictures and posters. During the inspection we saw many examples of staff respecting the privacy of patients by knocking their door before entering. Patients could lock their rooms, but staff could override the locks if required.

Suitable rooms were available for patients to meet staff and other healthcare professionals in private. Patients were encouraged to meet family and visitors within the community as part of their rehabilitation. However, suitable visiting arrangements were in place for patients to also meet visitors at the hospital.

The majority of patients had use of their own mobile phone, but a telephone was available in the corridor of the main building for patients to use if required.

Patient information and consent

A patient information guide was available to patients and their relatives/carers that described what they can expect from their stay at the hospital. The registered provider's statement of purpose[2] also described the aims and objectives of the service. We saw that both documents were up to date and contained all the relevant information required by the regulations. Registration certificates from HIW were on display in the entrance area of the main building.

There was a patient status at a glance board[3] in the staff office in the main building that displayed sensitive information regarding each patient being cared for at Aderyn. The location of the board meant that it was out of sight of patients and visitors, which helped protect patient confidentiality.

[2] A statement of purpose is a legally required document that includes a standard set of information about a provider's service.

[3] A board that provides staff with a quick reference to essential information about the individual patients being cared for at the hospital.

Patient information was displayed throughout the corridor of the main building. This included details about how patients could contact, and access, advocacy services and about how patients could raise a complaint. However, limited information was available for patients on health promotion, such as healthy eating guidance. We also noted that no information was displayed about the role of HIW, or how patients could contact the organisation should they wish.

Improvement needed

The registered provider must display more information for patients about how to make positive decisions about their health, and about how to contact HIW.

Communicating effectively

We saw staff communicating appropriately and effectively with patients. We observed staff displaying patience by stopping to speak to patients irrespective of other commitments they may have been dealing with at the time. The patients we spoke with said that staff were kind and helpful, and that staff were available to talk to.

Daily planning meetings were being held every morning to discuss upcoming activities within the hospital and the community, and other relevant information, such as tribunals and medical appointments. Weekly community meetings were also being held and chaired by staff. These meetings provided patients with the opportunity to provide feedback on the care received at the hospital and discuss any developments or concerns. We saw minutes of previous community meetings which showed that staff were keeping patients informed of what actions had been taken in response to issues that had been raised.

A handover meeting was being held every weekday morning for senior nursing staff to update the multi-disciplinary team (MDT) on any concerns, issues or incidents that had taken place the day before. We attended a handover meeting during the inspection and saw that staff demonstrated a good level of understanding of the patients they were caring for, and that discussions focused on what was best for the individual patient.

Care planning and provision

Aderyn provides patients with a locked rehabilitation environment to prepare them for discharge to a less secure environment. We found there was a focus on providing programmes of care based on the individual needs of patients, and supported by least restrictive practices.

The care plan we reviewed during the inspection focussed on setting individual recovery, rehabilitation and independence goals that would support the patient towards discharge from the hospital. We saw evidence of regular MDT involvement in the development of the care plan and subsequent reviews. There was also a record of discussions held about discharge and aftercare planning.

We saw that the contact details of relatives / carers had been identified where appropriate to do so, and that they had been involved in the development of the patient's care plan.

Equality, diversity and human rights

During the inspection we looked at the patient records of four individuals that had been detained at the hospital under the Mental Health Act (the Act). We found that legal documentation we reviewed was compliant with relevant legislation, and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code). Further information on our findings on the legal documentation is detailed in the Mental Health Act Monitoring section of this report.

The hospital had policies in place to help ensure that patients' equality and diversity were respected, and their human rights maintained. Regular discussions took place between the MDT to review and discuss practices to minimise the restrictions on patients based on individual patient risks.

We were told a mental health advocate regularly visits the hospital to provide information and support to patients with any issues they may have regarding their care. The patients we spoke with confirmed that they are aware of the advocate that visits the hospital, and told us that they had also received leaflets in relation to the advocacy service.

Citizen engagement and feedback

We found patients could engage and provide informal feedback to staff on the provision of care at the hospital in a number of ways. The hospital identifies patient representatives whose role is to be a point of contact for other patients to talk to about any issues they may have. The role is rotated regularly to allow all patients the opportunity to be the patient representative during their stay at the hospital. During our inspection we observed the patient representative chairing the daily planning meeting and feeding back issues to staff. We noted this as a positive way of encouraging patients to participate in these meetings.

