Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Independent Mental Health Service Inspection (Unannounced)

## Coed Du Hall

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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 Coed Du Hall on the evening of 4 November 2019 and following days of 5 and 6 November.

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

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with the 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 governance arrangements in place that helped enable staff to provide safe and clinically effective care for patients. However, improvements are required in medicines management and emergency equipment and medication checks.

Staff were dedicated and knowledgeable and had a good understanding of the individual needs of the patients at the hospital.

Improvements are required in the completion of mandatory training and the registered provider must ensure that all staff have annual performance appraisals.

This is what we found the service did well:

- Maintained an environment of care that was appropriate for the patient group
- Therapies and activities within the hospital and community supported patients to maintain and develop skills
- Staff interacted and engaged with patients respectfully
- Maintained detailed patient records and Care and Treatment Plans reflected the domains of the Welsh Measure.

This is what we recommend the service could improve:

- The range and format of information displayed for patients
- Medicine management arrangements
- Emergency equipment and medication checks
- Mandatory training compliance.

We identified regulatory breaches during this inspection regarding medicine management. Further details can be found in Appendix B. Whilst this has not resulted in the issue of a non-compliance notice, there is an expectation that the registered provider takes meaningful action to address these matters, as a failure to do so could result in non-compliance with regulations.

# 3. What we found

## Background of the service

Coed Du Hall is registered to provide an independent hospital at Coed Du Hall, Nant Alyn Road, Rhydymwyn, Mold, CH7 5HA.

The service has 22 registered beds and comprises of Ash Ward with seven beds, Beech Ward with five beds, Cedar Ward with 6 beds and four single bed Studio Suites; Ash Ward and Beech ward are gender specific wards.

Ash Ward and Cedar Ward accommodates patients between the ages of 18 and under 65 years and Beech Ward for patients aged over 65. The hospital provides accommodates patients whose primary need for care and treatment arises from a diagnosis of mental illness. At the time of inspection, there were ten patients.

The service employs a hospital manager, however at the time of the inspection the newly appointed hospital manager was awaiting to take up their post and the Director of Operations was overseeing the day-today management of the hospital. The hospital also had an assistant hospital manager in post.

The multi-disciplinary team includes a consultant psychiatrist, psychologist (due to commence role in December 2019), occupational therapist and occupational therapy assistants with a team of registered nurses and healthcare support workers.

The hospital employs a team of catering, domestic and maintenance staff.

The service was first registered on 1 April 2002.

## 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 that staff interacted and engaged with patients appropriately and treated patients with dignity and respect.

There were a range of suitable activities and therapies available at Coed Du Hall and that could be accessed within the community. These provided patients with recovery and rehabilitation opportunities as part of Activities of Daily Living[1].

A range of information was available for patients and visitors, however improvements could be made in what is displayed and consideration must be given to how the hospital displays information for patients to aid their understanding.

### Health promotion, protection and improvement

Coed Du Hall had a range of facilities to support the provision of therapies and activities. There were hospital vehicles which assisted staff to facilitate patient activities and medical appointments in the community.

Patients' records evidenced that patients were supported to be independent. Patients were engaged and supported in undertaking Activities of Daily Living that promoted recovery and rehabilitation.

Coed Du Hall had an occupational therapy kitchen which patients could access to prepare meals, with support from staff as required. In addition, each ward had

[1] These activities can include everyday tasks such as dressing, self-feeding, bathing, laundry, and meal preparation.

a kitchenette and the studios had their own kitchen that patients could use independently.

There was a dedicated occupational therapy team at the hospital that provided a range of assessments and activities to support patient rehabilitation. Throughout the inspection we observed patients taking part in a range of therapeutic and leisure activities, with many patients regularly using Section 17 Leave[2] from the hospital to access the local community. Staff and patients confirmed that community leisure facilities are accessed regularly; this was also documented within patient records. There was a large communal dining room area that was also used for activities outside of meal times.

Each ward had its own lounge area where patients could relax when not involved in activities. Patients were also able to have electronic equipment within their bedroom such as a TV, music system and games consoles.

Patients had unrestricted access to an enclosed garden area so they were able to freely access fresh air. Staff also facilitated walks around the hospital grounds and the local community.

### Dignity and respect

We observed that all staff interacted and engaged with patients appropriately and treated patients with dignity and respect. The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients.

