Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection (Unannounced)

Gellinudd Recovery Centre

Hafal

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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 Gellinudd Recovery Centre on the evening of 22 July and days of 23 and 24 July 2019. The following sites and wards were visited during this inspection:

- Gellinudd Recovery Centre

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

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with Act.

HIW explored how the service complied with the Care Standards Act 2000, requirements of the Independent Health Care (Wales) Regulations 2011 and met the National Minimum Standards (NMS) for Independent Health Care Services in Wales. Where appropriate, HIW also consider how services comply with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Further details about how we conduct independent mental health service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, we found evidence that the service provided safe and effective care within a pleasant environment. The service demonstrated an emphasis on patient centred care.

Care was recovery focused with significant consideration for the dignity and independence of patients.

However we found some evidence that the hospital was not maintaining clinical records to the expected standard.

This is what we found the service did well:

- Good evidence of mentoring for students on the wards by the management team
- Established governance arrangements that provided safe and clinically effective care
- We observed respectful and positive engagement between staff and patients
- A range of suitable facilities were provided in a well maintained and pleasant environment of care
- Introduction of peer support staff, facilitated by the peer mentor training programme.

This is what we recommend the service could improve:

- Review processes around emergency call buttons and placement of panic buttons
- The information displayed within the hospital for patients and visitors
- Completion of clinical documentation
- Implementation of the Mental Health Act.

There were no areas of non-compliance identified at this inspection.

3. What we found

Background of the service

Gellinudd Recovery Centre is registered to provide an independent mental health rehabilitation service at Gellinudd Recovery Centre, Lôn Catwg, Gellinudd, Pontardawe, Neath Port Talbot, SA8 3DX.

The service has a total of 16 beds across five wards; Meadow Suite, two beds; Spring Suite, three beds; Summer Suite, four beds; Autumn Suite, four beds; and Winter Suite three beds.

Gellinudd Recovery Centre is a mixed gender hospital with each ward being gender specific. At the time of inspection, there were five patients.

The service was first registered on 3 March 2017 and opened on 31 May 2017.

The service employs a staff team which includes a recovery centre manager, a psychiatrist, a psychotherapist, a team of registered mental health and general nurses, peer support workers[1] and recovery practitioners[2]. The day to day operation of the hospital was supported by dedicated teams of administration staff.

The registered provider has given clear consideration to the language used within the service. The hospital is called Gellinudd Recovery Centre and patients are referred to as guests and the workforce as practitioners. This report will use the terminology of the Independent Health Care (Wales) Regulations 2011 and the National Minimum Standards (NMS) for Independent Health Care Services in Wales, i.e. hospital, staff and patients.

[1] Members of staff who have previously been in contact with mental health services.

[2] Staff who provide direct care to patients but are not professionally registered, commonly known as healthcare support workers.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We observed staff interacting and engaging with patients appropriately, and treated patients with dignity and respect.

The hospital was well equipped and furnished to a high specification which provided a very pleasant environment of care.

The service was focussed on accessing local community services as part of its rehabilitative care. Patients were encouraged to participate and were supported in a range of activities to be as independent as possible.

Health promotion, protection and improvement

The hospital had a range of well-maintained facilities to support the provision of therapies and activities. These facilities included a dedicated activity room which was equipped with appropriate resources, and access to a large garden, which included a separate therapeutic, tranquil garden space.

Patients were given membership to a local gym and other leisure facilities within the local community that they could access whilst on Section 17 leave[3]. Staff had access to two designated hospital vehicles which enabled staff to facilitate patients' activities and medical appointments in the community.

Patients had open access to the kitchen area and were encouraged to plan and prepare their own meals with support from staff. This gave patients the opportunity to have an input on what they ate on a daily basis. All patients and staff had received the appropriate food hygiene training. It was also pleasing to note that the recovery centre had a food hygiene rating of 5, which reflects excellent standards in food preparation, storage, and the cleanliness of the kitchen and storage areas. Patients also had access to the laundry room with

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

supervised support. The laundry room enabled patients to use the washing machine, tumble dryer, iron and ironing board. This clearly demonstrated the recovery centre's philosophy to empower patients to become more independent.