We were told that annual surveys are issued to patients and their relatives / carers to also help identify any improvements. Patients also have weekly individual meetings with an allocated primary nurse, which is another opportunity for patients to provide informal feedback about their care.

Delivery of safe and effective care

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

Patient care plans were being maintained to a good standard and in line with the criteria set out in the Mental Health (Wales) Measure.

Staff were committed to providing safe and effective care and we observed the multidisciplinary team working well together to provide individualised care.

Robust procedures were in place to help control the risk of infection from COVID-19. However, improvements are needed in relation to the maintenance, upkeep and cleanliness of the hospital site to ensure the environment, furniture, fixtures and fittings are appropriate for the patient group.

A review of the current attack alarm system was also needed to ensure it is working appropriately to protect the safety of staff and visitors at the hospital.

Managing risk and health and safety

Overall, we were assured that Aderyn had processes in place to manage and review risks to help maintain the health and safety of patients, staff and visitors at the hospital.

The hospital entrance was secured to prevent unauthorised access. Access to the main entrance outside was via some stairs, but an accessible ramp was located at the side of the property. The main building was split over two floors, and a lift and a stairlift were available to assist people with mobility difficulties.

We saw that a wide range of up-to-date health and safety policies were available for staff. A health and safety lead had been appointed at the hospital whose role was to undertake audits and attend regular corporate health and safety meetings organised by Elysium Healthcare. We were told that any learning from the corporate meetings is shared with staff at the hospital at monthly clinical governance meetings.

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 a number of ligature cutters located throughout the hospital for use in the event of a self-harm emergency.

The hospital director informed us that they personally undertake a weekly informal check of the environment, and complete a documented checklist monthly. The monthly check is undertaken alongside the patient representative, which we noted as a positive initiative. We reviewed a previously completed environmental checklist and found that it was comprehensive and included updates on progress with identified actions.

While the ground floor of the main building had recently been repainted, we found many other areas of the hospital were also in need of redecoration and maintenance. This included the communal coffee lounge, which had recently been damaged, the courtyard, and the general fixtures and fittings of both the main building and the flat within the grounds of the hospital. We were told that funding had been allocated to repair the coffee lounge, continue painting upstairs and to replace the furniture in one of the main communal lounges. The hospital director acknowledged the need to also improve the outlook of the courtyard, replace the carpets, communal toilets and en-suite bathroom floors and refurbish the flat. These improvements would considerably enhance the living environment for patients at the hospital.

During our tour of the hospital we were told that some patients currently have a lot of possessions stored within their bedrooms, including electrical items that could cause an overload on sockets. The hospital director informed us that this has been escalated centrally and that a corporate policy is being developed to outline the procedures to safely store patient property. However, in the meantime, the service must identify and mitigate against any current health and safety or fire risks posed by this issue to ensure patients are protected while the policy is being developed.

During the inspection we noticed that some electrical items that had been recently purchased for the coffee lounge had not been checked beforehand to ensure they were safe to use. We spoke to the hospital director about this who immediately arranged for a staff member to undertake Portable Appliance Testing (PAT) on the items.

There were nurse call points around the hospital and within patient bedrooms so that patients could summon assistance if required. During the inspection we observed that when a nurse call point was activated there was an immediate response by staff to assist.

We noted that staff wore radios to call for assistance if required, instead of personal attack alarms. This was in line with the policy on the use of attack alarms and the nurse call system. The policy also stated that visitors would be issued with attack alarms. However, we were informed by some members of staff that they wore radios because the attack alarms were not always effective, or reliable. We recommend the service undertakes a review of the current attack alarm system used at the hospital to ensure it is appropriate, suitable and responsive when operated to ensure the safety of staff and visitors at the hospital.

Improvement needed

The registered provider must continue with the maintenance programme of improvements at the hospital to ensure the living environment is enhanced for patients residing in the main building and in the flat.

The registered provider must identify and mitigate against any current health and safety or fire risks of excessive patient property within bedrooms to ensure patients are protected.

