Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Delfryn House and Delfryn Lodge

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at Delfryn House and Delfryn Lodge on 04, 05 and 06 July 2022.

The following hospital wards were reviewed during this inspection:

- Delfryn House – 28 single gender beds (male) providing locked rehabilitation services
- Delfryn Lodge – 24 single gender beds (female) providing locked rehabilitation services.

Our team for the inspection comprised of three HIW Inspectors, four clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

At the time of the inspection, the hospital was being managed by Cygnet Health Care.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Staff interacted and engaged with patients appropriately and with dignity and respect. Patients had their own programme of care that reflected their individual needs and risks. Patients could engage and provide feedback to staff on the provision of care at the hospital in a number of ways. Patients had access to a mental health advocate who provided information and support with any issues they may have regarding their care.

This is what we recommend the service can improve

- The service must consider installing observation panels on all bedroom doors at the hospital to reduce the impact on patients at night
- Health promotion information must be made available for patients in the Lodge
- Physical health checks and observations must be regularly carried out and recorded in the physical health files for patients.

This is what the service did well:

- The appointment of patient representatives was a positive initiative that helped promote patient engagement and ensure the voice of patients is heard.

Safe and Effective Care

Overall summary:
Staff appeared committed to providing safe and effective care. Patient care plans were being maintained to a good standard. Suitable protocols were in place to manage risk, health and safety and infection control. Regular checks were being undertaken of resuscitation and emergency equipment. The statutory documentation we saw verified that the patients were appropriately legally detained.

This is what we recommend the service can improve

- The service must consider whether they are capturing information in the most streamlined way to ensure new staff members can access documentation quickly when reviewing care and treatment for patients
- The room temperature checklist must be completed as required in the treatment room in the Lodge

- All overhead lights at the hospital need to be checked to ensure they are working, and cleaned to remove the build up of dirt and insects.

This is what the service did well:

- Robust procedures were in place for the safe management of medicines and Medication Administration Records were being well maintained.
- There was evidence of good oversight in place from the Mental Health Act administration team to monitor compliance with national guidelines and to review upcoming deadlines to ensure detentions remained lawful.

Quality of Management and Leadership

Overall summary:
The majority of staff who completed HIW questionnaires provided positive feedback about working at the hospital. Established governance arrangements were in place to provide oversight of clinical and operational issues. Recruitment was being undertaken in an open and fair process with appropriate employment checks being carried out prior to employment.

This is what we recommend the service can improve

- The service must engage with staff to better ensure the House and Lodge are not considered as separate entities, but rather operating as one hospital.
- The service should review their induction programme to ensure new members of staff are provided with the required knowledge and sufficient support when starting their role.
- Efforts to recruit more permanent staff must be continued to reduce the feeling among some staff that they do not have enough time to give patients the care they need.

3. What we found

Quality of Patient Experience

Health promotion, protection and improvement
We looked at a sample of four patient records and saw evidence that patients received appropriate physical assessments upon their admission in addition to their mental healthcare. Patients had physical health care plans which documented checks such as health screening. However, we found evidence that some monthly observations had not been recorded in physical health files being stored in the treatment room in the Lodge.

Patients had access to a range of therapy facilities at the hospital to support and maintain their health and wellbeing, including gym equipment, a hair salon and occupational therapy kitchen. An IT room was available but we were told it was not regularly used. The service should consider how to better engage patients with the IT facilities.

A communal lounge was available at the Lodge and at the House. Large outdoor spaces were accessible within the hospital grounds, and we observed patients using these spaces regularly during the day times. Staff had access to a minibus to facilitate activities in the community for patients that were authorised to leave the hospital.

Patients could smoke outside each ward. We were informed that the hospital would become smoke-free from October 2022. Patients have been provided with smoking cessation support ahead of the change coming into force.

Dignity and respect
Throughout the inspection we observed staff treating patients appropriately and with dignity and respect. Staff took the time to speak with patients to understand their needs or any concerns the 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 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.

We saw that bedroom doors in the Lodge had an observation panel which enabled staff to undertake observations without having to open the door. However, not all

doors at the House had an observation panel, which meant patients could potentially be disturbed during repeated observations, particularly at night.

Suitable visiting arrangements were in place for patients to meet visitors at the hospital. Patients had access to their own mobile phone where appropriate, but a telephone was available on each ward for patients to use if required.