Throughout the inspection we gathered information from staff, patients, and we attended meetings. We were advised by staff that patients take part in a variety of activities and planned events such as a beach walks and cinema visits which were discussed during the meetings we attended. However at the time of the inspection we did not observe any patients participating in recreational activities within the hospital. A variety of resources were available for patients, which included an interactive television located in the main communal area. The hospital also had table tennis, jigsaws, board games and an exercise bike for patients to exercise within the hospital.

Upon admission to the hospital patients were provided with a detailed "guest information leaflet" the leaflet provided patients with a range of information regarding their stay at the hospital. The information leaflet made reference to a shop being available at the hospital however this was not the case. Upon reviewing the guest information booklet, we advised the registered provider to review the information to ensure that the content is accurate and reflects the current services available to patients.

Improvement needed

The Registered provider must update the guest information booklet to be updated to reflect current services available to patient.

Dignity and respect

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

We 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.

Each patient had their own bedroom which they could access throughout the day. The bedrooms provided patients with a high standard of privacy and dignity. Patients had electronic door fobs to access their ward and individual bedroom. It

was positive to note that the registered provider had given great consideration to the appearance of the observation panels on bedroom doors; these were pleasant pictorial representations of the bedroom's name which meant the ward appeared less clinical. Bedroom doors automatically locked on closing which prevented other patients entering; staff could override the locks if required. We also observed staff knocking on patients' bedrooms before entering which demonstrated that staff respected the patient's privacy and dignity. Window vision panels were used to check on patients during the night. Lights were also available which were operated by clickers to enable staff to effectively undertake night time observations without unnecessarily disturbing the patients. There were a number of rooms available for patients to have private conversations with staff. Patients were able to use their own mobile phones and they also had access to a telephone located within the hospital.

During our inspection we observed family members visiting patients and spending time with the patients in a variety of locations throughout the hospital. The children's visiting room, Katkins was extremely well furnished with a range of toys and activities for children available. It was really positive to note that the children's visiting suite also had its own secure garden with outdoor toys, providing suitable provisions for children who visit the centre.

Patient information and consent

An information board was displayed within the communal area, the board in the communal area provided appropriate and relevant information for patients including posters and leaflets for advocacy services. However we felt that there was insufficient information available for families and visitors. For example visiting times were included in the guest information booklet but this was not provided to families/visitors unless they specifically asked for it. Posters and leaflets were also displayed for advocacy services.

Improvement needed

The registered provider must ensure the information board has additional information for families and visitors.

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 each individual patient. Where patients remained unclear, or what they were trying to

communicate was misunderstood, staff would patiently attempt to clarify what they had said.

Some staff working within the hospital are peer mentors who have completed accredited mentor training. The trained staff have their own personal experiences in dealing with mental illness and recovery. During the inspection we observed staff listening to patients and sharing experiences to help patients discuss and understand their own journey in the recovery process.

We observed a number of meetings taking place where arrangements for daily activities were discussed and patients allocated specific activities for the day, within the hospital and the community. These meetings also covered care planning meetings, medical appointments and tribunals. In addition there was an evening meeting where patients could again discuss any matters regarding the hospital.

We attended a number of clinical meetings and it was evident that discussions focused on what was best for the individual patient. Where the patient was present at the meeting all staff engaged respectfully and listened to the patient's views and provided the patient with clear reasons for the decisions taken.

Patients and visitors were able to access an electronic screen at the entrance point of the communal area which enabled patients and visitors to complete short surveys and feedback on the hospital. Thank you cards were also displayed within the communal area.

Care planning and provision

There was a clear focus on providing safe and effective care for patients, with measured steps for positive risk taking and exposure to minor hazards. Care was individualised, focused on recovery and was supported by least restrictive practices, both in care planning and hospital practices. There was clear evidence within the patient notes examined that patients are actively involved in their care and treatment plans.

Each patient had their own individual activity planner. This included individual and group sessions, based within the hospital and the community (when required authorisation was in place). Activities were varied and focused on recovery.

Equality, diversity and human rights

Staff practices aligned to established hospital policies and systems ensured that patients' equality, diversity and rights were maintained.

Mental Health Act detention papers had been completed correctly to detain patients at the hospital. However, the registered provider must implement improvements to the application of the Act to fulfil its statutory duties under the Act and as set out in the Mental Health Act Code of Practice for Wales 2016. These are detailed later in the report.

