Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Coed Du Hall Hospital

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at Coed Du Hall Hospital on 25, 26 and 27 March 2024.

The following wards were visited during this inspection:

- Ash – a seven bedded female ward, which was providing care for five patients
- Beech – a five bedded male ward, which was providing care for three patients
- Cedar – a mixed gender six bedded ward, which was providing care for four patients
- Studio Suites – four mixed gender suites, which were providing care for four patients.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. A total of four patient questionnaires and one family/carer questionnaire were completed. We also spoke to staff working at the service during our inspection. 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 patients had their own programme of care that reflected their individual needs and risks. Patients were provided with a range of therapeutic facilities and activities to support and maintain their health and wellbeing. Patients had access to a mental health advocate who provided information and support with any issues they may have regarding their care.

Suitable processes were in place for patients to engage and provide feedback about their care. However, some improvements were required to ensure patient meetings were formally recorded and that they were provided with updates of service actions taken as a result of their feedback.

Staff had undertaken equality, diversity and inclusion training to help recognise the importance of treating all patients fairly and we witnessed respectful interactions between staff and patients. However, during the inspection we identified that several improvements were required to protect patient privacy and ensure dignified and respectful patient care.

This is what we recommend the service can improve:

- The service must consider installing vision panels in patient bedroom doors to ensure therapeutic observations can be conducted with minimal disruption to patients
- The service must ensure patient bedrooms cannot be seen from the external areas of the hospital to protect their privacy and dignity
- The service must ensure that staff maintain patient information confidentiality within the nursing office
- The service should install pictorial information boards to identify the hospital staff for patient and visitor awareness
- The service must ensure that hospital staff are appropriately attired and easily identifiable to support patient safety.

This is what the service did well:

- We saw instances whereby good professional relationships had been developed between staff and patients, which supported their health and wellbeing.

Delivery of Safe and Effective Care

Overall summary:
The patient records evidenced detailed and appropriate physical assessments and monitoring. Patient Care and Treatment Plans (CTPs) were individualised, person centred and reflected the needs and risks of the patients in the hospital. The statutory documentation we saw verified that the patients were legally detained.

We found well-organised paper records throughout the hospital, which were easy to navigate through clearly marked sections. However, staff told us that the dual paper and electronic record systems presented challenges for them, as they were often required to duplicate complex patient information within both systems.

Staff confirmed there was a governance structure in place in terms of activities and meetings to discuss incidents, findings and issues related to patient care. We saw examples of hospital audits, schedules and processes which had been suitably completed to support patient safety. However, during the inspection we identified numerous immediate potential risks to patient safety and found a lack of robust governance oversight of environmental risks, maintenance issues and Infection Prevention and Control audit processes within the hospital.

Immediate assurances:
During the inspection HIW could not be assured that the health, safety and welfare of patients, staff and visitors was being actively promoted and protected. In addition, potential risks of harm were not being identified, monitored and where possible, reduced or prevented. We saw many examples of environmental and health and safety risks which had not been appropriately identified, escalated nor addressed. We found that the hospital was not equipped with suitable furniture, fixtures and fittings for the patient group.

Furthermore, we identified poor standards of cleanliness throughout the hospital. The environment of the premises did not provide sufficient assurance that patients and staff were being protected against identifiable risks of acquiring health care associated infections by the maintenance of appropriate standards of cleanliness and hygiene.

We were provided with recent audit reports and environmental checklists undertaken throughout the hospital. Following review of these documents, we were concerned about the accuracy and quality of data being recorded because they had not identified the same issues and therefore did not provide a true reflection of the environment observed during the inspection.

Our concerns were dealt with through our non-compliance process. Details of the remedial action taken by the service in response are provided in Appendix B.

This is what we recommend the service can improve:

- The service must ensure outstanding maintenance issues are appropriately addressed, monitored and finalised
- The service must reinforce the fire safety and evacuation procedure with all staff
- The service must explore ways to ensure patient whereabouts are accurately accounted for at all times
- The service must ensure the cleaning roles and responsibilities of nursing staff are enforced and regularly monitored to ensure compliance
- The service must ensure all staff engage and interact in a positive way with patients when undertaking therapeutic observations
- The service must implement a single records management system which captures information in a streamlined and consistent way, to avoid duplication for staff.

This is what the service did well:

- We saw examples of good practice in relation to managing challenging patient behaviours
- Medication side effects were measured and appropriately escalated using the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS), which we identified as an example of good practice
- We found robust monitoring and audit processes in place in relation to Mental Health Act documentation and record keeping
- Hospital staff had developed a robust care records audit process and a schedule to record forthcoming multidisciplinary team (MDT) and care planning meetings, which we recognised as good practice.

