Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Delfryn Lodge and Rhyd Alyn

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

Our Purpose

We check the safety and quality of healthcare across Wales.

Our Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

Our Values

We place people at the heart of what we do.

We are:

Independent – we are impartial, deciding what work we do and where we do it.

Objective - we are reasoned, fair and evidence driven.

Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find.

Inclusive - we value and encourage equality and diversity through our work.

Proportionate - we are agile and we carry out our work where it matters most.

Our Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued, and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.



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1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at Delfryn Lodge and Rhyd Alyn on 27, 28 and 29 July 2026.
The following hospital wards were reviewed during this inspection:

- Delfryn Lodge - 24 beds providing locked female rehabilitation services
- Rhyd Alyn - 6 beds providing female community rehabilitation services.

Our team for the inspection comprised two HIW healthcare inspectors, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one patient experience reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of five patient questionnaires and one family/carer questionnaire were completed, and two were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

We found that staff treated patients with kindness, respect and compassion, responding promptly and appropriately to their needs. Patients were supported through structured and effective care processes, including comprehensive assessments, timely access to healthcare services and regular multidisciplinary (MDT) reviews.
The unit environments were generally well maintained and provided safe, comfortable and therapeutic spaces, including pleasant communal and outdoor areas. All patients had access to their own en-suite bedroom, which they were encouraged to personalise. Observation panels on bedroom doors were fitted with blinds to help maintain privacy and dignity.

Patients were involved in decisions about their care and were encouraged to develop independent living skills. A wide range of therapeutic activities and facilities were available to support patients' wellbeing, with input from occupational therapy and the wider MDT. These contributed positively to patient experience and recovery.
We found a variety of opportunities for patients, families and carers to provide feedback and saw evidence that this was used to support service development and improvement. Positive arrangements were also in place to support carer engagement, including ongoing work through the Triangle of Care programme.

A wide range of suitable and accessible information was available to support patients during their stay, although improvements were needed to ensure information boards on Delfryn Lodge remained up to date and to introduce a dedicated "You Said, We Did" board on Rhyd Alyn.

Staff demonstrated a clear commitment to respecting patients' rights and individual preferences, supported by advocacy services and person-centred care planning. We found high compliance with Equality and Diversity training, and reasonable adjustments were in place to support equitable access to services.

This is what we recommend the service can improve:

- Ensure patient information displayed throughout the service is accurate, up to date and appropriately maintained
- Communicate actions taken in response to patient feedback consistently across both units.

This is what the service did well:

- Clear, supportive and respectful communication with patients

- Achieved Stage 1 Triangle of Care accreditation, demonstrating a commitment to involving and supporting families and carers
- Wide range of therapeutic activities
- Strong focus on rehabilitation and independence
- Regular opportunities for patient and carer feedback
- Independent lived experience representative involvement in patient care
- Support for Welsh-speaking patients and other language needs
- Positive support for transgender patients
- Development of a multi-faith room to support religious and cultural needs.

Delivery of Safe and Effective Care

Overall summary:

Overall, we found patients were receiving safe and effective care from a skilled and committed MDT. Suitable governance arrangements, policies and processes were in place to support safe and effective care, including MDT working, safeguarding arrangements, discharge planning, audit activity and systems for reporting and managing incidents.

Patient care was delivered in a coordinated and person-centred way, with staff demonstrating a good understanding of patients' needs and risks. Risk management was supported by individual risk assessments, Positive Behaviour Support plans, therapeutic observations and preventative approaches. Care plans were comprehensive, person centred and reflected patients' assessed needs, risks and preferences. We found patients were involved in their care and discharge planning wherever possible, and care records demonstrated MDT involvement in treatment and recovery planning.

Medicines management was well organised, with appropriate governance and auditing processes in place to support safe practice. However, medicines for Rhyd Alyn were being stored within Delfryn Lodge due to concerns regarding medicines room temperatures on Rhyd Alyn. In addition, checks of first aid equipment were not always completed at appropriate intervals. We also identified a documentation error within one consent to treatment form, which was addressed during the inspection.

We found good compliance with the requirements of the Mental Health Act, supported by a dedicated Mental Health Act administrator who provided oversight of statutory processes, monitoring and documentation.

Infection prevention and control (IPC) arrangements were generally well established, with good housekeeping standards observed throughout the service and an estates team based on site. However, we identified some environmental issues on Delfryn

Lodge, including damp within a patient bathroom and some damage to wall and floor surfaces requiring repair. Additionally, we noted gaps in occupational therapy department fridge temperature monitoring records. These issues required attention to support ongoing compliance with IPC arrangements.

This is what we recommend the service can improve:

- Address environmental issues promptly, including those affecting medicines storage and infection prevention and control arrangements
- Complete and document first aid equipment checks at the required frequency
- Strengthen fridge temperature monitoring processes to ensure they are completed consistently.

This is what the service did well:

- Robust risk management systems supported safe care delivery
- Compassionate and person-centred safeguarding practices
- Person-centred, recovery-focused care planning with patient involvement
- Strong Mental Health Act governance, dedicated administrative oversight and meaningful patient involvement in leave planning and decision-making
- Positive Behaviour Support principles within care delivery, with restrictive practices used as a last resort
- Strong support for patient self-administration of medication
- Electronic prescribing medicines administration (ePMA) system planned for implementation in late 2026
- Staff described a range of quality improvement initiatives that were ongoing or completed.