Citizen engagement and feedback

There were regular patient meetings and surveys to allow for patients to provide feedback on the provision of care at the hospital. The guest information booklet contained details on how patients can make complaints and also contained appropriate information and contact details for HIW. There was also a poster on display which detailed the hospital's complaints process.

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 well maintained and equipped with suitable furniture, fixtures and fittings for the patient group.

There were established processes and audits in place to manage risk, health and safety, medicine management and infection control. This enabled staff to continue to provide safe and clinically effective care.

However, the hospital should review process around emergency call buttons and the placement of the alarms.

Managing risk and health and safety

Gellinudd Recovery Centre had established processes in place to manage and review risks and to maintain health and safety at the hospital. This enabled staff to continue to provide safe and clinically effective care.

Access to the hospital building was direct from the car park level which provided appropriate access for persons with mobility difficulties. The hospital entrance was secured to prevent unauthorised access.

The layout of the hospital contributed to making it a very welcoming and pleasant setting which had a homely feel to the environment. It was positive to see that patients were also involved in maintaining the environment. However, we did note that patients with mobility issues may have some problems with accessing the en-suite shower facilities due to the placement of a step within this area. We also noted that the garden area needed some lawn maintenance.

Although there were nurse call points around the bedroom and communal rooms, there were no alarms located along the ward corridors. Staff told us that they had access to 'walkie talkies'. However we were not satisfied that patients or staff had access to immediate help if an incident occurred in the ward corridors and would recommend that the registered manager reviews processes around emergency call buttons and the placement of the alarms within the ward corridors.

The registered provider had implemented an electronic recording system which documented all incidents and complaints. This system supported staff to identify risky behaviours or trigger points for patients. Staff could then use this information

to develop care plans that focussed on managing the risks for each individual patient and included the staffing resources required to manage the risks.

We noted evidence of some positive risk taking and exposure to minor hazards within the hospital environment which was appropriate for the current patient mix. The furniture, fixtures and fittings at the hospital were also appropriate for current patient group. However if the patient group changes over time, the registered provider must ensure that the environment develops and remains suitable for any changes to the type of patients accommodated in the hospital.

The hospital was well staffed with an appropriate skill mix. A new occupational therapist had been appointed and was due to commence the position in August. We were advised that patient activities had not been adversely affected due to the absence of an occupational therapist as all staff would engage in activities with the patients. There were no other staff vacancies based on the current patient numbers at the hospital and it was evident that the current patients' needs were being met.

Improvement needed

The registered provider must undertake a review of nurse call point's locations.

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. Both the staff and patients have responsibility for maintaining the cleanliness of the hospital. There were hospital laundry facilities available so that patients could undertake their own laundry with appropriate level of support from staff based on individual needs.

A comprehensive system of regular audit in respect of infection control was in place. Daily audits were completed and filed accordingly. Staff confirmed that cleaning schedules were in place to promote regular and effective cleaning of the hospital and they were aware of their responsibilities around infection prevention and control. Staff also had access to infection prevention and control and personal protective equipment when required. There were suitable arrangements in place for the disposal of waste. Appropriate bins were available to dispose of medical sharp items. These were not over filled.

There were hand hygiene products available in some areas of the hospital; these were accompanied by appropriate signage, however no hand hygiene products

were available at the entrance point of the hospital and we would recommend that hand hygiene products are available at this location.

Improvement needed

Hand hygiene products to be made available at entrance point of the hospital.

Nutrition

We found that patients were supported in fulfilling their nutritional needs. As part of patient rehabilitation, staff supported patients to plan and prepare their own meals or communal meals for patients and staff at the hospital. This equipped patients with cooking skills and additional skills in menu preparation and food shopping as part of their community focused rehabilitation activities.

It was positive to note that patients and staff prepared and ate food together; this provided a communal activity which engaged patients and staff. A good selection of fresh fruit was located in the communal area which was freely available to all patients.

There were suitable facilities available to patients for hot and cold drinks. We observed patients accessing the patient kitchen facilities throughout the inspection. It was noteworthy that each ward's communal area had a drinks-bay which enabled patients to make their own drinks throughout the day and night without them having to attend the main hospital kitchen.