Quality of Management and Leadership

Overall summary:
Staffing levels appeared appropriate to maintain patient safety within the hospital at the time of our inspection. Most staff members we spoke with confirmed that they felt supported in their roles and that the number of staff was sufficient to support safe patient care. However, the service must ensure there is sufficient cover for nursing staff to allow them to take breaks during their shift, without leaving the ward unsupervised.

Suitable arrangements were in place for senior staff to monitor compliance with mandatory training. We reviewed the mandatory training statistics for staff and found that overall support staff compliance with mandatory training was generally high, but improvements were required in respect of overall nursing staff compliance with several mandatory training courses.

We found an established governance structure in place to provide oversight of clinical and operational issues. Audit activities and monitoring systems and processes were in place to ensure the hospital focussed on continuously maintaining standards. However, the issues we observed during the inspection were not identified within the hospital's audit processes and internal inspections. As a result, we were not assured that the governance arrangements ensured that key risks were being effectively identified, addressed and monitored to prevent reoccurrence.

Throughout the inspection we noted that staff were receptive and responsive to our views, findings and recommendations. Staff took immediate action to address the concerns we raised, and we received additional progress updates from senior staff following the inspection.

This is what we recommend the service can improve:

- The service must continue to strengthen the leadership systems within the hospital to ensure key issues are identified, addressed and monitored
- The service must ensure staff meetings are conducted on a regular basis to engage staff and encourage their feedback

3. What we found

Quality of Patient Experience

Patient feedback
We invited patients, family and carers to complete HIW questionnaires to obtain their views on the service provided at the hospital. We also spoke with patients on the wards when appropriate to do so. At the time of our inspection there were sixteen patients being cared for in the hospital and we received four completed patient questionnaires and one family/carer questionnaire. Therefore, the sample size is too small to draw robust conclusions and identify themes or trends.

However, the patients who did respond provided mixed feedback on the care and treatment they received in the hospital. Half of the patients who completed a questionnaire rated the care and service provided as 'very good,' while half rated the care and service as 'poor'. Half agreed that staff treated them with dignity and respect, but most agreed that staff were polite and listened to them.

Most patients agreed that staff provided care and treatment when needed. Half agreed that staff had talked to them about their medical conditions and helped them to understand them.

Despite these mixed responses, the patients we spoke with during the inspection told us they felt supported and were treated well by staff. The family/carer who completed our questionnaire rated the setting as 'very good' and told us they felt welcomed and safe at the hospital.

Patients who completed our questionnaire were asked for service improvement suggestions and made the following comments:

> *"Improve smoking area. Like to do gardening"*
>
> *"Metal bin for smoking area"*
>
> *"Studio … Pool or table tennis"*
>
> *" Facilities … Opportunity to speak/learn Welsh."*

Health promotion, protection and improvement
The hospital had suitable processes in place to help protect and promote the physical health of patients. We reviewed the records of four patients and saw

evidence that patients received appropriate physical assessments in addition to their mental health care. Patients had physical health care plans which documented regular health screening and regular review of their goals and progress. Long term health conditions were supported and managed appropriately. Patients were able to access GP, dental services and other physical health professionals as required.

We saw evidence that measures were in place to support patients to maintain and improve their health, wellbeing and independence. During our tour of the hospital, we saw appropriate health promotion and improvement information displayed on the wards for patient and visitor awareness. Fresh fruit was available throughout the day, and we found suitable measures in place to monitor patient dietary requirements and cigarette intake.

The hospital's multidisciplinary team (MDT) included a full-time occupational therapist (OT) and two occupational therapy assistants to support the provision of therapies and activities. We found patients were provided with a range of therapeutic facilities and activities to support and maintain their health and wellbeing, including games, an occupational therapy kitchen and spacious garden areas. Activity timetables were suitably displayed and included indoor and outdoor activities such as gardening, walking and excursions. Patients with authorised leave from the hospital were also able to use local community services as part of their rehabilitative programme of care.

The majority of patients who completed our questionnaire agreed that they were able to go outside for exercise and wellbeing as needed. However, only half agreed that there were sufficient and appropriate recreational and social activities in the hospital. Additionally, most patients stated that the hospital did not offer education/training and/or work-based skills. The service may wish to conduct further discussions with patients to ensure the current provision of patient therapies and activities continues to be appropriate.

During the inspection we found that the environment of care did not support the health, safety and wellbeing of patients. We saw many examples whereby the hospital's furniture, fixtures, fittings were damaged, unclean or not fit for purpose. More findings on the environmental risks we identified during the inspection can be found in the Managing Risk and Health and Safety and Infection Prevention and Control (IPC) and Decontamination sections of this report.

Dignity and respect

The registered provider's statement of purpose and patient guide outlined how hospital staff supported patients to maintain their privacy and dignity. Each patient had their own ensuite bedroom which provided a good standard of privacy

and dignity. Patients were able to store possessions and personalise their rooms as desired. During the inspection we saw examples of staff respecting the privacy of patients by knocking their door before entering. We were told that patients were not able to lock their rooms but were provided with an electronic wrist band which afforded them access to their individual rooms and communal patient areas as appropriate.