Quality of Management and Leadership

Overall summary:

We found effective management and leadership arrangements across both Delfryn Lodge and Rhyd Alyn. Staffing establishments were aligned with service requirements and were sufficient to support patient safety. Established governance systems provided effective oversight of all aspects of the service, including patient safety, clinical effectiveness, staffing, safeguarding, incidents, complaints and quality improvement activity. Governance meetings, audits and monitoring processes supported accountability and ensured that identified issues were reviewed, addressed and managed in a timely manner.

Staff we spoke with during the inspection described leaders as visible, approachable and supportive. Staff reported feeling able to raise concerns and report unsafe practice, and appropriate arrangements were in place to support staff wellbeing and

engagement. Established meeting structures provided opportunities for staff to raise concerns; however, we noted that senior staff meetings had not been held in line with the required frequency during the previous six months.

Recruitment processes were appropriate, with evidence of suitable pre-employment checks completed prior to staff commencing employment. Appraisal and supervision compliance rates were high, and overall training compliance exceeded 90% across both units. However, we found low compliance with Safer People Handling training and sought immediate assurance regarding arrangements to mitigate associated risks. The service took prompt action to address the matter during the inspection.

We also identified several additional mandatory and role-specific training courses where compliance required improvement. Some lower compliance figures reflected small staff cohorts, newly introduced courses, specialist training requirements and delays in the training system being updated following completed training and staff role changes. Whilst these issues were being monitored through governance arrangements, further work was required to ensure outstanding training was completed and records remained accurate and up to date.

This is what we recommend the service can improve:

- Ensure staff meetings are held in accordance with required frequency
- Ensure all staff complete all outstanding mandatory and role-specific training within expected timescales
- Review the training management system to ensure staff training requirements are relevant to their current roles and that compliance records are accurate and up to date.

This is what the service did well:

- Effective MDT working
- Up-to-date policies and procedures supporting safe and effective care
- Appropriate staffing levels, with no agency staff used since January 2026
- A range of staff wellbeing and support mechanisms
- Introduction of an After Action Review (AAR) initiative to strengthen learning and reflective practice following incidents
- Compliments significantly outweighed complaints across both units
- Staff were receptive and responsive to our inspection findings.

3. What we found

Quality of Patient Experience

Patient feedback

We invited patients, families and carers to complete HIW questionnaires and spoke with patients on the units where appropriate. A total of five patient questionnaires and one family/carer questionnaire were completed. The sample size was therefore too small to draw robust conclusions, and not all respondents answered every question. Patient feedback was mixed. Most patients were positive about the care they received from staff, the information provided to them, and aspects of the unit environment, including their bedrooms, food, outdoor space and activities. However, one patient commented:

> *"Need more staff to facilitate our needs etc going into the garden, going on days out, going for a little walk twice a day."*

Patients also raised concerns regarding involvement in care planning. Whilst they reported being able to attend meetings and ward rounds relating to their care and treatment, not all were aware of their care and treatment plan and none felt involved in its development. Additionally, one patient reported that they did not feel listened to during ward rounds and MDT meetings.

Patient views regarding safety were mixed, with three of the five respondents reporting that they did not feel safe. One patient commented:

> *"Because there isn't enough staff to have a chat with sometimes the staffing is so short that I and others have not felt safe."*

Despite these concerns, most respondents (3/5) rated the overall quality of the setting as 'good'.

The family/carer feedback received was positive. The respondent described staff as "amazing", felt welcomed and safe when visiting the hospital, reported being appropriately involved in the patient's care, and commented that the range of activities available for patients was exceptionally good.

The service should review the feedback received and consider further opportunities to strengthen patient involvement in care planning and address concerns regarding safety and access to activities.

Health promotion, protection and improvement

We found effective processes in place to promote and maintain patients' physical and mental health. Patients were able to access a range of suitable information to support their health and wellbeing. A Registered General Nurse (RGN) led on physical healthcare, ensuring patients received physical health assessments on admission, ongoing monitoring and referrals where required. Patients were encouraged to participate in health screening programmes and were supported to manage long-term conditions. The RGN provided health promotion advice, monitored the side effects of prescribed medication and offered flexible support through a health drop-in clinic.

Patients were supported to engage in a range of therapeutic, recreational and community-based activities which contributed to their physical and mental wellbeing. Activity programmes were clearly displayed to promote participation. Occupational Therapy (OT) provision was available across both units, and an activities co-ordinator was available daily to support patient engagement. A wide range of self-directed activities was also provided, including access to televisions, games and puzzles.

Dignity and respect

Throughout the inspection, we observed staff engaging with patients appropriately and treating them with dignity and respect. Staff interacted with patients in a calm, considerate and professional manner, contributing to a positive and supportive unit environment. An appropriate mix of staff was in place across both units to meet patients' needs.

Patients' privacy and dignity were promoted throughout the service. Both units provided care for females only, with en-suite bedroom and bathroom facilities. Communal areas were available for social interaction, alongside quieter spaces where patients could spend time alone, including a sensory room. All patients had their own bedroom and were able to personalise their rooms and keep personal belongings, subject to individual risk assessments. Patients were also able to lock their bedrooms, with staff able to override locks if necessary.