We heard staff speaking with patients in calm tones throughout our inspection. We observed staff being respectful toward patients; when patients approached staff members, they were met with polite and responsive, caring attitudes.

The patients we spoke with, along with visiting family members, were complimentary about the staff engagement and the care that was provided at the hospital.

[2] Section 17 of the Mental Health Act 1983 is the authorisation of a detained patient's leave from hospital.

Each patient had their own bedroom which they could access throughout the day; the bedrooms provided patients with a good standard of privacy. Patients could only access their own bedroom using their smart-key wrist bands, staff had their own which accessed all bedrooms if required.

We observed a number of patient bedrooms, it was evident that patients were able to personalise their rooms and that there was sufficient storage for their possessions.

The hospital had suitable rooms for patients to meet ward staff and other healthcare professionals in private. There were visiting arrangements in place for patients to meet visitors at the hospital.

### Patient information and consent

Throughout the hospital there was some information displayed and available for patients, however this could be improved.

There were notice boards which displayed information for patients regarding advocacy, complaints and safeguarding. There was also information displayed within the dining room on healthy eating. In addition, the menus for patients to choose their meals included photographs of the meals to aid some patients in choosing wat they wished to eat.

The hospital had a range of information leaflets regarding the Mental Health Act 1983 (the Act), however these were not displayed or readily available for patients.

Information on Healthcare Inspectorate Wales (HIW) was included within the complaints information but further details on the role of HIW and how to contact us needs to be displayed.

Whilst there was some information displayed in a variety of formats, such as pictorial menus, consideration must be given to how the hospital displays information for patients to aid their understanding.

Improvement needed

The registered provider must ensure that:

- Information about Mental Health Act is displayed
- Information about HIW and how to contact us is displayed on the wards
- Information is displayed in a format to aid patient understanding.

## Communicating effectively

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

There was a daily morning meeting where staff arranged the activities, within the hospital and the community, alongside other activities and meetings, such as care planning meetings, tribunals and medical appointments. Any incidents, concerns or maintenance issues are also discussed and actions agreed.

The hospital had a monthly patient forum where patients had the opportunity to provide feedback on the care that they receive at the hospital and discuss any developments or concerns. There was a poster displayed advising patients of the forum and staff described methods to encourage patients to attend and participate.

The hospital held regular multi-disciplinary team meetings where patients or their elected representative meet with the clinical team to discuss their care and future care planning.

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

## Care planning and provision

Care was individualised, focused on recovery and was supported by least restrictive practices, both in care planning and ward or hospital practices.

Each patient had their own programme of care based on their individual needs such as medication, therapy sessions and activities. These included individual and group sessions, based within the hospital and the community.

Coed Du Hall provided patients with a rehabilitation environment with a wide range of well-maintained facilities to support the provision of therapies and activities. The occupational therapy team undertook assessments of patients' abilities and what therapies, support and activities would be beneficial to assist the patient's recovery.

In addition, the four studio suites located within the hospital provided the opportunity for patients to receive care within an environment with minimal support from staff in preparation for discharge to a less secure environment.

Throughout the inspection we observed patients participating in individual and group activities within the hospital and accessing the community.

## Equality, diversity and human rights

Staff practices aligned to established organisational policies and systems which ensured that the patients' equality, diversity and rights were maintained. The design of the hospital and organisational policies ensured an accessible environment for people who may have mobility needs.

Legal documentation to detain patients under the Act was compliant with the legislation and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code).

Documentation for the use of Deprivation of Liberty Safeguards (DoLS) was in place which ensured the validity of the DoLS authorisations.

The hospital had a multi-faith room and relevant literature available to support patients in worship of their chosen religion.

## Citizen engagement and feedback

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

There was a complaints policy and procedures in place at Coed Du Hall. The policy provides a structure for dealing with all patients’ complaints for services within the hospital.

There was information displayed explaining how patients could raise a concern or complaint. As stated earlier, the consideration must be given to how the hospital displays information for patients to aid their understanding.

## Delivery of safe and effective care

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

The hospital environment was equipped with suitable furniture, fixtures and fittings for the patient group.

There were established processes and audits in place to manage risk and health and safety. This enabled staff to provided safe and clinically effective care for patients. However, improvements are required in medicines management at the hospital.