We observed staff treating patients with respect and supporting patients in a dignified manner during the inspection. We saw instances whereby good professional relationships had been developed between staff and patients, which supported their health and wellbeing. Patients we spoke with during the inspection told us that staff treated them with dignity and respect.

During the inspection we identified that several improvements were required to protect patient privacy and ensure dignified and respectful patient care. During our evening tour of the hospital, we noted that there were no observation panels on the patient bedroom doors to enable staff to undertake observations without having to open the door and disturbing the patients. This meant that patients under observation were monitored by staff within their bedrooms, which compromised their privacy and dignity. This issue was also identified during our previous inspection of the hospital in 2022.

At the time of our previous inspection, we were informed that the issue had been considered and that a discussion would be held with patients to gain their views on this matter. However, during this inspection, staff were not able to provide evidence of any discussions or actions taken in respect of this since our previous inspection.

The service must consider installing vision panels in patient bedroom doors to ensure therapeutic observations can be conducted with minimal disruption to patients.

The registered provider's statement of purpose outlined that "*each resident has their own individual room; privacy screening is consistent for all windows ensuring privacy and dignity is maintained*". However, during the inspection we found there was no privacy glass to prevent patients from being seen within their bedrooms. All patient bedrooms were located on the ground floor and were clearly visible from the external areas of the hospital, which compromised their privacy and dignity.

The service must ensure patient bedrooms cannot be seen from the external areas of the hospital, to protect their privacy and dignity.

Patient status at a glance information was printed and affixed to a board in the nursing office for staff awareness. During our tour of the hospital, we noted that the nursing office blinds were left open and confidential patient information was visible from outside the office. This issue was also identified during our previous inspection in 2022, at which time we were informed that the nursing office was being renovated and that mirrored film would be placed on the office window to maintain confidentiality. However, this action had not been completed as outlined.

The registered provider must ensure that staff maintain patient information confidentiality within the nursing office.

Patient information and consent
The registered provider's statement of purpose described the aims and objectives of the service. Patients also received a written information guide on admission that included guidance on patient rights, care and treatment processes, advocacy services and how to make a complaint.

We found a wide variety of appropriate information displayed for both patients and visitors within the communal areas of the hospital. Relevant patient information was appropriately displayed or provided to patients on the following topics:

- Advocacy services
- Information about the role of HIW and how patients can contact HIW
- Mental Health Act information
- How to raise a concern or complaint.

We observed that patient information was predominantly only displayed in English. We discussed this matter with staff who advised that patient information could be made available in Welsh or other languages on request, and that translation services were available if required.

During the inspection we noted there were no pictorial information boards to identify the hospital staff for patient or visitor awareness. We further noted that staff wore their own casual clothing and were not provided with uniforms nor badges to identify them as staff members. We observed some staff members wearing hats, coats and hooded tops over their heads inside the hospital, which projected a negative image of the professionalism of staff. We identified that the informal staff attire could cause difficulty for patients, visitors and unfamiliar staff to distinguish between staff and patients, and therefore posed a potential safety risk.

The service should install pictorial information boards to identify the hospital staff for patient and visitor awareness.

The service must ensure that hospital staff are appropriately attired and easily identifiable, to avoid confusion and support patient safety.

Communicating effectively

We witnessed staff treating patients with respect and kindness during the inspection. The patients we talked with spoke positively about their interactions with staff during their time at the hospital.

Daily handover and risk review meetings were held to discuss patient care requirements, upcoming activities within the hospital and other relevant information. There were regular (MDT) meetings during which information was shared to ensure the timely care of patients. The service used digital technology as a tool to support effective communication and ensure timely patient care.

Suitable visiting arrangements were in place for patients to meet family and carers at the hospital. Rooms were available for patients to meet ward staff and other healthcare professionals in private. Patients were able to have access to their own mobile phones and electronic devices, depending on individual risk assessment.

Care planning and provision

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

We found that patients were regularly monitored and received timely care in accordance with individual and clinical need. A risk review meeting was being held every morning for staff to update the MDT and senior management on any events that had taken place the day before. We attended one of these meetings during the inspection and heard effective discussions taking place in relation to concerns, issues or incidents regarding each patient. However, some staff we spoke with during the inspection felt that the daily risk review meeting process would be improved by the attendance and involvement of healthcare support workers as well as multidisciplinary (MDT) staff members.

The service must conduct further discussions with staff with a view to involving healthcare support workers in hospital meeting processes.