Observation panels on bedroom doors were fitted with blinds, allowing privacy to be maintained whilst enabling observations to be undertaken when required. Staff were observed to knock before entering bedrooms and respected patients' privacy. Feedback gathered through our patient and carer engagement during the inspection was generally positive, with staff described as polite, approachable and respectful. Whilst one patient expressed concerns about not always feeling listened to, most patients spoke positively about their relationships with staff and told us they were treated with dignity and respect.

Patient information and consent

We found that patients had access to a wide range of information to support their care and treatment. The Statement of Purpose was readily available and comprehensive unit guides were provided to help patients and their families understand the service, their care and treatment, available facilities, patients' rights and sources of support. Information was also clearly displayed throughout the units, including details about advocacy services, Healthcare Inspectorate Wales (HIW), how to raise concerns or complaints, visiting arrangements and available support services.

Whilst a range of relevant patient information was available, we identified some opportunities for improvement. Some patient information boards on Delfryn Lodge, including the staff picture board and menu board, were not consistently up to date.

The service must ensure patient information displayed throughout the service is accurate, up to date and appropriately maintained.

Communicating effectively

We observed staff communicating with patients in a clear, supportive and respectful manner. Patients appeared comfortable approaching staff, and staff responded promptly to requests and concerns. Suitable rooms for confidential discussions were available on each unit.

Patients were supported to maintain contact with family members and others outside the service through access to digital technology, including personal devices and supervised computer facilities. Arrangements were in place to ensure safe use, with restrictions and monitored access applied in accordance with individual risk assessments.

Patients were provided with information in formats appropriate to their individual needs. Whilst information was primarily available in English, some bilingual information was available within the service and translation services could be accessed when required. We were provided with examples of how the service met the language needs of Welsh-speaking patients, including support to participate in meetings and formal proceedings through the medium of Welsh. Staff also told us that information could be provided in other languages where required.

Care planning and provision

We reviewed the Care and Treatment Plans for four patients and found them to be person centred and tailored to individual needs and risks. Records we reviewed showed that patients were involved in decisions about their care wherever possible, although questionnaire feedback showed that some patients did not feel fully involved in care

planning. Further findings relating to care planning are detailed within the Monitoring the Mental Health (Wales) Measure 2010: Care Planning and Provision section of this report.

Patients received care and treatment from an established MDT comprising nursing, medical, psychology, psychiatry, occupational therapy and other healthcare professionals. Established meeting processes, including daily handovers, communication meetings and ward rounds, supported the delivery and oversight of patient care. We attended a daily communication meeting and observed that staff demonstrated a good understanding of the patients in their care. Discussions focused on patients' needs, risks and recovery, helping to ensure care remained coordinated and responsive.

We found a strong focus on rehabilitation across both units. Staff actively supported patients to make personal choices and express preferences, including decisions about food, clothing and, where appropriate, self-administration of medication. Patients were encouraged to undertake everyday tasks to develop independent living skills.

Equality, diversity and human rights

We reviewed the records of five patients detained under the Mental Health Act and found documentation to be compliant with relevant legislation and the Mental Health Act Code of Practice for Wales (2016). Further detail is provided in the Mental Health Act Monitoring section of this report.

Advocacy services were well promoted throughout the service. Patients had access to an Independent Mental Health Advocate (IMHA), and dedicated advocacy support was available for carers and families.

Staff demonstrated a clear commitment to upholding patient rights and respecting individual preferences. Policies and processes were in place to promote equality and protect staff and patients from discrimination. Training records showed 100% compliance with Equality and Diversity training across both units.

Staff described a range of initiatives to promote equality and diversity, including anti-harassment initiatives, support for Black, Asian and Minority Ethnic (BAME) staff, disability awareness and processes for raising concerns. Staff were also able to access network leads for advice and support if required.

Reasonable adjustments were in place to support equitable access to services, including a hearing loop, lift access and suitable arrangements for patients with mobility needs. We also identified good practice in the ongoing development of a multi-faith room to support patients' religious and cultural needs.

Staff demonstrated consideration of equality and human rights when supporting transgender patients. We were provided with an example of how a patient undergoing gender transition was being supported in line with their preferences, with ongoing individual risk assessments and discussions used to balance the rights, needs and safety of all patients.

Citizen engagement and feedback

We found a range of opportunities for patients, carers and families to provide feedback about the service. These included weekly community meetings, monthly People's Council meetings and patient representatives who shared feedback and contributed to service development. An independent lived experience representative also attended regularly to engage with and support patients. We also found positive arrangements to support carer engagement, with clear evidence of work to involve them in service development and care planning where appropriate.

The service actively sought feedback through patient, carer and discharge surveys. Feedback was reviewed and used to inform service improvements, with action plans developed to address identified themes. Survey findings were generally positive regarding care and support and were used to support ongoing service development. We saw evidence that feedback was used to make improvements within the service. A 'You Said, We Did' board was displayed within Delfryn Lodge to demonstrate actions taken in response to patient feedback. However, a similar arrangement was not evident within Rhyd Alyn.

The service should ensure that actions taken in response to patient feedback are communicated consistently across both units.