Medicines management

Medication was stored securely in cupboards and medication fridges locked within the locked clinic. There was evidence that there were regular temperature checks of the medication fridge and clinic rooms to ensure that medication was stored at the manufacturer's advised temperature. The clinical room was very well organised and cupboards were clearly labelled. However, there was limited medication storage space remaining. At the time of the inspection the hospital was not fully occupied with vacancies for up to an additional 11 patients. Therefore with additional patients there may be insufficient medication storage within the clinic room.

At the time of the inspection the hospital was experiencing delay and difficulties with their external pharmacy in providing medication in a timely manner. Whilst we acknowledge that the hospital is reliant upon the efficiency of third parties who are involved in this process (GP & Pharmacy) the registered manager needs to ensure that the issues surrounding delays are resolved promptly.

The Medication Administration Record (MAR) charts were reviewed including copies of the consent to treatment certificates. MAR charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. However, whilst the front of the MAR charts include the patient name, pertinent information required to be completed on the front page was omitted, such as allergy information. It is essential that the patient information on each MAR chart is fully completed. In addition we also noted some patients' MAR charts had out of date Consent to Treatment Certificates filed alongside the chart. Therefore registered nurses may not be referring to the correct Consent to Treatment Certificates to confirm that medication had been authorised under the Mental Health Act.

Improvement needed

The registered provider should review the medicine ordering process.

The registered provider must ensure that patient information on each MAR chart is fully completed.

The registered provider must ensure that only the most recent consent to treatment certificate(s) is included with the MAR chart.

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 nominated safeguarding lead worked within Hafal and in addition to being the point of contact for safeguarding this individual provided all safeguarding training for the hospital. During our discussions with the registered manger she clearly demonstrated her knowledge on what constituted a safeguarding referral.

As detailed above, a child visiting suite was available with its own garden area that assisted in safely facilitating child visitors.

Medical devices, equipment and diagnostic systems

There were regular clinical audits at the hospital including a nightly audit of resuscitation equipment. Staff documented when these had occurred to ensure that the equipment was present.

There were a number of ligature cutters located throughout the hospital in case of an emergency. During staff discussions it was evident that all staff were aware

of the locations of ligature cutters. There were up-to-date safety audits in place, including ligature point risk assessments.

Safe and clinically effective care

We found governance arrangements in place that helped ensure that staff provided safe and clinically effective care for patients.

Clinical governance arrangements for the hospital fed through to Hafal central governance arrangements, which facilitated a two way process of monitoring and learning.

Participating in quality improvement activities

The registered provider was pro-actively engaged with peer organisations and individuals to develop and improve the service. The hospital also had an independent Professional Advisory Committee that reviewed and advised on practice and policies and which included members of the local community and independent external auditors. This practice was really praiseworthy and displayed the hospitals transparency and integrity to incorporate independence within their governance meetings and Professional Advisory Committee meetings.

It was noteworthy that the hospital was engaging with local universities with PhD studies being undertaken that provided the hospital with external evaluation as part of the academic research. Links with local colleges, leisure centres and community initiatives ensured that patients had access to courses and activities, enabling patients to participate in meaningful activities during their time at the hospital and when they are also on unescorted leave. Staff at the hospital were also trained in a variety of different psychological therapies, offering patients opportunities to access different types of therapies at the hospital.

Records management

Patient records were paper files that were stored and maintained within locked offices. We observed staff storing the records appropriately during our inspection. Patient records were very well organised and the quality of entries were of a high professional standard. We did identify in one set of clinical records, a medical entry being crossed out. Good practice would be for the incorrect entry to be initialled and dated, and the new correct entry added. It was positive to note that entries by staff, including incident reports, were respectful of the patient and provided clear and objective information.

Clinical notes were well organised and dividers used to separate different sections. However we did note that in one file we reviewed, the section relating to correspondence had loose pages and was at risk of being lost.

Improvement needed

The registered provider must ensure that any crossed out clinical entries are clearly initialled and dated.

Mental Health Act Monitoring

We reviewed the statutory detention documents of three patients in the hospital.

The statutory documentation reviewed verified that the patients were legally detained. We noted that consent to treatment certificate forms were not adequately maintained at the hospital. Some patient files had documentation that was no longer valid which were not clearly marked as so or removed, therefore they could be mistaken for the current documentation.