Patient information and consent

We were told that patients receive written information on their admission that included guidance on the Mental Health Act and how to make a complaint. Other information, such as how patients could contact and access advocacy services, was displayed in the reception areas outside both wards. These areas are not easily accessible to patients and the service may wish to consider displaying this information inside each ward.

Health promotion information regarding smoking cessation, drug and alcohol use and healthy eating was on display in the House. However, such information was not available for patients in the Lodge. We also noted that the contact details for HIW on posters throughout the hospital were incorrect and needed to be updated.

We noted that patient information was predominantly only available in English. However, signs were displayed which informed patients that patient information can be made available in Welsh on request.

Patient status at a glance boards were located in the nursing offices on each ward. The boards had covers which helped protect patient confidentiality.

Communicating effectively

Staff communicated appropriately and effectively with patients throughout the inspection. Patients appeared confident in approaching staff to engage in discussions. The patients we talked to spoke positively about their interactions with staff during their time at the hospital.

The hospital has adopted the principles of the ‘safewards’ model. There was a picture board of who’s who for patients to recognise staff on each ward, and information about therapeutic job opportunities that were available to patients. However, we saw that these were displayed in areas that were not easily accessible to patients, and the service should consider moving them to increase their impact.

Daily planning meetings were held every morning to discuss upcoming activities within the hospital and the community, and other relevant information, such as tribunals and medical appointments. Patient representatives had been appointed

to act as a point of contact for other patients to talk to about any issues they may have which we recognised as good practice.

Care planning and provision
During the inspection we reviewed the care plans of four patients. We found that care plans were person centred with each patient having their own programme of care that reflected the needs and risks of the individual patients. It was also evident that patients had been involved in the development of their care plans. More findings on the care plans can be found in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

A handover meeting was being held every weekday morning for 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.

Equality, diversity and human rights
During the inspection we looked at the patient records of five individuals that had been detained at the hospital under the Mental Health Act (the Act). The 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).

The hospital had policies in place to help ensure that patients' equality and diversity were respected. We noted that some patients at the hospital had informed staff that their gender identity was now different from their sex assigned at birth and we observed staff referring to patients using their preferred pronouns.

We were told that all patients have access to a mental health advocate who visits the hospital once a week to provide information and support to patients with any issues they may have regarding their care.

Citizen engagement and feedback
We found strong evidence that patients could engage and provide informal feedback to staff on the provision of care at the hospital in a number of ways. As well as the daily morning meetings, weekly community and monthly patient council meetings were being held for patients to discuss any developments or concerns they may have. We saw minutes of such meetings which showed that staff were keeping patients informed of what actions had been taken in response to issues that had been raised.

A ‘You said, we did’ board was displayed at the House to inform patients of changes made as a result of their feedback. However, we noted a ‘You said, we did’ board was not similarly on display at the Lodge.

We were told that annual surveys are issued to patients and their relatives / carers to also help identify any improvements.

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety
Overall, we were assured that the service 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 entrances were accessible to everyone and were secured at all times throughout the inspection to prevent unauthorised access.

The wards were split over two floors and lifts were available to assist people with mobility difficulties. Each ward provided a clean and comfortable environment for patients and we noted that work had been undertaken to replace the carpets in the main corridors of each ward since our last visit. Further maintenance was currently being undertaken to improve the environment during the inspection, including renovation of the sensory room in the Lodge. However, we noted some damage to the countertop in the dining room of the Lodge, and some overhead lights were not working, for example in the occupational therapy kitchen. The lights had also accumulated dirt and insects and needed to be cleaned.

A range of up-to-date health and safety policies were available for staff. Monthly health and safety audits were being completed and submitted to the central health and safety team at Cygnet Health Care for them to monitor compliance.

There were up-to-date ligature point risk assessments in place and a number of ligature cutters located throughout the hospital for use in the event of a self-harm emergency.

We saw evidence of weekly checks being undertaken on resuscitation and emergency equipment held on each ward. Staff had documented when these had occurred to ensure that the equipment was present and in date. However, we found some gaps in the checklist to monitor the room temperature in the treatment room where the emergency medication is stored in the Lodge.

There were nurse call points around the hospital and within patient bedrooms so that patients could summon assistance if required. Staff wore personal alarms which they could use to call for assistance if required.