Delivery of Safe and Effective Care

Environment

Each unit provided a comfortable therapeutic environment, with appropriate fixtures and fittings to meet the needs of the patient group. We found both units to be clean, tidy and generally well maintained. Patients had access to a range of suitable facilities, including comfortable communal areas, activity rooms, outdoor spaces and well-furnished bedrooms.

Daily environmental security checks were undertaken to provide assurance that the unit environments remained safe and well maintained. We found these checks were completed and recorded appropriately. Estates and maintenance processes were well managed through an on-site estates team, with maintenance issues reviewed as a standing agenda item within daily meetings to support timely resolution of environmental concerns.

Whilst the environment was generally well maintained, we identified some areas requiring attention. Further findings relating to the environment are detailed within the Infection Prevention and Control section of this report.

Managing risk and health and safety

Established policies, processes and audits supported the management of risk and the delivery of safe care. Risk management processes were embedded within day-to-day practice, and staff demonstrated a good understanding of individual patient risks and the measures required to manage them safely. We reviewed arrangements in place to maintain the health and safety of patients, staff and visitors, and found the following suitable measures in place:

- The unit entrances were accessible to everyone and were secured throughout the inspection to prevent unauthorised access
- All patient areas were fitted with suitable anti-ligature fixtures and fittings
- A range of ligature cutters were readily accessible for staff, with clear guidance on their use and maintenance
- Personal safety alarms were available for all staff and were carried throughout the inspection
- Nurse call points were located within patient bedrooms to enable patients to summon assistance when required.

Up-to-date ligature risk assessments and audits were in place for both units. However, we identified some inconsistencies within the documentation. At Delfryn Lodge, occupational therapy room computers, cables, gym equipment and a fridge had not been included within the ligature risk assessment. At Rhyd Alyn, fridges and small

kitchen appliances with cables had not been recorded. During the inspection, staff provided assurance that the assessments had been updated to address the identified issues.

Infection prevention and control (IPC) and decontamination

We found infection prevention and control (IPC) arrangements to be generally well managed across both units. Appropriate housekeeping arrangements were in place, and we observed good standards of cleanliness throughout the inspection. A range of audits were undertaken to monitor compliance with IPC requirements and provided assurance regarding standards of practice.

Staff demonstrated awareness of IPC requirements. Training compliance was generally high on Delfryn Lodge; however, compliance on Rhyd Alyn was 75% and required improvement. Further detail regarding training compliance is provided within the Workforce Planning, Training and Organisational development section of this report.

Whilst IPC arrangements were generally effective, we identified several environmental issues in Delfryn Lodge that had the potential to compromise effective IPC. These included a bathroom sink and flooring area affected by damp, damaged or worn skirting boards in communal corridors, areas of damaged wall surfaces, and dirty bins requiring cleaning. Staff took immediate action to clean the bins during the inspection.

The service must ensure that environmental repair and maintenance issues are addressed promptly to support effective infection prevention and control.

We also found that fridge temperatures within the Occupational Therapy department were not being monitored consistently. This posed a risk that items stored within the fridge may not have been maintained at safe temperatures.

The service must ensure that fridge monitoring processes are undertaken consistently and in accordance with local procedures.

Nutrition

We found that patients' nutritional and hydration needs were assessed, recorded and monitored appropriately. Physical health assessments were completed on admission and reviewed in response to changing needs.

The service had access to specialist support when required. Staff described how referrals could be made to speech and language therapy (SALT) and dietetic services and confirmed that choking assessments were completed for all patients. We were told that external dietitians attended the service to provide advice regarding nutrition, weight management and exercise.

Staff demonstrated awareness of patients' dietary requirements and preferences and described how individual dietary needs and specialist diets could be accommodated to meet medical, cultural and personal requirements.

Kitchen facilities were available on both units, enabling patients to prepare food and drink and supporting the development of independent living skills. Patients also had access to a choice of meals and drinks throughout the day and were able to provide feedback on the food provided. We saw evidence that patients had raised feedback regarding access to cooking sessions through governance and representative forums, and actions had been identified to improve access to these activities.

Medicines management

We reviewed the service's clinic arrangements and found robust procedures in place for the safe management of medicines. Relevant policies were in place and were accessible to staff.

Medicines, including controlled drugs, were stored securely in locked cupboards and refrigerators, and medication room and refrigerator temperatures were monitored in line with policy. However, at the time of inspection, the medication room on Rhyd Alyn was operating above the recommended temperature range for medicines storage. As an interim measure, medicines were being stored and administered from Delfryn Lodge. Whilst this reduced the immediate risk, it had the potential to delay patients' access to medication.

The service must ensure that the environmental issues affecting medicines storage on Rhyd Alyn are addressed promptly.

Effective governance arrangements were in place to oversee medicines management. Medication incidents and errors were reported and managed through Datix, with learning shared to support continuous improvement. Medication stock was accounted for appropriately, and effective internal auditing arrangements, supported by pharmacy input, helped promote the safe management and administration of medicines. We were informed that an electronic prescribing and medicines administration (ePMA) system was planned for implementation in late 2026, which would further strengthen medicines management, prescribing processes and governance arrangements.