Legal documentation in relation to the Mental Health Act and Deprivation of Liberty Safeguards was compliant with the relevant legislation.

### Managing risk and health and safety

Coed Du Hall had established processes in place to manage and review risks and to maintain health and safety at the hospital. These aided staff to provide safe and clinically effective care.

Access to the hospital was direct from the hospital car park, this provided suitable access for people who may have mobility difficulties. Visitors were required to enter the hospital via a reception area; this helps to deter unauthorised persons from entering the building. Access through the hospital was limited to maintain the safety of patients, staff and visitors.

Staff had access to personal alarms which they could use to call for assistance when necessary. There were also nurse call points around the hospital and within patient bedrooms that were within reach of the beds, this aided patients to summon assistance if required. However, one call point within a toilet on Beech Ward was not in easy reach of the toilet or floor, therefore it could pose difficulty to a person in that area wishing to call for assistance.

Patient bedroom doors had an alert if the patient within the room had opened their door to leave their bedroom, this notifies staff so they could support and monitor the patient's movements. It was also noted, that where a patient was susceptible to falls, pressure mats were used to notify staff that the patient was

raising from bed. Aids were also in place to support the patient to manage this as independently as possible.

The hospital looked well maintained and suitably furnished. The furniture, fixtures and fittings at the hospital were appropriate for the patient group. The hospital had a dedicated maintenance staff member who we were informed was responsive; throughout the inspection, we saw them responding and undertaking maintenance work to rectify environmental issues. Where required referrals to external contractors were completed.

Improvement needed

The registered provider must ensure that nurse call buttons are suitably located to aid patients calling for assistance.

### Infection prevention and control (IPC) and decontamination

Throughout the inspection we observed the hospital to be visibly clean and free from clutter. Cleaning equipment was stored and organised appropriately. A system of regular audits in respect of infection control was in place. These were completed with the aim of identifying areas for improvement so that appropriate action could be taken where necessary.

There were hand hygiene products available in relevant areas around the hospital; these were working throughout the inspection. Staff also had access to personal protective equipment (PPE) when required, and we observed these to be used at appropriate times.

Designated plastic bins (sharps bin) were used for the safe storage and disposal of medical sharps, for example, hypodermic needles. However, the sharps bin within the clinic was assembled without the lid, therefore there was a risk that the contents could spill and cause a needlestick injury[3].

[3] A needlestick injury is the penetration of the skin by a hypodermic needle or other sharp object that has been in contact with blood, tissue or other body fluids before the exposure. These injuries can lead to transmission of blood-borne diseases, placing those exposed at increased risk of

Training statistics evidenced that 81% of staff had completed Infection Prevention and Control training.

Improvement needed

The registered provider must ensure that sharps bins are assembled with the lids in situ.

## Nutrition

We found that patients were provided with a choice of meals. We saw a varied menu and patients told us that they had a choice of what to eat. We sampled a selection of meals and these looked appetising and tasted good.

As stated earlier, patient menus were also pictorial to aid patient choice, in addition there was a colour code system to help patients identify how healthy each meal was. Patients had fresh fruit readily available and access to drinks within the dining room and ward areas.

As part of patient rehabilitation care, patients were able to use the occupational therapy kitchen and ward or studio kitchenettes to prepare their own meals which enabled them to maintain and learn culinary skills. Where patients had Section 17 Leave authorised they could also undertake food shopping as part of their community focused rehabilitation activities.

Patients could also utilise the hospital facilities to make snacks and were able to order takeaway deliveries to the hospital.

contracting infectious diseases, such as hepatitis B (HBV), hepatitis C (HCV), and the human immunodeficiency virus (HIV).

Patient records evidenced input from dietician and SALT[4] when required. There was also evidence that weight and BMI[5] was monitored as part of patients' care, and when required food and fluid intake monitoring was completed.

### Medicines management

There was a regular external pharmacy audit undertaken that assisted the management, prescribing and administration of medication at the hospital. However, improvements are required in medicines management at the hospital.

The clinic room was secured to prevent unauthorised entry. During our review of the clinic, the medication cupboards, trolley and fridge were locked.