Infection prevention and control (IPC) and decontamination
We found suitable IPC arrangements in place at the hospital. A range of up-to-date policies were available that detailed the various infection control procedures to keep staff and patients safe. Regular audits had been completed to check the

cleanliness of the environment and monitor compliance with hospital procedures. However, some nursing staff we spoke with were unaware of the results of such audits. It would be beneficial to communicate results of audits such as hand hygiene audits to ensure staff know whether they are meeting expected IPC standards.

The environment of both wards and the wider hospital was clean and uncluttered. Furniture and fixings were appropriate for the patient group and in a good state of repair apart from some chairs in the communal lounges of both wards. The material on the arms of the chairs had worn away and must be replaced as they are unable to be cleaned effectively in their current condition.

The clinical managers for each ward were the designated IPC leads. We saw a high compliance rate among clinical staff at the hospital for mandatory training in infection prevention and control. The staff we spoke with seemed clear about their individual responsibilities in relation to infection control measures at the hospital.

There were appropriate procedures in place to help control the risk of transmitting COVID-19 throughout the hospital. Multiple hand gel dispensers were available for both staff and patients to use. Staff wore face masks on the wards, and staff did not highlight any issues relating to access to other PPE during our discussions. Visitors have to return a negative lateral flow test (LFT) before being admitted.

Nutrition

We saw that the dietary needs of patients had been assessed on admission using the Malnutrition Universal Screening Tool (MUST). Care plans had been put in place to manage specific dietary needs where required. All patients receive ongoing weight management checks during their stay.

There were suitable facilities available for patients to have hot and cold drinks and we saw patients accessing these throughout the inspection. Staffed kitchens are located on site to provide patients on each ward with a variety of meals throughout the day. Patients receive the same meal choices on each ward. The menu is colour coded to help patients identify healthier options. We saw that the current menu choices for the Lodge were on display in the dining room, however the menu choices were not on display in the House.

Patients are able to feedback their suggestions and opinions to members of the catering team about the food at the hospital during their weekly community meetings.

Medicines management
We reviewed the hospital's clinic arrangements and found that robust procedures were in place for the safe management of medicines on each ward. The clinic rooms were clean and tidy and well organised. Medication fridges were locked when not in use. We saw that daily temperature checks of the medication fridges and clinic rooms were being completed accurately to ensure that medication was stored at the manufacturer's advised temperature.

Appropriate arrangements were in place for the storage and safe use of controlled drugs and drugs liable to misuse. Drugs were stored securely and the records we viewed evidenced that stock was accounted for when administered and that stock checks were being undertaken.

Relevant policies, such as medicines management and rapid tranquillisation, were in date and were available to staff in each clinic room. We found a positive culture of supporting and encouraging patients to take ownership for taking medication prescribed to them.

We viewed a sample of Medication Administration Records (MAR charts) and found they were being maintained to a good standard on both wards. The MAR charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. All relevant consent to treatment certificates were stored alongside the MAR charts as required.

We were told that regular audits of the MAR charts are undertaken internally by clinical staff and externally by an independent pharmacist to monitor ongoing compliance.

Safeguarding children and safeguarding vulnerable adults
We found processes in place to help ensure that staff at the hospital safeguarded patients appropriately. A comprehensive safeguarding policy was in place and up to date. A flow chart for escalating safeguarding concerns was available to all staff.

We saw that incidents had been subject to internal investigations and had also been appropriately referred to external safeguarding agencies. We were told the service has developed better relationships with the police and safeguarding leads from the local health board and local authority. The organisations meet monthly to improve communication and share information to help ensure resources are used appropriately and unnecessary visits to the hospital by the police are reduced. We noted this as good practice.

We saw evidence that safeguarding is included at monthly clinical governance meetings as a standing agenda item to help identify any themes and lessons learned. Compliance among staff at the hospital with safeguarding training was high at over 80 per cent.

Safe and clinically effective care
The hospital had policies in place to help protect the safety and wellbeing of patients and staff.

Principles of positive behavioural support were being used as a primary method of de-escalation to manage challenging behaviour. We were told that staff would observe patients more frequently in line with the safe and supportive observations policy if patients continued to present with increased risks. We saw that records of observations being undertaken on patients were being completed appropriately by nursing staff. We were told that there were some restricted practices in operation at the hospital including limiting access to restricted items, community leave and to some areas of the hospital grounds.