The registered provided must undertake a review of the current attack alarm system used at the hospital to ensure it is appropriate, suitable and responsive when operated to ensure the safety of staff and visitors at the hospital.

Infection prevention and control (IPC) and decontamination

We found suitable procedures were in place to help control the risk of infection from COVID-19 throughout the hospital. Visitors have to return a negative lateral flow test (LFT) and complete a screening checklist upon arrival, before being admitted. Patients are isolated in a separate observaton bedroom on admission until they return a negative polymerase chain reaction test (PCR). Staff are required to take daily LFTs and random checks were being undertaken to monitor compliance. Personal Protection Equipment (PPE) was available at the main entrance and we observed staff wearing masks throughout the inspection.

We saw that cleaning schedules were in place to document regular cleaning of the hospital. We were told that monthly infection prevention and control (IPC) audits were also completed by the hospital director. However, during our inspection we found areas of the hospital to be unclean and dirty. This included dust on tops of surfaces, dirty oventops in the occupational therapy kitchen, dead plants in the coffee lounge and a build up of cigarette ends in the courtyard. Furthermore, during our tour of the observation room, we noted a

build up of cobwebs and dead insects behind glass panels that were covering the windows. We discussed this with the hospital director and it was positive to see that actions were taken before the end of the inspection to rectify this. However, the service must improve the general standard of cleanliness of the hospital site and ensure that audit activities are appropriately identifying areas of concern in relation to cleanliness and IPC.

During the inspection we saw nursing staff undertaking cleaning duties such as hoovering and changing sheets. The service must ensure that these duties do not impact on the ability of nursing staff to undertake their clinical and therapeutic roles.

We saw a high compliance rate among permanent members of clinical staff for mandatory training in infection prevention and control level one (100 per cent) and level two (95 per cent). However, compliance rates for the same training courses were low among bank members of clinical staff (62 per cent for level one, and 46 per cent for level two).

There were hospital laundry facilities available so that patients could undertake their own laundry with appropriate level of support from staff based on individual need. We noted the washing machine was very old and in need of replacing; the hospital manager confirmed that a new washing machine had already been ordered.

Improvement needed

The registered provider must ensure that the overall standard of cleanliness of the hospital is improved going forward, and that any audits undertaken are effective at identifying cleanliness and IPC issues.

The registered provider must ensure that cleaning duties undertaken by clinical staff do not impact on their ability to undertake their clinical and therapeutic roles.

Nutrition

We saw that patients' dietary needs had been assessed on admission and that measurements such as body mass index (BMI) were being regularly calculated. However, in the care plan we reviewed, we noted that the BMI of the patient had increased recently, yet it was not documented what interventions, or discussions, had taken place around this.

A staffed kitchen is located on site that provides patients with a variety of meals throughout the day. We were told that regular surveys are undertaken to find out patients' views on the food and menu choices. We also observed constructive discussions being held between staff and patients at the weekly community meeting regarding possible changes to the menu.

There were suitable facilities available for patients to have hot and cold drinks and we saw patients accessing these throughout the inspection. An occupational therapy kitchen was available in the main building where patients were encouraged to prepare their own food with assistance from a staff member. During our tour of the occupational therapy kitchen we noticed some items of food in the fridge had exceeded their expiry dates. Patients should be encouraged to regularly check that their fresh produce remains within its expiry date.

We observed patients with Section 17 leave[4] returning to the hospital after undertaking food shopping as part of their rehabilitation activities within the local community.

Improvement needed

The registered provider must ensure that care plans reflect any interventions, or discussions held by the MDT, around fluctuations in the weight of patients.

The registered provider must ensure that staff work with patients to help them check that their food in the occupational therapy kitchen remains within its expiry date.

Medicines management

We reviewed the hospital's clinic arrangements and found that on the whole the management of medicines was safe, but that some improvements were needed.

A policy for the safe storage, control and administration of medicines was in date, and available to staff. However, we noted that the policy outlining the safe

[4] Section 17 leave allows the detained patient leave from hospital.

practices to administer rapid tranquillisation, was beyond its review date of October 2021.