There was evidence that there were regular temperature checks of the medication fridge to monitor that medication was stored at the manufacturer's advised temperature. However, we saw that the fridge temperature was recorded outside the required range on numerous occasions with no action being taken as a result. Following advice from their pharmacy provider the registered provider disposed of the medication that would have been affected by the exposure to temperatures outside the required range. The registered provider also confirmed that no affected medication had been administered to patients.

There was evidence that there were regular temperature checks of the clinic room temperature and that this remained within the manufacturer's advised temperature for storing of medication.

During our review of the medication stock it was identified that there was a reconciliation discrepancy between the stock stated and the actual stock quantity of Drugs Liable to Misuse. It was also noted that for Drugs Liable to Misuse that it was standard practice at the hospital for one registered nurse on shift to administer and check the stock balance. It is common professional practice to

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[4] Speech and language therapists (SALTs) assess difficulties with swallowing and communication. They can offer support through swallowing and speech exercises, dietary advice and changes to medication.

[5] Body mass index (BMI) is a measure that uses a person’s height and weight to work out if their weight is healthy. BMI takes into account natural variations in body shape, giving a healthy weight range for a particular height.

follow Controlled Drug standards and have one registered nurse on shift to be accompanied by another suitably trained member of staff to manage Drugs Liable to Misuse. This provides additional scrutiny and security with the management of these medications.

We reviewed samples of Medication Administration Record (MAR Charts)[6]. All the MAR Charts reviewed contained the patient name and their legal status under the Act. MAR charts were consistently signed and dated when medication was prescribed and administered. On the whole when medication was not given to a patient this was recorded appropriately, however on one occasion it was noted that the standardised coding to identify why medication was not given was not used and a non-descript "x" inserted.

MAR Charts included a copy of the most recent Consent to Treatment Certificates that authorised medication (for mental disorder) under the Act. Therefore registered nurses were able confirm that medication had been authorised under the Act.

Each patient has a "My Medication" document which is kept within their physical health file of their records. However, it was not evidenced how the patient is supported to understand their medication; the reason why they are taking it and any side-effects. This is important as it ensures patients are best informed about their medication and supported in their choice to consent or otherwise.

It was positive to note that as part of rehabilitative model of care, when appropriate, patients would be able to manage and administer their own medication.

There was emergency resuscitation equipment and medication available which was easily accessible to staff and there was evidence that weekly checks were completed. However, we identified one item that had recently expired, September 2019, and one item where the package was no longer sealed; these items were removed and replaced immediately. The registered provider also confirmed that

[6] 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.

a new contents checklist would be put in place that includes the individual expiry dates of the contents.

Improvement needed

The registered provider must ensure that:

- Refrigerated medication is stored at the required temperature
- Appropriate arrangements are in place for medicines management and stock reconciliation, including Drugs Liable to Misuse
- Staff specifically code why medication has not been administered
- Patients are supported to understand their medication; the reason why they are taking it and any side-effects
- Appropriate arrangements are in place to ensure that emergency resuscitation equipment and medication is present and in date.

## Safeguarding children and safeguarding vulnerable adults

There were established processes in place to ensure that the hospital safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

The training statistics provided by the registered provider evidenced that 91% of staff were up to date with their adult safeguarding training and 84% with their child safeguarding training.

## Safe and clinically effective care

We found governance arrangements in place that helped enable staff to provide safe and clinically effective care for patients. However, improvements are required in medicines management and emergency equipment and medication checks. Further details on these are included within the medicines management section of this report and the improvement plan at Appendix B.

## Records management

Patient records were mostly paper documentation and were stored securely within locked offices to prevent unauthorised access and breaches in confidentiality; where there were electronic records these were password protected. We observed staff updating and storing the records appropriately during our inspection.

On the whole patient records were organised and easy to navigate. However some improvements are required in the consistency of indexing, particularly in the individual patient physical health files, to aid filing and referring to information.

There was also limited storage within the nursing office which meant that some files were not stored on shelving or within cabinets for ease of access but left disorganised on the desk surfaces.

Improvement needed

The registered provider must ensure that:

- There is a consistent indexing of patient records
- Designated storage is available for all patient files within the nursing office.

## Mental Health Act Monitoring

We reviewed the statutory detention documents of three patients. We also reviewed the governance and audit processes that were in place for monitoring the use of the Act at the hospital.