We saw that Short Term Assessment of Risk and Treatability (START) assessments were being completed by nursing staff. These were reviewed daily by the MDT and we observed discussions being held in relation to each patient on potential changes to care plans, restricted items, observation levels and Section 17 leave status.

We saw that any use of restraint was documented in patient records and recorded on the corporate electronic system. This included details such as duration of the intervention and type of restraint used. We were told that debriefs take place with staff following incidents to reflect and identify any areas for improvement. We noted that incidents of restraint are summarised and discussed by the MDT at each monthly clinical governance meeting.

Records management
Patient records were being maintained on paper files and electronically. We saw that paper records were being stored securely. The electronic system ‘myPath’ was password protected to prevent unauthorised access and breaches in confidentiality.

Information was being captured comprehensively. However, we found reviewing patient records challenging due to not being familiar with the electronic systems or where certain documents are located. Some information was also recorded in both paper and electronic systems, which appeared duplicative. The service should ensure information is captured in a streamlined way to improve efficiency and ensure new staff members can access documentation quickly when reviewing care and treatment for patients.

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 five patients currently residing at the hospital. All records were found to be compliant with the Mental Health Act and Code of Practice.

Mental capacity assessments were being undertaken on patients upon admission and regularly reviewed. We noted that patients were being encouraged to provide their views on the assessment which was positive. Information is provided to patients following their admission about their detention, their legal rights and contact details for an independent advocate.

All relevant consent to treatment certificates were stored alongside the MAR charts as required. We saw that Second Opinion Appointed Doctor (SOAD) assessments had been sought when patients had refused to provide consent.

Good arrangements were in place to document Section 17 leave appropriately. We saw that leave was being suitably risk assessed and that the forms determined the conditions and outcomes of the leave for each patient. Patients had signed their leave form to indicate their agreement to the terms and there was evidence that patients had been provided with, or offered, a copy.

The MHA documentation was well organised, easy to navigate and was being stored securely. There was evidence of good oversight in place from the MHA administration team to monitor compliance with national guidelines and to review upcoming deadlines to ensure detentions remained lawful.

We were told that information about the section of the MHA under which patients are detained are provided to patients every three months. However, during our review we noted that one patient had not had their rights read to them since March 2022.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision
The care plans we reviewed were being maintained to a good standard. Each patient had their own programme of care that reflected their individual needs and risks. The domains of the Welsh Measure were being reflected and objectives focussed on rehabilitation and independence.

Appropriate pre-admission and upon admission assessments were being undertaken and documented. It was clear that patients had been involved in the development

of their care plans, with the patient voice being well reflected within the documentation. There was evidence of multidisciplinary involvement in the development and ongoing review of the care plans to ensure they are updated to reflect current needs and risks.

We saw that patients also had individual crisis and restrictive practice care plans, which was positive. However, we noted these were stored in a separate area on the shared drive. The service should consider whether these documents can be incorporated onto myPath to ensure they remain a contemporaneous part of the patient records.

There was evidence of discharge and aftercare planning and we noted that patients and care co-ordinators had been involved in the process.

Quality of Management and Leadership

Staff Feedback

We invited staff to complete HIW questionnaires following the inspection to obtain their views on the service provided at the hospital. In total, we received 13 completed questionnaires. Staff responses were positive across all areas, with all respondents (who gave an opinion) recommending their mental health setting as a place to work and agreeing that they would be happy with the standard of care provided for their friends or family. Some of the questionnaire results appear throughout the report.

Governance and accountability framework
It was positive that throughout the inspection staff were receptive to our views, findings and recommendations. Staff we spoke with were passionate about their roles. All staff who completed a questionnaire told us that the hospital encourages teamwork and that they are supported to identify and solve problems. Staff also agreed that they know who the senior managers are, that they are visible, and that they are committed to patient care.

We found established governance arrangements in place to provide oversight of clinical and operational issues. Audit activities and monitoring systems and processes were in place to ensure the hospital focussed on continuously maintaining standards. Agendas for 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 Cygnet Health Care corporate teams.

Senior managers at both the Lodge and the House come together to attend operational meetings, such as the monthly clinical governance meetings. However, during the inspection there was a feeling among the inspection team that the Lodge and the House were operating independently. In line with this, one staff member who completed a questionnaire proposed the following service improvement:

> *"Both hospitals on site to work together and for there to be no divide."*

The service should consider how best to engage with staff to ensure it is governed as one hospital rather than two separate wards.