Appropriate bins were available in the clinic room to dispose of medical sharp items and we noted that these were not over filled. We saw that daily temperature checks of the medication fridge and clinic room were being completed to ensure that medication was stored at the manufacturer's advised temperature. During our visits to the clinic room throughout the inspection, we found the medication trolley to be locked at all times, but the medication fridge to be unlocked on one occasion. All fridges must be kept locked to reduce the risk of unauthorised access to medication.

Reviews of medication were being undertaken and discussed and documented in MDT meetings. We reviewed five Medication Administration Record[5] (MAR) charts and found they were being maintained to a good standard. The MAR charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. We found copies of consent to treatment certificates included alongside the MAR charts. However, we identified the following issues during our review:

- The MAR charts were being well scrutinised by an external pharmacist. However, it was not clear to us how guidance from the pharmacist, such as monitoring advice for certain medication, was being acknowledged by nursing staff to ensure such checks were taking place.

- We saw easy read versions of medication information leaflets included alongside the MAR charts. However, we noted that some versions, such as a Lorazepam leaflet, were out of date, and therefore were not based on the most recent available evidence.

[5] 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.

- Similarly, posters on display in the clinic room were not displaying the most up to date guidance for some medication such as anti-psychotics.

- We found that some medication, such as analgesia[6], was prescribed as available to patients on PRN[7] forms and discretionary medication forms. This increased the risk of medication errors, such as providing patients with double the prescribed amount of medication.

Improvement needed

The registered provider must review their Rapid Tranquillisation policy.

The registered provider must remind staff to ensure medication fridges are locked when not being directly used.

The registered provider must ensure that the issues we identified in this report in relation to MAR Charts are rectified going forward.

Safeguarding children and safeguarding vulnerable adults

We found policies and processes in place to help ensure that staff at the hospital safeguarded patients. We were told that safeguarding incidents do not occur often and saw evidence that only three incidents had been referred to external agencies over the previous eight months.

The mandatory training statistics provided by the registered provider showed that 86 per cent of permanent members of clinical staff, and 69 per cent of bank members of clinical staff, had completed training in safeguarding children and adults level three.

[6] An analgesic is a drug used to relieve pain.

[7] PRN medication is a medicine that is usually prescribed, but is not required by the patient on a regular basis, such as paracetamol. It is usually prescribed to treat a short term or intermittent medical condition such as pain or indigestion.

Medical devices, equipment and diagnostic systems

We saw evidence that regular documented checks were being undertaken of resuscitation and emergency equipment to ensure that the equipment was present and in date. However, we noted that some items on the checklist looked to have exceeded their expiry date. We were assured that the items had actually been replaced, but that the checklist had not been updated with the new expiry dates. The service must take care to ensure the checklist is amended with the new expiry dates of recently purchased items. We also noted that the checklist did not record the content level of the oxygen cylinders. The service may wish to consider adding this measurement to help identify when the oxygen cylinders are running low.

We were told that all medical equipment at the hospital is calibrated yearly to ensure it is taking accurate readings and measurements. However, we saw that labels on the medical equipment indicated that they were due to be next calibrated in December 2021. The service must take action to ensure that all medical equipment is checked and calibrated when required.

The clinic room and medical equipment appeared clean. However, there was no record of cleaning or decontamination undertaken between each use of the equipment, for example the manual blood pressure monitor. The service may wish to consider creating a cleaning checklist to evidence that the medical equipment has been decontaminated after every use.

Improvement needed

The registered provider must ensure that all medical equipment is checked and calibrated when required.

Safe and clinically effective care

The hospital had a policy in place that promoted the safe and theraputic management of challenging behaviour to help protect the safety and well-being of patients. We were told that staff would observe patients more frequently in line with the safe and supportive observation policy if their behaviour became a cause for concern.

We saw that one bedroom had been set aside for use as a de-escalation / observation bedroom. A policy was in place that described the protocol to be followed to use the room, which included ensuring that the decision had been agreed by the MDT and that an enhanced observation care plan was completed. We were assured by the hospital director that the room would not

be used as a seclusion room and that the door must remain open, or only closed if the patient requested it to be closed. During our tour of the de-escalation / observation bedroom we noted that the bed was located to the side of the door, and was also placed in the corner next to two walls. We discussed this with the hospital director, who agreed to move the bed into the middle of the room in front of the door. This meant that staff would have better access to each side of the bed if necessary, and that observations could be made on patients without opening the door and potentially disturbing the patient if it was closed.