The three sets of statutory documentation verified that the patients were legally detained. It was evident that detentions had been renewed within the requirements of the Act. The renewal of detention was correctly applied on statutory forms and copies of legal detention papers were available.

It was documented within patient records that they had been informed of their rights in line with Section132 of the Act. Records evidenced that appeals against the detentions were held within the required timescales.

Medication was provided to patients in line with Section 58 of the Act, Consent to Treatment; as stated above, consent to treatment certificates were kept with the corresponding MAR Chart. However, still outstanding from our inspection in February 2019, there was no record of the statutory consultees' discussions with the Second Opinion Appointed Doctor (SOAD). During the inspection a standardised form was developed to enable statutory consultees to record their discussion with the SOAD.

All patient leave had been authorised by the responsible clinician on Section 17 Leave authorisation forms. Section 17 Leave clearly stated the conditions of leave, i.e. escorted or unescorted, location and duration. It was also documented

whether the patient had been offered and received a copy of their Section 17 Leave form.

Improvement needed

The registered provider must ensure that there is a clear record of each statutory consultee's discussion with the SOAD.

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

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

There was evidence that care co-ordinators had been identified for the patients. The Care and Treatment Plans reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed.

To support patient care plans, there were a range of patient assessments to identify and monitor the provision of patient care, along with risk assessments that set out the identified risks and how to mitigate and manage them.

Individual care plans drew on the patient's strengths and focused on recovery, rehabilitation and independence. These were developed with members of the multi-disciplinary team and utilised evidence based practice. There was evidence of discharge planning where appropriate for patients on that pathway.

Since our previous inspection the hospital had introduced comprehensive physical health files. Two out of three patient records evidenced a fully completed and current overall physical health assessment. There were standardised detailed assessments to accompany these, which included pressure ulcer score risk assessments and falls risk assessment. However, one of the three contained only a partially completed overall physical health assessment.

Physical health files also included standardised monitoring documentation such as, NEWS[7] and MUST[8]. However, in one patient record their physical health monitoring documentation was not fully completed, this means that changes within their physical health may not be identified promptly, causing a delay in addressing the issue which may lead to deterioration in the patient's health.

It was positive to note that patient records included an up to date Hospital Passport. These assist people with learning disabilities to provide staff in general hospitals with important information about the person and their physical health when they are admitted.

Whilst the patients that we spoke with confirmed that they were encouraged to be involved in developing their care, care plans did not fully reflect this. We found that even though care plans were written from the perspective of the patient in first person, there was a lack of patient quotes or language to truly reflect patient involvement and their views on the care plans.

Improvement needed

The registered provider must ensure that:

- All patients to have a complete and current physical health overview assessment
- Physical health monitoring documentation is completed and acted upon when required
- Care plans demonstrate patient involvement and include their views.

[7] The National Early Warning Score is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs such as, respiratory rate, oxygen saturation, temperature, blood pressure, pulse/heart rate, AVPU (alert, verbal, pain, unresponsive) response.

[8] MUST (Malnutrition Universal Screening Tool) is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan

## Mental Capacity Act and Deprivation of Liberty Safeguards

As stated earlier, DoLS documentation was in place which ensured the validity of the DoLS authorisations. There were also DoLS care plans in place to direct staff in managing the patient under these safeguards.

## 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.*

There were defined hospital structures and systems that provided clinical and corporate governance to direct the operation of the hospital.

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

Staff were dedicated and knowledgeable and showed good understanding of the individual needs of the patients at the hospital.

Improvements are required in the completion of mandatory training and the registered provider must ensure that all staff have annual performance appraisals.

### Governance and accountability framework

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

Since our previous inspection there had been a number of changes in senior personnel at the hospital. The hospital manager (registered manager) and assistant manager had departed in August and July respectively. Both posts had been appointed to with the new assistant manager in post since August and the hospital manager due to commence the week following the inspection. In the interim the Director of Operations was overseeing the day-to-day operation of the hospital. We were informed that the newly appointed hospital manager will be

submitting their registration application to become registered manager once in post.

Staff spoke positively about the leadership and support provided by the current management at the hospital. Through our conversations with staff it was positive to note that they stated that staff morale had continued to improve since our last inspection helped by the current hospital leadership.

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

Improvement needed

The registered provider must ensure that a designated person submits their application to become registered manager.