Medication records were maintained to a good standard, with appropriate recording of prescribing and administration. Consent to treatment forms were stored alongside medication administration records to ensure they were readily accessible to nursing staff. However, we found one consent to treatment form contained an incorrect patient name, which was raised with staff and rectified during the inspection. Further details are provided in Appendix A of this report.

We observed safe and appropriate prescribing practices, with medications prescribed in line with individual patient needs and reviewed regularly. Patients were supported to understand and be involved in decisions about their medication, and staff were observed explaining prescribed medicines and assessing patients' understanding. Patients and their families and carers were encouraged to attend ward rounds where medication was discussed, and any changes were clearly documented.

The service supported patient independence through a risk-assessed self-medication process. At the time of inspection, six patients were self-medicating, with medication stored in lockable storage within their bedrooms and random spot checks in place to support safe practice. We identified this as an example of good practice.

Safeguarding children and safeguarding vulnerable adults

We found effective safeguarding arrangements in place to protect vulnerable adults. Safeguarding policies, procedures and reporting pathways were readily available to staff, who demonstrated a good awareness of safeguarding responsibilities and reporting procedures.

Safeguarding training compliance was generally good across both units. Compliance with Safeguarding Individuals at Risk (Intermediate) e-learning was 100% across Delfryn Lodge and Rhyd Alyn. However, compliance with the associated virtual classroom session was lower on Rhyd Alyn at 75%. Further detail regarding training compliance is provided within the Workforce Planning, Training and Organisational development section of this report.

Appropriate systems were in place to identify, report and manage safeguarding concerns. Safeguarding incidents were recorded using Datix, monitored through governance arrangements and escalated to external agencies where required. We saw evidence that safeguarding concerns and trends were reviewed regularly, with learning shared to support continuous improvement.

Most patients we spoke with during the inspection told us they felt safe within the service and knew who they could speak to if they had any concerns. During the inspection, we observed staff responding to an emerging safeguarding concern in a compassionate and person-centred manner, balancing safeguarding responsibilities with the patient's wishes and capacity.

Medical devices, equipment and diagnostic systems

We found appropriate arrangements in place to ensure medical devices and equipment were safe, clean, fit for purpose and readily available to support patient care. Suitable systems were in place for the routine checking and maintenance of equipment, including weekly checks of resuscitation equipment and oxygen cylinders.

Whilst equipment management systems were generally robust, we identified that the first aid equipment checklist did not clearly state the required checking frequency and records indicated checks were not always completed at consistent intervals. Staff advised that the documentation would be amended to clearly identify the required checking frequency and due dates.

The service must ensure that first aid equipment checks are completed at the required frequency and that documentation clearly states when checks are due.

Safe and clinically effective care

We found appropriate systems in place to support the delivery of safe and clinically effective care. The hospital had up-to-date policies and procedures to guide staff in delivering safe care and treatment. Established governance arrangements, meeting processes and incident management systems supported the identification, review and management of patient safety risks. Staff told us they felt supported to raise concerns and contribute to discussions regarding patient safety and risk management.

Effective processes were in place for the management and review of patient observations. Observation levels were adjusted according to individual risk, and records were completed appropriately by staff. An up-to-date Safe and Supportive Observation policy was in place to support staff in carrying out observations consistently and safely.

The service promoted safe and therapeutic responses to behaviours that challenge. Positive Behaviour Support (PBS) principles were embedded within the service and were used to inform the management of individual patient risks. Staff used a range of interventions, including therapeutic activities and individualised support, as preventative strategies. We saw evidence that physical restraint was used as a last resort and that restrictive practices were monitored through governance arrangements, with bespoke MDT meetings held where challenging themes or trends were identified for individual patients.

Participating in quality improvement activities

We found a positive culture of continuous quality improvement across the service. A range of audits and monitoring activities were undertaken to review the quality, safety and effectiveness of care. Audit findings were discussed through clinical governance arrangements, with actions identified, monitored and revisited to support ongoing improvements in practice. The service also undertook monthly internal quality inspections, with findings reviewed, action plans developed and progress monitored through governance arrangements. We found evidence that incidents, complaints and errors were used as opportunities for learning and service improvement.

Staff described a range of quality improvement initiatives that were ongoing or recently completed. These included work to improve the quality of care planning documentation, enhance involvement of families and carers, reduce agency staffing usage, strengthen medicines management processes and develop Rhyd Alyn as a Level 1 rehabilitation service. The service had also recently achieved Stage 1 Triangle of Care accreditation, demonstrating a commitment to strengthening engagement with carers and families.

It was positive to note that a recent NHS Wales Joint Commissioning Committee inspection of Delfryn Lodge found all assessed standards to be achieved, including standards relating to governance, audit, patient involvement and learning from incidents, providing additional assurance regarding the quality and effectiveness of care being delivered.

Records management

Clinical records were maintained electronically and in paper format. Paper records were stored securely, and the electronic system was password protected to prevent unauthorised access. Clinical details were recorded contemporaneously and comprehensively, providing a detailed overview of the patients and their care. Further information on our findings regarding patient records and care plans is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Mental Health Act monitoring

We reviewed five patient records to assess compliance with the Mental Health Act (MHA). All patients reviewed were detained under the MHA, and we found that detention was lawful and in line with the legislation and the Code of Practice. MHA documentation was well organised, complete, easy to navigate and stored securely. Records contained all relevant information required to support the lawful detention and ongoing monitoring of patients.