We saw that the use of restraint was documented in patient records and recorded on the coporate electronic incident, reporting and information system (IRIS). We noted that incidents of restraint are discussed at the monthly clinical governance meetings. Positively, we noted that there had been a low number of recent incidents of restraints; seven incidents had been recorded over the past eight months, the majority of which resulted in the use of least restrictive techniques of restraint.

Participating in quality improvement activities

We found arrangements were in place to help assess and monitor the quality of the services and care being provided to patients. Clinical governance information in relation to safety and performance of the hospital was collated by staff at the hospital and submitted to the central team at Elysium Healthcare to be monitored corporately. We were told that learning from other Elysium Healthcare settings was shared to ensure a consistent approach to improvement.

Information management and communications technology

Throughout the inspection we were shown the electronic systems in place for capturing and recording data such as incidents, clinical audits, and human resources documentation. These systems allowed staff to manage information and data effectively, to maintain business continuity and support and facilitate patient care and delivery.

Records management

Patient records were being maintained electronically. The electonic system was password protected to prevent unauthorised access and breaches in confidentiality. We used the system throughout the inspection and found patient records to be comprehensive and well organised, which made it easy to navigate through the sections.

Further information on our findings in relation to patient records and care plans is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Mental Health Act Monitoring

We reviewed the statutory detention documents of four patients currently residing at the hospital. All records were found to be compliant with the Mental Health Act and Code of Practice. Original documents were being kept in the Mental Health Act Administrator's office and staff at the hospital maintained electronic versions. The documents we viewed were well organised and contained detailed and relevant information.

The Mental Health Act Administrator appeared well organised and was knowledgeable about their role. We found robust systems were in place for managing, auditing and scrutinising the legal documentation.

We saw evidence that patients were being made aware of their rights in relation to their detention at the hospital and that this was revisited regularly to ensure patients continued to have an understanding. Contact details and information about the role of advocacy services was readily available and clearly displayed for patients and their relatives / carers.

We saw that Section 17 leave was suitably risk assessed and determined the conditions and outcomes of the leave for each patient. Positively, we found that good documented discussions had been held with patients to evaluate how the leave went. However, we noted the documentation did not contain a section to highlight whether patients had been offered, or accepted, a copy of their Section 17 leave form.

All staff undertake Mental Health Act training as part of their mandatory training programme. We saw that compliance among permanent members of clinical staff was relatively high at 84 per cent, compliance among bank members of clinical staff was lower at 62 per cent.

Improvement needed

The registered provider must ensure Section 17 leave forms document whether patients had been offered, or accepted, a copy of their leave form.

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

We reviewed the care plan of one patient at the hospital. Overall, the nursing documentation we reviewed was being maintained to a good standard. We found it reflected the domains of the Welsh Measure, clearly stated the treatment plan and described clear objectives that focussed on recovery, rehabilitation and independence.

Unmet needs of the patient were identified, and risk assessments completed that set out the mitigations in place to manage identified risks. There was evidence of multidisciplinary involvement in the development and ongoing review of the care plan we saw.

Interventions described in the care plan were appropriate to meet the needs of the patient and the care plan clearly stated who was responsible for delivering each intervention.

It was positive to see that the care plan demonstrated patient involvement in discussions about their care. However, we did not see evidence that the patient had agreed to the care plan and recommended treatment, or received a copy.

We were told that there has often been difficulty in identifying and obtaining regular input from care coordinators[8]. The Welsh Measure requires a care coordinator to be appointed as soon as reasonably practicable for each person upon becoming a relevant patient. A care coordinator is a key professional for a patient and not having one also places a reliance on hospital nursing staff to take up elements of this role in addition to their substantive duties.

[8] Care coordinators are the principle source of information for patients and are responsible for seeking their active involvement and engagement in the care planning process. They also have a significant role in managing relationships with a wider range of partners in the care and treatment process.