Through reviewing the patients' records we also identified the following areas that require compliance and improvements:

- Hospital Managers are required to ensure detained patients understand the reason for their detention, paragraph 4.2
- Patients must be told what the Act says about treatment for their mental disorder , paragraph 4.23
- All expired section 17 leave forms should be clearly marked as no longer valid, paragraph 27.17
- No record of capacity to consent to treatment evidenced, paragraph 24.34

Improvement needed

The registered provider must ensure that MAR charts are accompanied by the current corresponding consent to treatment certificate(s).

The registered provider must consider how to best equip ward staff with a greater understanding of the Mental Health Act and the Code.

The registered provider must review their administration processes to ensure compliance with the Codes of Practice for Wales (Revised 2016) and provide further training to equip staff with a greater understanding of the Mental Health Act and the Code

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

We reviewed the care plans of a total of 2 patients.

They were generally of a good standard. The notes and care plans we inspected clearly evidenced that patients are involved in their care and treatment plans. However we did identify some areas of improvements

- Strengths not highlighted within the care plans
- Hafal clinical risk management plan not dated or signed
- Notes reflected that medication was discussed within multidisciplinary team meetings. However notes did not reflect or evidence that the patient was involved in the discussion
- Unmet needs were not documented within the care plan.

The provider must ensure that all the above information is documented and contained in the care plans.

Improvement needed

Hafal clinical risk management plan to be signed and dated.

The registered provider must ensure that unmet needs are evidenced and documented within patient care plans.

Individual Care and Treatment Plans to include patient's strengths and patients' involvement in discussions surrounding medication.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of our inspection, staff confirmed that there were no patients subject to Deprivation of Liberty Safeguards (DoLS) authorisations.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Independent Health Care Regulations and National Minimum Standards.

We saw good management and leadership at the hospital which was supported by the Hafal organisational structure. We observed a committed staff team who had a good understanding of the needs of the patients at the hospital.

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

It was positive to note that there was an introduction and investment in the Peer Mentorship programme for patients.

Governance and accountability framework

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

Identified senior managers had specific responsibilities for ensuring that the programme of governance remained at the forefront of service delivery. Those arrangements were recorded so that they could be reviewed both within the hospital and the wider organisational structure.

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

Dealing with concerns and managing incidents

There was a complaints policy and procedure in place at the hospital. The policy provides a structure for dealing with all patients' complaints for services within the hospital.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the system that included the name of patient(s) and staff involved, a description, location, time and length of

the incident. This provided staff with appropriate data to identify trends and patterns of behaviour.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and reviewed at hospital and organisation level so that the occurrence of incidents could be reviewed and analysed.

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. We did suggest that staff sign and date minutes of meetings to demonstrate that the minutes have been read and understood.

Workforce planning, training and organisational development

The staffing establishment at Gellinudd Recovery Centre met what was detailed within their Statement of Purpose. It was positive to note that the multi-disciplinary team was well established; the records we reviewed and conversations with staff evidenced collaborative multi-disciplinary team working.

We reviewed the mandatory training and clinical supervision statistics for staff at the hospital and found that completion rates were high. There was a programme of training so that staff would receive timely updates. The electronic records provided the senior managers with details of the course completion rates and individual staff compliance details. Staff were also trained in some 'train the trainer' which enabled the trainers to provide onsite training to staff. All staff had regular Professional Development Meetings with senior management and we saw evidence of meaningful and relevant professional development discussions and plans which were documented in individual staff records.

Workforce recruitment and employment practices

It was evident that there were systems in place to ensure that recruitment followed an open and fair process. All recruitment was undertaken centrally by Hafal . Prior to employment staff references were received, Disclosure and Barring Service (DBS) checks were undertaken and professional qualifications checked.

Therefore we were assured that recruitment was undertaken in an open and fair process with appropriate employment checks being carried out prior to employment.

A staff induction process was in place. New staff undertake a 6 monthly probation period and are continually supported by an experienced member of staff who is

responsible for the completion of a competency form. We observed senior staff at the hospital monitoring students administering medication and we observed students leading a staff hand over briefing. This was really positive to see and clearly evidenced the senior staff investment in developing, supporting, and mentoring staff new to the role.