The service benefited from a dedicated and experienced MHA administrator who supported staff with MHA processes. We found robust auditing and monitoring arrangements in place to support compliance with the MHA, including systems to track key dates and requirements, such as renewal dates, tribunal referrals, consent to treatment requirements and the re-reading of patients' rights. A six-monthly audit of MHA files was also undertaken to identify and address any gaps.

MHA compliance was proactively integrated into patient care, with effective systems in place to safeguard the rights of detained patients. Patients were provided with information about their detention both verbally and in writing, with evidence that rights were re-read at regular intervals and following key events such as renewals and tribunal

processes. Patients were also provided with information regarding advocacy, appeals and complaints processes. It was positive to note that suitable signage advised informal patients of their right to leave the unit, and informal patients were provided with fobs to support independent access and egress.

Section 17 leave arrangements were appropriately documented. Leave forms identified risks and conditions of leave, and we saw strong evidence of patient involvement and empowerment in leave planning and decision-making from admission onwards. Records also showed that outcomes of leave were recorded and that patients were provided with copies of relevant documentation.

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

We reviewed four patient records and found a good standard of clinical record keeping. Records were well organised, stored securely, easy to navigate and contained a contemporaneous record of care. Overall, records were individualised, up to date and reflected patients' identified needs and risks, with strong MDT involvement throughout.

Care and Treatment Plans (CTPs) were in place for all patients and aligned with the domains of the Mental Health (Wales) Measure 2010. Comprehensive mental health, physical health and risk assessments informed the development of individualised CTPs. We found evidence of ongoing physical health monitoring throughout admission, with referrals to specialist healthcare services where required.

CTPs were person centred, outcome focused and included clear goals, planned review arrangements and identified interventions. For relevant patients, PBS or risk management plans were in place and linked to individual triggers, coping strategies, relapse prevention and risk reduction. Care planning supported recovery, rehabilitation and independence, including discharge planning and step-down arrangements where appropriate.

We saw evidence that patients were involved in the development of their care and treatment plans wherever possible, with the patient voice reflected throughout assessments, care planning and review processes. Records included patients' views, wishes and aspirations, demonstrating a co-produced approach to care planning. Patients regularly attended ward rounds and MDT meetings, with involvement from families, carers and representatives where appropriate. Regular MDT reviews supported the ongoing review of care, including input from relevant professionals and external agencies as required.

Mental Capacity Act and Deprivation of Liberty Safeguards

We reviewed the application of the Mental Capacity Act 2005 (MCA) and found that capacity assessments and consent arrangements were appropriately considered and documented within patient records.

We reviewed the records of a patient subject to a Deprivation of Liberty Safeguards (DoLS) authorisation and found all relevant documentation was in place. The authorisation, completed by a Best Interests Assessor, included appropriate review arrangements and evidence that the MDT had considered the need for DoLS and less restrictive alternatives. The assessment concluded that the arrangements were in the patient's best interests and represented the least restrictive option to maintain their safety and wellbeing.

Quality of Management and Leadership

Staff Feedback

We engaged with staff throughout the inspection and invited staff to complete HIW questionnaires. We only received two completed staff questionnaires. The sample size was therefore too small to draw robust conclusions.

Questionnaire feedback from staff was mixed. Both respondents stated they were satisfied with the quality of care and support they personally provided and that patient care was the organisation's top priority. However, both raised concerns regarding staffing levels, workload pressures, involvement in decision-making, senior management visibility and communication, and confidence that concerns raised would be addressed. Both respondents also reported that they did not receive feedback following incidents, errors or near misses.

These concerns were not reflected in our wider staff engagement undertaken during the inspection. Staff we spoke with during the inspection were positive about the care provided, described a supportive team culture, and told us that safe care was being maintained. Staff also spoke positively about teamwork and leadership support within the service.

The provider may wish to consider the feedback received through the staff questionnaire as part of its ongoing staff engagement arrangements.

Governance and accountability framework

We found effective governance and oversight arrangements in place across Delfryn Lodge and Rhyd Alyn to support the delivery of safe and effective care. A range of suitable and up-to-date policies were available to support staff in their roles, with effective arrangements in place to communicate policy updates and organisational developments.

There was a clear organisational structure with defined lines of accountability, supported by structured meeting arrangements, escalation processes and incident reporting systems. We observed effective MDT working during meetings, with all disciplines contributing to discussions regarding patient care, risk management and service delivery.

Governance arrangements were supported by regular clinical governance meetings and established audit processes, which provided oversight of service performance and supported ongoing improvement. We found evidence that actions arising from governance meetings and audits were monitored and reviewed to ensure progress and

accountability. We found evidence of service provider oversight through Regulation 28 visits and established regional governance arrangements.

Staff demonstrated a strong commitment to delivering safe, person-centred care. Feedback regarding colleagues and managers during the inspection was consistently positive, with staff describing leaders as visible, approachable and supportive. We were informed of regular staff meetings held to provide opportunities for staff to raise concerns and provide feedback. However, we noted that senior staff meetings had not been held in accordance with the service's required frequency during the previous six months. This may limit opportunities for staff engagement, feedback and discussion of service developments.

The registered provider must ensure that senior staff meetings are held in accordance with the service's required frequency.