Improvement needed

The registered provider must document whether patients have indicated their agreement with, and received a copy of, their care and treatment plan.

The registered provider must work with relevant mental health service providers to ensure all patients are appointed with a care coordinator.

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.

Established governance arrangements were in place to provide oversight of clinical and operational issues.

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

The hospital director was committed to investigating and taking action to address concerns raised during the inspection in relation to the leadership of the hospital.

Governance and accountability framework

It was positive that throughout the inspection the staff at the hospital were receptive to our views, findings and recommendations.

We found established governance arrangements in place at the hospital level to provide oversight of clinical and operational issues. A series of clinical audits had been scheduled to take place throughout October 2021 to September 2022. This demonstrated the hospital was committed to checking whether care was being provided in line with best practice guidelines to continuously maintain standards.

Agendas for senior management team and clinical governance meetings showed a wide range of standing items to help ensure that the hospital focussed on all aspects of the service. Further oversight of the performance of the hospital is managed corporately through the Elysium Healthcare central governance teams, and we were told that there is open and constructive communication between the hospital director and registered provider. We saw that visits were being undertaken by compliance officers on behalf of the responsible individual to monitor the standard of care being provided at the hospital.

During the inspection some staff members raised concerns with us about the leadership of the hospital. This included poor visibility of senior managers, a lack of communication from senior managers in relation to issues raised by staff and senior staff inappropriately delegating duties to lower grade staff members. We raised these issues with the hospital director who took on board the feedback and assured us that actions would be taken to address the concerns raised.

Improvement needed

The registered provider must provide assurance to HIW on the actions that will be taken to address the concerns raised by some staff members during the inspection.

Dealing with concerns and managing incidents

There was a complaints policy and procedure in place which provided a structure to deal with formal complaints within the hospital. We reviewed the policy and found that the procedures would enable staff to handle any complaints effectively and in a timely manner. We were told that the opportunities for patients to provide informal feedback to staff has meant that the hospital does not handle many formal complaints.

As previously mentioned, an established electronic system was in place for dealing with concerns and recording, reviewing and monitoring incidents. Regular incident reports were produced and reviewed at the hospital level,

We were told that debriefs and reflective practice take place with staff following any incidents. We saw that complaints, incidents and safeguarding issues at the hospital are discussed at clinical governance meetings and are also reviewed at a corporate level, to help identify trends and patterns of behaviour.

Workforce planning, training and organisational development

At the time of our inspection there appeared to be sufficient numbers of appropriately trained staff to meet the assessed needs of the patients at the hospital. From a review of previous staff rotas and from discussions with staff members, it was evident that it has often been a challenge to ensure each shift is fulfilled as required. This has mainly been due to issues from staff sickness throughout the pandemic. We were told that despite the difficulties, no agency staff have needed to be used to fulfil shifts. The hospital director informed us that plans were being developed to increase the staffing establishment during the day, which we welcome as a positive step.

We noted that the MDT personnel had been stable and consistent, but that there was a vacancy for an adult tutor. Being able to participate in educational programmes and acquire new learning and skills is an important benefit to patients at the hospital and the service should ensure this post is recruited to as soon as possible.

We reviewed the mandatory training statistics for staff at the hospital and found that overall, completion rates were relatively high at 79 per cent. However, throughout this report we have identified areas where compliance rates have been lower, particularly in IPC, safeguarding and Mental Health Act training.

We noted that only 30 per cent of staff had received their annual appraisal. However, the hospital director informed us that this was due to a recent change implemented at the hospital, whereby all staff appraisals would subsequently take place in the same quarter, instead of spread throughout the year. We saw that all outstanding appraisals had been booked with staff in line with this change.

Improvement needed

The registered provider should ensure that all staff, including bank staff, complete any outstanding mandatory training as soon as possible.

Workforce recruitment and employment practices

A recruitment policy was in place that set out the arrangements to be followed to ensure recruitment followed an open and fair process. Prior to employment, potential staff must provide references and evidence of professional qualifications. Disclosure and Baring Service (DBS) checks are also carried out, and then renewed every three years, to ensure staff are fit to work at the hospital.