### Dealing with concerns and managing incidents

We found there were established processes in place for dealing with concerns and managing incidents at the hospital.

It was evident that concerns and incidents were monitored locally at Coed Du Hall, these were discussed daily. There was a review system in place to provide additional oversight and understand lessons learnt from incidents.

### Workforce planning, training and organisational development

We reviewed the staffing establishment at Coed Du Hall, the hospital was pro-actively attempting to recruit to vacant registered nurse and health care support worker posts. To cover any shortfalls in fulfilling the staffing rota that may occur due to vacancies, the registered provider had a staff bank system in place along with the use of agency staff. Agency registered nurses were typically frequent individuals who were familiar with working at the hospital and the patient group; this assisted with the continuity of care for patients.

The registered provider had a file of agency workers, this contained evidence that the agency staff member had relevant training and checks undertaken, along with completing their hospital induction prior to working at Coed Du Hall. We reviewed a sample of 10 agency staff that were frequently used at the hospital, the induction information for three of the staff was not present within the file. This was sourced from the agency and the omission rectified during the inspection. It is necessary for the hospital to have a copy of this information available onsite so this can be checked at any time.

We reviewed the mandatory training statistics for staff and found that e-learning completion rates were above 75% except for risk assessment training which was at 69%. Classroom based training statistics evidenced that improvements were required in the three courses: physical intervention (79%), Basic Life Support (56%) and Fire Training (65%). The registered provider had booked further classroom training sessions for these modules to improve compliance.

We reviewed the clinical governance meeting records which showed that there was a clear record of training compliance being monitored and actions being taken to improve compliance. It was also positive to note that staff had completed additional training appropriate for caring for the patient group which included Tissue Viability training and Sepsis training. However, there wasn't specific training provided to staff in relation to the Act. Some staff we spoke with stated that they felt they lacked knowledge in this area and would benefit from training to benefit their understanding and implementation of care for patients.

Staff completed annual performance appraisals and these were documented to evidence that these had been completed. 88% of staff had received their annual appraisal and there was plans to ensure all staff had completed their appraisal before the end of November.

Improvement needed

The registered provider must ensure that:

- All agency worker training and induction documentation is held within the hospital
- All staff complete their mandatory training
- Staff have training on the Mental Health Act and its implementation
- All staff complete their annual performance appraisals.

### Workforce recruitment and employment practices

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

We reviewed six staff files that evidenced that on the whole this was the case however one file only contained one reference. Not all files had a copy of their

contract of employment however they did have up to date terms and conditions of employment.

It was positive to note that it was practice for renewals of DBS checks were completed every three years, however for one member of staff reviewed the latest DBS on file was dated 2014, and therefore older than three years.

Improvement needed

The registered provider must ensure that all staff have DBS checks in line with the registered provider's policy.