Dealing with concerns and managing incidents

An established electronic system was in place for recording, reviewing and monitoring incidents. We reviewed a sample of incident records and found they had been appropriately recorded, investigated and managed, with documented outcomes and actions escalated where required. Individual incidents were discussed with members of the MDT and learning was shared with staff to support continuous improvement. We were informed that the service was implementing an After Action Review (AAR) initiative to strengthen learning and reflective practice following incidents.

Complaints were appropriately recorded, investigated and reviewed to identify themes and trends. We found evidence that complaints were generally resolved locally where possible, with actions identified and monitored through governance processes. It was positive to note that compliments significantly outweighed complaints across both units.

Workforce recruitment and employment practices

We found suitable processes in place to support the safe recruitment, retention and development of staff. A recruitment, selection and appointment of staff policy was in place to support open and fair recruitment practices. Staff records demonstrated that appropriate pre-employment checks were completed prior to staff commencing employment, including identity verification, employment history checks, references and Disclosure and Barring Service (DBS) checks. Staff records also contained signed job descriptions which clearly outlined their individual roles and responsibilities.

At the time of the inspection, the service was undergoing workforce changes associated with the redevelopment and planned reopening of Delfryn House. Senior staff outlined recruitment plans and confirmed that staff would be consulted on roles within the

revised service model. They told us that communication and engagement had increased throughout the redevelopment process.

Staff described a supportive and inclusive culture and told us they had access to a range of wellbeing and support mechanisms, including supervision, reflective practice, psychological support, Freedom to Speak Up representatives and TRiM support. A 'Raising Concerns: Freedom to Speak Up' (whistleblowing) policy was in place to support staff to feel empowered and safe to raise concerns.

Workforce planning, training and organisational development

We found there were sufficient staff with an appropriate skill mix to support the safe delivery of care. Staffing arrangements considered patient acuity, observation levels and clinical need, with additional staffing deployed when required. It was positive to note that the service had not used agency staff since January 2026 and used regular bank staff where required to support continuity of care.

We found high levels of appraisal and supervision compliance, supporting staff development and competency. Staff told us training was accessible and development opportunities were encouraged. Training records showed generally good compliance across both units, with overall compliance of 94% at Delfryn Lodge and 92% at Rhyd Alyn. Whilst overall compliance was positive, we noted several mandatory, supplementary and role-specific training courses where compliance required improvement. This included lower compliance in some advanced and refresher Safety Intervention modules on Rhyd Alyn.

Staff explained that lower compliance rates reflected smaller staff cohorts on Rhyd Alyn, newly introduced or specialist training, and delays in the electronic training system reflecting completed training, booked training sessions and staff role changes. We were assured that these issues had been identified through governance arrangements and were subject to ongoing monitoring and improvement activity.

However, we identified low compliance with Safer People Handling training across both units, with compliance rates of 25% at Rhyd Alyn and 65% at Delfryn Lodge. Given the importance of this training in supporting the safe movement and management of patients, and in reducing the risk of injury to both patients and staff, we sought immediate assurance that appropriate risk mitigation measures were in place. The service responded promptly and took immediate action to address the issue during the inspection. Further details are provided in Appendix A of this report.

The service must:

- **Ensure all staff complete all outstanding mandatory and role-specific training within expected timescales**

- **Review the training management system to ensure staff training requirements are relevant to their current roles and that compliance records are accurate and up to date.**

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

The table below summarises 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
We identified omissions within the ligature risk assessments. At Delfryn Lodge, occupational therapy room computers, cables, gym equipment and a fridge had not been included within the ligature risk assessment. At Rhyd Alyn, fridges and small kitchen appliances with cables had not been recorded.	Incomplete ligature risk assessments may result in environmental risks not being fully identified, assessed or mitigated, potentially affecting patient safety.	The concern was raised with senior staff during the inspection and immediate assurance was sought regarding the completeness and accuracy of the ligature risk assessment process.	During the inspection, staff provided assurance that the ligature risk assessments had been reviewed and updated to include the omitted items.
We found one consent to treatment form contained an incorrect patient name.	Incorrect consent to treatment documentation could lead to confusion regarding a patient's authorised treatment.	The issue was raised immediately with senior staff and the accuracy of consent to treatment documentation was reviewed.	The incorrect patient name was rectified during the inspection and assurance was provided that the documentation had been corrected.

We identified low compliance with Safer People Handling training across both units, with compliance rates of 25% at Rhyd Alyn and 65% at Delfryn Lodge.	This may increase the risk of injury to patients and staff during moving and handling activities and reduce assurance that staff are appropriately equipped to respond safely to patient needs.	HIW sought immediate assurance regarding arrangements to mitigate the risks associated with low training compliance.	During the inspection, the service took immediate action and provided evidence that additional training sessions had been secured for August 2026, staff had been allocated to earlier courses and appropriately trained staff would be rostered on each shift until outstanding training requirements had been completed. We were also advised that staff awaiting training would be supervised by trained colleagues until training had been completed.