Newly appointed staff receive a period of induction to learn about the hospital, read company policies and complete mandatory training. Staff are assessed after three months to ensure they have demonstrated their competence to do the job in practice. We were told that all staff have contracts of employment and up-to-date job descriptions, which are reviewed during annual appraisals to ensure they remain accurate.

A freedom to speak up / whistleblowing policy was in place should staff wish to raise any concerns directly with the hospital director, registered provider or an alternative appropriate body if required. Staff have access to occupational

health support as employees of Elysium Healthcare, which can assist staff with many aspects of work and personal life.

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 B – Improvement plan

Service: Aderyn

Date of inspection: 31 January 2022 – 02 February 2022

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 ensure that ongoing physical health checks on patients are undertaken as required to ensure any changes in the health of patients is identified promptly.	3. Health promotion, protection and improvement 3. Health promotion, protection and improvement	The physical health nurse attends Aderyn two days a week. Two members of staff will be tasked with monitoring patients physical health in collaboration with the physical health nurse.	Keith Barry, Hospital Director Physical Health Leads	30 April 2022
The registered provider must improve the upkeep of the poly-tunnel in the horticultural area.		To clear all items from the poly-tunnel and ensure area is weed free.	Keith Barry, Hospital Director	28 February 2022 *Action complete*

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must display more information for patients about how to make positive decisions about their health, and about how to contact HIW.	9. Patient information and consent	To order sealed notice boards for ward area to prevent literature that was in situ being removed. Physical health literature and the role of HIW and the relevant contact information to be displayed again, once the boards are installed.	Jenny Delaney, Administration Manager	30 April 2022
Delivery of safe and effective care				
The registered provider must continue with the maintenance programme of improvements at the hospital to ensure the living environment is enhanced for patients residing in the main building and in the flat.	22. Managing risk and health and safety 12. Environment	The maintenance schedule / action plan to be reviewed and updated accordingly. To ensure that the cottage refurbishment and courtyard are made a priority within this schedule.	Keith Barry, Hospital Director	Ongoing
The registered provider must identify and mitigate against any current health and safety or fire risks of excessive patient property within bedrooms to ensure patients are protected.	4. Emergency Planning Arrangements	All patients bedrooms to be audited to include review of excess possessions / property and the amount of electrical goods. Overloaded sockets to be addressed. To implement local procedure with regards to amount of property the hospital is able to store safely for each patient and ensure	Keith Barry, Hospital Director	31 May 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		that this is discussed with the relevant bodies pre-admission.		
The registered provided must undertake a review of the current attack alarm system used at the hospital to ensure it is appropriate, suitable and responsive when operated to ensure the safety of staff and visitors at the hospital.		To review current attack alarm system and identify any necessary adjustments. To produce an action plan to address any necessary adjustments from the review of the attack alarms. To provide refresher training on the alarm system to all staff and send reminders of the local procedure. To ensure that all visitors are provided with an alarm, as and when necessary.	Keith Barry, Hospital Director	30 May 2022
The registered provider must ensure that the overall standard of cleanliness of the hospital is improved going forward, and that any audits undertaken are effective at identifying cleanliness and IPC issues.	13. Infection prevention and control (IPC) and decontamination	Current cleaning audits and working hours to be reviewed in liaison with the housekeeping department. A full review of cleaning schedules will be undertaken by a support services manager from another Elysium Service and an action plan developed.	Keith Barry, Hospital Director	30 April 2022
The registered provider must ensure that cleaning duties undertaken by clinical staff do		To ensure that clinical staff and housekeeping are aware of their individual	Keith Barry, Hospital Director	30 April 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
not impact on their ability to undertake their clinical and therapeutic roles.		roles and duties although there has been increased cross-over of IPC tasks throughout the pandemic. A review of cleaning duties and IPC duties undertaken by the nursing department will be completed.	Keith Barry Hospital Director	30 April 2022
The registered provider must ensure that care plans reflect any interventions, or discussions held by the MDT, around fluctuations in the weight of patients.	14. Nutrition	To ensure that any weight gain is identified in the monthly physical health clinics and taken forward to the patients Individual Case Review (ICR)/Care Programme Approach (CPA) meetings for documented discussion.	Physical Health Leads / MDT	30 April 2022
The registered provider must ensure that staff work with patients to help them check that their food in the occupational therapy kitchen remains within its expiry date.		To ensure that the Practice Kitchen Checklist is completed on a daily basis and signed off weekly by a member of SMT. This will also form part of the monthly SMT walkabout. A weekly kitchen clean audit is in place and this will be monitored by the Senior Occupational Therapist that this is being completed once weekly. This will also be monitored by a Support Services Manager	Keith Barry, Hospital Director Occupational Therapist	30 April 2022 31 March 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		from another site. Patients will be encouraged following their self-catering trip to access the fridges to check that stock rotation is being completed at least once weekly. A patient has recently been appointed to complete a real work opportunity to deep clean the practice kitchen (Monday-Friday) and this is signed by staff members who have witness completion. The patient will be asked to check food items and report to staff if there are items out of date.		30 April 2022 30 April 2022
The registered provider must review their Rapid Tranquillisation policy.	15. Medicines management	To replace the Rapid Tranquilisation policy that was due for review in October 2021 with the updated version, once it has been ratified.	Keith Barry, Hospital Director	31 March 2022
The registered provider must remind staff to ensure medication fridges are locked when not being directly used.		To send a reminder to all clinical staff the importance of locking the medication fridges. To include in clinical supervision sessions for February and March 2022.	Jocelyn Fell, Ward Manager	28 February 2022 *Action complete*