# 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 | Not applicable | Not applicable | Not applicable |

## Appendix B – Improvement plan

## Service: Coed Du Hall

## Date of inspection: 4 - 6 November 2019

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| **Quality of the patient experience** | | | | |
| The registered provider must ensure that information about Mental Health Act is displayed. | 9. Patient information and consent | Information about the Mental Health Act to be placed on all notice boards.<br>Information about the Mental Health Act to be posted in the visitor's room. | LM | 20.11.2019 |
| The registered provider must ensure that information about HIW and how to contact us is displayed on the wards. | 9. Patient information and consent | HIW contact information to be placed on the notice boards and in public areas. | LM | 20.11.2019 |
| The registered provider must ensure that information is displayed in a format to aid patient understanding. | 9. Patient information and consent | Purchase a stand and print off easy read information to display in the visitor's room. | LM | 20.11.2019 |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| **Delivery of safe and effective care** | | | | |
| The registered provider must ensure that nurse call buttons are suitably located to aid patients calling for assistance. | 22. Managing risk and health and safety<br>12. Environment | Red cord in Beech toilet to be easily accessible by patients.<br>Maintenance to deliver remedial action<br>All areas of Nurse call checked and fit for purpose. | RJ | With immediate effect. |
| The registered provider must ensure that sharps bins are assembled with the lids in situ. | 13. Infection prevention and control (IPC) and decontamination | Lids placed on sharps bins. | ME | With immediate effect. |
| The registered provider must ensure that refrigerated medication is stored at the required temperature. | 15. Medicines management | New fridge with electronic and visual alarm (when fridge goes off range) to be ordered to ensure medication is always stored at required temperature.<br>Adjust the recording documentation to show highest, lowest and exact temperature. | MF | Fridge ordered for December 19 delivery<br>Document completed 07.11.2019 |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| The registered provider must ensure that appropriate arrangements are in place for medicines management and stock reconciliation, including Drugs Liable to Misuse. | 15. Medicines management | Another staff member to double sign in Drugs Liable to Misuse book. | MF | 07.11.2019 |
| The registered provider must ensure that staff specifically code why medication has not been administered. | 15. Medicines management | Remind Nurses of the importance of recording the correct code (3) if medication not given and to document the reasons in the daily entries (Care Plans) | MF | 20.11.2019 |
| The registered provider must ensure that patients are supported to understand their medication; the reason why they are taking it and any side-effects | 15. Medicines management | Record that patients are given medication fact sheets in easy read format during Primary Nurse sessions.<br>Complete LUNSERS (Liverpool University Neuroleptic Side Effect Rating Scale) for all patients | MF/Nurses/RC | 20.11.2019 |
| The registered provider must ensure that appropriate arrangements are in place to ensure that emergency resuscitation equipment and medication is present and in date. | 15. Medicines management | Replaced unsealed mask and reorder expired epi pen.<br>Deliver monthly audit of emergency equipment to ensure scrutiny and | GT/RJ | With immediate effect. |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | prompt actions and activity as required. | | |
| The registered provider must ensure that there is a consistent indexing of patient records. | 20. Records management | Print off indexes for two patient files that were missing to aid filing correctly. | NIC | With immediate effect |
| The registered provider must ensure that designated storage is available for all patient files within the nursing office. | 20. Records management | Review and organise locked filing for Physical Health files | MF | 20.11.2019 |
| The registered provider must ensure that there is a clear record of each statutory consultee's discussion with the SOAD. | Mental Health Act | Develop and use new form to record SOAD consultations. | LM | With immediate effect |
| The registered provider must ensure that all patients to have a complete and current physical health overview assessment. | Mental Health (Wales) Measure 2010 | Complete outstanding physical health overview for one patient.<br>Ensure all patients have a current physical health overview assessment. | MF | 20.11.2019 |
| The registered provider must ensure that physical health monitoring documentation is completed and acted upon when required. | Mental Health (Wales) Measure 2010 | Complete all physical health monitoring documentation for all patients.<br>Review and audit once complete. | MF/AG | 20.11.2019<br>Audited 18.12.2019 |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| The registered provider must ensure that care plans demonstrate patient involvement and include their views. | Mental Health (Wales) Measure 2010 | Complete Camberwell to reflect patient's own views in their own words and ensure copy of care plan is offered to the patients, recording decision to accept or otherwise. | MF/Nurses | 20.11.2019 |
| **Quality of management and leadership** | | | | |
| The registered provider must ensure that a designated person submits their application to become registered manager. | 1. Governance and accountability framework | New Manager to register with HIW and submit application | MF | 06.12.2019 |
| The registered provider must ensure that all agency worker training and induction documentation is held within the hospital. | 25. Workforce planning, training and organisational development | Update agency file to include compliance with training and induction documentation.<br>Deliver regular audit to ensure compliance. | LM | 20.11.2019 |
| The registered provider must ensure that all staff complete their mandatory training. | 25. Workforce planning, training and organisational development | Email all staff to complete outstanding training and arrange Basic Life Support, Fire and Physical Intervention training to capture outdated staff.<br>Complete monthly audit | LM | 20.11.2019 |

| Improvement needed | Regulation/ Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| The registered provider must ensure that staff have training on the Mental Health Act and its implementation. | 25. Workforce planning, training and organisational development | Develop Power point presentation.<br>Staff training dates to be arranged. | Dr T/ LM | To commence Jan 2020. (5th and 12th) |
| The registered provider must ensure that all staff complete their annual performance appraisals | 25. Workforce planning, training and organisational development | Ensure 3 (was 9) outstanding appraisals are completed.<br>Complete and deliver database to ensure compliance. | MF/LM | New RM to complete by 31.12.19 |

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): Laura Morgan**

**Job role: Assistant Manager**

**Date: 19 December 2019**