Appendix B – Immediate improvement plan

Service: **Delfryn Lodge and Rhyd Alyn**

Date of inspection: **27, 28 and 29 July 2026**

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

Findings	No immediate non-compliance issues were identified during this inspection.		
Improvement needed		**Standard / Regulation**	
1.			
Service Action:		**Responsible officer**	**Timescale**

Appendix C – Improvement plan

Service: **Delfryn Lodge and Rhyd Alyn**

Date of inspection: **27, 28 and 29 July 2026**

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.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Patient feedback indicated concerns regarding involvement in care planning, perceptions of safety and access to activities.	The service should review the feedback received and consider further opportunities to strengthen patient involvement in care planning and address concerns regarding safety and access to activities.	Patient feedback	The Senior leadership team, OT and activity coordinator's will attend community meetings and peoples Council to gather more information from patients on how to improve their involvement in care planning, perceptions of safety and access to activities. All primary nurses will meet with the patients on a 1-1 to review	Leanne Smith Hospital Director, Registered Manager	October 2026 Ongoing monitoring via monthly Clinical governance.

				progress and their feedback on improved involvement, this is to be documented in the pink notes.		
2.	Some patient information boards on Delfryn Lodge were not consistently up to date.	The service must ensure patient information displayed throughout the service is accurate, up to date and appropriately maintained.	Patient information and consent	All notice boards are now up to date and a check in place for the ward clerk to check all posters on a weekly basis	Jade Davies Clinical manager	Completed August 2026
3.	A 'You Said, We Did' board was displayed within Delfryn Lodge but was not evident within Rhyd Alyn.	The service should ensure that actions taken in response to patient feedback are communicated consistently across both units.	Citizen engagement and feedback	This is now displayed in the communal area at Rhyd Alyn and updated by the patients and the activity coordinators.	Jade Davies Clinical manager	Completed August 2026

4.	We identified several environmental issues in Delfryn Lodge that had the potential to compromise effective IPC. These included a bathroom sink and flooring area affected by damp, damaged or worn skirting boards in communal corridors, areas of damaged wall surfaces.	The service must ensure that environmental repair and maintenance issues are addressed promptly to support effective infection prevention and control.	Infection prevention and control (IPC) and decontamination	The bathroom flooring is now complete. The sink area and surrounding panels are on order and we are awaiting delivery. The entire of the Lodge communal areas is under a repainting programme, this includes all wall surfaces and skirting boards. Maintenance to attend morning meeting daily for any repairs or works. Any delays will be reported Registered Manager on the same day.	Leanne Smith Hospital Director, Registered Manager Justin Burke Maintenance Manager	Bathroom Flooring Complete Sink areas aim to compete by 1/10/26 Decorating programme aim to complete by 1/11/26
5.	Fridge temperatures within the Occupational Therapy department were not being monitored consistently.	The service must ensure that fridge monitoring processes are undertaken consistently and in accordance with local procedures.	Infection prevention and control (IPC) and decontamination	All Fridge monitoring processes are now in place and being recorded by the Activity coordinators and overseen by the OT department.	Jade Davies Clinical Manager	Completed August 2026

				This will be randomly checked by the Clinical Manger on the weekly workarounds		
6.	The medication room on Rhyd Alyn was operating above the recommended temperature range for medicines storage. As an interim measure, medicines were being stored and administered from Delfryn Lodge.	The service must ensure that the environmental issues affecting medicines storage on Rhyd Alyn are addressed promptly.	Medicines management	Works are currently being completed to fit out a dedicated area for the safe storage and management of medications, this includes medicines cabinet, air conditioning, and fridge. This will allow all medications to be administered from Rhyd Alyn.	Leanne Smith Hospital Director, Registered Manager Justin Burke Maintenance Manager	1/10/26
7.	The first aid equipment checklist did not clearly state the required checking frequency and records indicated checks were not always completed at consistent intervals.	The service must ensure that first aid equipment checks are completed at the required frequency and that documentation clearly states when checks are due.	Medical devices, equipment and diagnostic systems	The first aid checklist now has the frequency printed at the top of the checklist; all the old ones have now been replaced with the new form.	Leanne Smith Hospital Director, Registered Manager	Complete 9/9/26

8.	We noted that senior staff meetings had not been held in accordance with the service's required frequency during the previous six months.	The registered provider must ensure that senior staff meetings are held in accordance with the service's required frequency.	Governance and accountability framework	All senior nurse meetings have now been diarised in outlook for the year ahead, these will take place each month. All minutes will be sent to admin for easy access and reference.	Leanne Smith Hospital Director, Registered Manager	Complete 9/9/26
9.	Whilst overall training compliance was positive, we noted several mandatory, supplementary and role-specific training courses where compliance required improvement. This included lower compliance in some advanced and refresher Safety Intervention modules on Rhyd Alyn.	The service must: • Ensure all staff complete all outstanding mandatory and role-specific training within expected timescales • Review the training management system to ensure staff training requirements are relevant to their current roles and that compliance records are accurate and up to date.	Workforce planning, training and organisational development	The advanced and refresher Safety Intervention modules at Rhyd Alyn are now complete and on the achieve training records. The training management system is currently under review and the introduction of an electronic training library will enhance role specific training. The senior leadership team will also review in the weekly compliance meeting role specific	Leanne Smith Hospital Director, Registered Manager	Complete 1/11/26 Complete

				training as well as all statutory/mandatory.		

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): Leanne Smith

Job role: Registered Manager/Hospital Director

Date: 14 September 2026