Dealing with concerns and managing incidents

There was an established electronic system in place for dealing with concerns and recording, reviewing and monitoring incidents. Regular incident reports were produced and reviewed at the hospital level, and at a corporate level, to help identify trends and patterns of behaviour.

We were told that complaints, incidents and safeguarding issues at the hospital are discussed at clinical governance meetings, with any learning shared with all staff. We also noted that there was evidence of informing patients following medication error incidents which demonstrated an open and transparent approach to dealing with incidents.

All staff who completed a HIW questionnaire said that they would know how to report unsafe practice. The majority of staff also said they would feel secure raising concerns about patient care or other issues at their mental health setting.

Workforce planning, training and organisational development

Staffing levels were appropriate to maintain patient safety within the wards at the time of our inspection. However, it was clear from discussions with the hospital director that there had been recent challenges in relation to a number of job vacancies at the hospital. We were told that regular agency staff who were familiar with working at the hospital and the patient group have been used to cover any staffing shortfalls. We were also informed about the recruitment initiatives currently being undertaken to attract new staff.

Just under a third of staff who completed a HIW questionnaire did not agree that there were enough staff to enable them to do their job properly. Just under a quarter of staff also did not agree that they had enough time to give patients the care they need. Staff proposed the following in relation to the staffing establishments:

> *"Employing more regular staff trained in all aspects of care delivery."*

> *"To have a nurse prescriber on site."*

We noted that there was no social worker presence on the MDT. We felt a social worker would provide added benefit and perspective to the MDT discussions about care and treatment plans for patients as well as support patients that are working towards discharge from the hospital.

We reviewed the mandatory training statistics for staff at the hospital and found that completion rates were high (89 per cent for the Lodge, 92 per cent for the

House). Staff who completed a questionnaire told us that training helped them do their job more effectively, stay up to date with professional requirements and deliver a better patient experience.

We saw that over 80 per cent of all staff at the hospital had received their annual appraisal.

Workforce recruitment and employment practices
A recruitment, selection and appointment of staff policy was in place that set out the arrangements to ensure recruitment followed an open and fair process. Prior to employment, potential staff are required to provide two professional 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 permanent staff receive a two week period of induction where they are supernumerary to the usual staffing establishment at the hospital. During the induction period staff are required to read company policies and complete mandatory training. We received the following proposed improvements from staff who completed a HIW questionnaire:

> *"For new starters to receive a more robust and informative induction before beginning their role on the wards."*

> *"Give new starters a 'buddy' system with experienced support/nursing staff."*

The service should review their induction programme in light of these comments to ensure they are providing new members of staff with the required knowledge and sufficient support when starting their role.

A freedom to speak up (whistleblowing) policy was in place should staff wish to raise any concerns about issues at the hospital. Staff were able to speak to the hospital director or contact a 'freedom to speak up guardian' in confidence.

All staff who completed a HIW questionnaire agreed that the hospital takes positive action on health and well-being and that staff are offered full support in the event of challenging situations. All staff also agreed that they were aware of the occupational health support available to them as an employee.

Next steps

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 immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: 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.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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.

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 - Immediate improvement plan

Service: Delfryn House and Delfryn Lodge

Date of inspection: 04-06 July 2022

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate non-compliance concerns were identified on this inspection.				

Appendix C - Improvement plan

Service: Delfryn House and Delfryn Lodge

Date of inspection: 04-06 July 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	Standard/ Regulation	Service action	Responsible officer	Timescale
Physical health checks and observations must be regularly carried out and recorded in the physical health files for patients.	Health promotion, protection and improvement	The specialist doctor has set up a physical health folder for all patients with timescales for physical health monitoring (dependent on each individual's needs) that is reviewed at a minimum prior to each ward round.	Specialist doctor, RC and Named Nurse	Complete
The service must consider installing observation panels on all bedroom doors at the hospital to reduce the impact on patients at night.	Dignity and respect	Currently discussions are in place regarding the consideration for observation panels on bedroom doors at the house. There are currently different viewpoints including the importance of staff	Regional Facilities Manager, Service Users and Clinical Manager.	3 months

		entering bedrooms to ensure they are checking for signs of life (dependent on the individual's current risks). Registered manager will update HIW once a decision has been reached.		
Health promotion information must be made available for patients in the Lodge.	Patient information and consent	Health Promotion information has been placed in key areas on the ward including notice boards, treatment room, dining area and individual service user bedrooms for those that wished to have this.	Senior Nurses and Clinical Manager	Complete
The contact details for HIW need to be updated on some posters throughout the hospital.	Patient information and consent	Review of all current posters were completed and those in need of updating have been done.	Hospital Manager and Administration staff	Complete
The service must consider installing a 'You said, we did' board for patients in the Lodge to be consistent with the House.	Citizen engagement and feedback	This has been discussed with the Occupational Therapy department and the 'You said, we did' board has been replicated across all wards.	Occupational Therapy Department	Complete