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that the issues we identified in this report in relation to MAR Charts are rectified going forward.		To ensure that medication is discussed within primary nurse sessions and ICR meetings and documented accordingly. To source easy read medication literature for the clinic. To audit medication that is listed on PRN and discretionary medication forms.	Jocelyn Fell, Ward Manager	31 March 2022
The registered provider must ensure that all medical equipment is checked and calibrated when required.	16. Medical devices, equipment and diagnostic systems	To arrange immediate calibration of any outstanding medical equipment that expired in December 2021. Medical equipment to be included in the calibration database so that it can be monitored accordingly. To develop a checklist to evidence cleaning of medical equipment in the clinic.	Keith Barry, Hospital Director Jocelyn Fell, Ward Manager	30 April 2022
The registered provider must ensure Section 17 leave forms document whether patients had been offered, or accepted, a copy of their leave form.	20. Records management	To ensure that Primary Nurses discuss leave in 1:1 sessions and provide each patient with a copy, as and when. To send reminders to all staff of the importance of evidencing within carenotes that patients have had a copy of their S17	Jocelyn Fell, Ward Manager	30 April 2022 30 March 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Leave.		
The registered provider must document whether patients have indicated their agreement with, and received a copy of, their care and treatment plan.		To ensure that Primary Nurses discuss individual care plans in 1:1 sessions and provide each patient with a copy, as and when required. To send reminders to all staff of the importance of documenting patients comments on their care plan/s along with evidence that they have received a copy.	Jocelyn Fell, Ward Manager	30 March 2022
The registered provider must work with relevant mental health service providers to ensure all patients are appointed with a care coordinator.		Dashboards will continue to be monitored to ensure patient contacts are documented within their EPR. Care coordinators details are sourced during the pre-admission stage and highlighted if unable to obtain. If patients are in between care coordinators then this documented in the patients ICR meeting.	Jocelyn Fell, Ward Manager	30 March 2022
Quality of management and leadership				
The registered provider must provide	1 Governance and	Survey to be devised and circulated to all	Keith Barry,	30 April 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
assurance to HIW on the actions that will be taken to address the concerns raised by some staff members during the inspection.	accountability framework	staff in relation to communication and visibility of Senior Managers. Results to be taken for discussion in staff meetings. 'You said we did' section added to monthly staff meetings.	Hospital Director Keith Barry Hospital Director	
The registered provider should ensure that all staff, including bank staff, complete any outstanding mandatory training as soon as possible.	25. Workforce planning, training and organisational development	All bank staff to be scheduled on any outstanding training. To review current bank staff and remove those who are no longer picking up shifts (over 6 months).	Jocelyn Fell, Ward Manager Jenny Delaney, Administration Manager	30 April 2022

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): Keith Barry

Job role: Hospital Director

Date: 24 March 2022