The hospital had a clear policy in place for staff to raise any concerns, this was displayed in the staff room area. Occupational health support was also available. Hafal have their own therapy service for staff, and staff can also be referred to an internal member of staff who is a trauma based therapist.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a non-compliance notice. The issuing of a non compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect independent mental health services

Our inspections of independent mental health services are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of independent mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards
- Comply with the Care Standards Act 2000
- Comply with the Independent Health Care (Wales) Regulations 2011
- Meet the National Minimum Standards for Independent Health Care Services in Wales.

We also consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within independent mental health services.

Further detail about how HIW inspects mental health and independent services can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection			

Appendix B – Improvement plan

Service: Gellinudd Recovery Centre

Ward/unit(s): Gellinudd Recovery Centre

Date of inspection: 22 – 24 July 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				
Guest information booklet to be updated to reflect current facilities available at the hospital	3. Health promotion, protection and improvement	Guest information booklet to be reviewed and updated.	Recovery Centre Manager	Completed
Display board to provide additional information for families and visitors	9. Patient information and consent	Visiting times to be displayed on existing notice board	Recovery Centre Manager	October 2019
Delivery of safe and effective care				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Review of nurse call point's locations to be undertaken.	22. Managing risk and health and safety 12. Environment 4. Emergency Planning Arrangements	Review of incidents under taken No change to existing practice required. No incidents to date have highlighted a concern with current position of call buttons Walkie talkies are handed out every shift with means of contacting staff in an emergency reinforced to staff	Recovery Centre Manager	Ongoing review of incidents Walkie talkies already provided
Hand hygiene products to be made available at entrance point of the hospital.	13. Infection prevention and control (IPC) and decontamination	Following discussion with HIW and an assessment of the risk we will purchase hand foams for use at the entrance to the unit. Such foam is less effective than alcohol gel but poses less of a risk to guests and staff on ingestion and fire	Recovery Centre Manager	October 2019
The registered provider must ensure that there is sufficient medication storage at the hospital	15. Medicines management	Medication storage unit sufficient for up to 8 guests. This will be reviewed once guest occupancy levels increase to 9. Additional storage is available within hospital and this would have been evidenced if requested at the time of inspection.		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider should review Medicine ordering process.		The Medicine ordering process will be reviewed with supplying pharmacy, GPs and Consultant Psychiatrist	Recovery Centre Manager	October 2019
The registered provider must ensure that patient information on each MAR Chart is fully completed.		All charts currently have the correct information on them so this is now complete. Physical health file audit developed. This audit will be carried out weekly and findings handed over relevant staff i.e. primary nurses and clinical leads. Physical health file audit will be able to monitor level of compliance and ensure that non-compliance including patient information being missed is handed over and actioned. The MAR chart is stored within physical health file.	Clinical lead/ Recovery Centre Manager	October 2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that only the most recent Consent to Treatment Certificate(s) is with the MAR Chart.		This is currently regularly audited by mental health act team and forms part of overall independent audit. The new physical health file audit will also monitor compliance. Training to be provided monthly re: MHA documentation.re: mental health act will also highlight the reasons as to why only the most recent CO2/ CO3 needs to accompany the prescription chart which will aid compliance also.	Recovery Centre Manager/ Mental Health Act Administrator	To commence October 2019
The registered provider must ensure that any crossed out clinical entries are clearly initialled and dated.	20. Records management	Audit of clinical entries to be updated Changes to audit to be handed over to all staff Full audit of clinical documentation is currently carried out by independent nurse consultant.	Recovery Centre Manager	Completed
The registered provider must consider how to best equip ward staff with a greater understanding of the Mental Health Act and the Code	Monitoring the Mental Health Act	Monthly training programme to be developed for staff team. Mental Health Act administrator currently studying Mental Health Law and Practice Certificate	Mental Health Act Administrator/ Recovery Centre Manager	Monthly training programme to commence October 2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must provide staff with further training on the Mental Health Act.				
Quality of management and leadership				
No area of improvement identified.	Not applicable	Not applicable	Not applicable	Not applicable

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): **Alun Thomas**

Job role: **Chief Executive; Responsible Individual**

Date: **8/10/19**