The countertop in the dining room of the Lodge needs to be repaired.	Managing risk and health and safety	This has been discussed with the Regional Facilities Manager and he has requested for the Estates lead to repair the identified area.	Regional Facilities Manager	Complete
All overhead lights at the hospital need to be checked to ensure they are working, and cleaned to remove the build up of dirt and insects.	Managing risk and health and safety	All lights were reviewed and changed during the inspection as this was highlighted. The build-up of insects and dirt has been removed post inspection. The estates lead has now placed this action on his audit for the hospital to minimise the risk of this reoccurring.	Estates Lead	Complete
The room temperature checklist must be completed as required in the treatment room in the Lodge.	Managing risk and health and safety	This has been discussed with the Senior Support Workers to ensure this is allocated to an individual to complete on each day and night shift.	Senior Support Workers	Complete
All chairs in the patient areas that have material worn away must be replaced.	Infection prevention and control (IPC) and decontamination	Chairs had already been ordered and were pending delivery during the inspection. These have now arrived and have replaced the	Regional Facilities Manager & Estates Lead	Complete

		chairs identified as having material worn away.		
The menu choices must be displayed for patients in the House.	Nutrition	This was discussed with the facilities manager and has been put in situ.	Facilities Manager	Complete
The service must consider whether they are capturing information in the most streamlined way to ensure new staff members can access documentation quickly when reviewing care and treatment for patients.	Records management	To minimise duplication of information a pen picture process is being implemented that will offer key information and direct staff to where further appropriate information can be obtained in an effort to prevent the need for staff to review multiple files and documentation. Also, any information that is recorded in the handover, clinical records and incident form is streamlined and consistent.	Key Nurses and MDT Nurses, support workers and MDT staff	3 months Complete
Detained patients must have their rights read to them as required by the MHA.	Mental Health Act Monitoring	Patients' rights are reviewed daily during the morning meetings to ensure none are outstanding.	MHA Administrators, Nurses, MDT	Complete

The service must engage with staff to better ensure the wards are not considered as separate entities, but rather operating as one hospital.	Governance and accountability framework	All key meetings which include Clinical Governance, Quality Improvement, Full Staff Meeting, Medication Management & Head of Departments are collaborative of all services (House and Lodge). There are no separate meetings.	Hospital Manager	Complete
		We have started a quality improvement team building workshop which include staff from the House and Lodge in an effort to ensure the wards do not consider themselves as separate entities. And to promote cross site working, information sharing (including best practice) and a stronger team approach.	Workshops - Hospital Manager, Head of Psychology and Clinical Managers	3 months to complete all the team building sessions.
		The Psychology department have embraced a new way of working by having all the psychology staff work across the House and Lodge.	Hospital Manager, Head of Psychology	Complete

Efforts to recruit more permanent staff must be continued to reduce the feeling among some staff that they do not have enough time to give patients the care they need.	Workforce planning, training and organisational development	We have fully recruited into all positions and are awaiting start dates via the recruitment process. There is a weekly recruitment meeting that is used to proactively manage the recruitment process. We are also looking at the possibility of a social worker and nurse prescriber in 2023. Although not all the ward based positions were not filled, the rotas demonstrated that the Hospitals SOP was met at all times, with regular staff and above the minimum safe staffing levels.	Hospital Manager, Senior Administrator and Clinical Managers	Complete
The service should review their induction programme to ensure new members of staff are provided with the required knowledge and sufficient support when starting their role.	Workforce recruitment and employment practices	There is an up to date induction booklet supported by the buddy process. During the first two weeks of the induction 50% of their allocated time is utilised for the completion of mandatory and specialist training.	Training Administration staff, Clinical Managers, Hospital Manager	Complete Complete

		There is an annual training review that looks at the induction process and needs of the Hospital.		Complete

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: 29 August 2022