Equality, diversity and human rights

During the inspection we looked at the records of five patients who were detained at the hospital under the Mental Health Act (the Act). The legal documentation we reviewed was compliant with relevant legislation and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code). We saw good evidence that patients were regularly reminded of their legal status and rights. Our main findings on the quality of the Mental Health Act documentation are detailed in the Mental Health Act Monitoring section of this report.

The hospital had policies in place to help ensure that patients' equality and diversity were respected. We were told that all patients have access to a mental health advocate who can provide information and support to patients with any issues they may have about their care. We saw high staff compliance with mandatory Equality, Diversity and Human Rights training.

Reasonable adjustments were in place so that everyone could access and use services on an equal basis. The hospital was located at ground level and had doors and corridors which could accommodate wheelchair access. Specialist accessible equipment was available for patient use if required.

During our discussions with staff, they demonstrated suitable regard for upholding patient rights and individual patient preferences. The Care and Treatment Plans (CTPs) we reviewed evidenced that the social, cultural and spiritual needs of patients had been considered.

Citizen engagement and feedback

We were informed that patients, family and carers could engage and provide feedback to staff on the provision of care at the hospital in a number of ways. The hospital had a suggestion box which invited patient and family carer feedback. The service also conducted a formal patient survey every six months, which was last undertaken in November 2023. We were told that the hospital engaged closely with family and carers who were invited to participate in MDT meetings and be involved in decisions regarding patient care.

Staff confirmed that the service held weekly patient forums where patients could discuss any issues or concerns they may have. We were told that any issues raised during patient meetings were addressed as appropriate. However, the meetings were not minuted and there was no recorded evidence of the meetings taking place. We further noted that there was no ‘You Said, We Did’ board in the hospital to inform patients and family/carers of changes made as a result of their feedback.

The service must ensure patient meetings are appropriately minuted to capture patient feedback and evidence any issues raised.

The service must implement suitable processes to update patients and family/carers of actions taken as a result of their feedback.

There was a complaints policy and procedure in place at the hospital and relevant information was displayed on the ward for patient awareness. We reviewed a sample of complaints which evidenced that these were dealt with in line with the registered provider's policy.

Delivery of Safe and Effective Care

Safe Care

Environment
The mission statement and service values outlined within the registered provider's statement of purpose included the 'provision of the highest quality environment that is aesthetically pleasing and promotes health and wellbeing'. However, during the inspection we found that the hospital was generally unclean, untidy, and not equipped with suitable furniture, fixtures and fittings for the patient group. We were not assured that the hospital provided a safe and comfortable environment for patients. Our main findings on the quality of the environment are detailed in the Managing Risk and Health and Safety and Infection Prevention and Control (IPC) and decontamination sections of this report.

We discussed the hospital's environmental issues with staff and were informed that the hospital kept a maintenance logbook to record outstanding estates actions. However, we found that some maintenance issues were not being routinely recorded in the logbook and saw examples where recorded issues were not signed off to indicate they had been completed. We also saw examples whereby recurrent maintenance issues were reviewed during monthly maintenance meetings but remained unresolved as follows:

- The January 2024 and February 2024 maintenance meeting notes detailed that the hospital's VW Caravelle vehicle had no fire extinguisher for both months
- The table of "Regular checks at Coed Du Hall" outlined identical issues and outstanding actions in both January and February 2024, in relation to emergency lighting checks, fire door physical checks and accessible bath issues
- The information outlined within the "Projects: what progress has been made with any projects/scheduled repairs (painting etc)" section of the document was duplicated in both January and February 2024, with one new item added and no clear evidence of any progress or updates.

Owing to the high number of environmental risks and outstanding estates issues we identified during the inspection, we were not assured that there were robust processes in place to ensure all maintenance issues were being identified, addressed and monitored.

The service must conduct a full environmental audit of the hospital to ensure all maintenance issues are identified and recorded.

The service must implement a robust programme of continuous governance oversight to ensure outstanding maintenance issues are appropriately addressed and monitored.

Managing risk and health and safety
We looked at the processes in place to manage and review risks to help maintain the health and safety of patients, staff and visitors at the hospital. Some suitable measures were in place, which included:

- A major disaster policy was in place that set out the procedures to follow in the event of a major incident occurring at the hospital
- There were nurse call points appropriately located throughout the hospital so that patients could summon staff when required
- We found suitable, up-to-date ligature point risk assessments that detailed the actions taken to mitigate and reduce the risk of ligature
- Ligature cutters were appropriately stored in the nursing office for use in the event of a self-harm emergency
- There were weekly audits of resuscitation equipment; staff had documented when these had occurred to ensure that the equipment was present and in date.

There were established processes and audits in place to manage risk, health and safety and infection control. We saw many examples of various hospital audits, schedules and processes which had been completed within set timescales to support patient safety. However, during the inspection we were not assured that potential risks of harm were being identified, monitored and where possible, reduced or prevented. We were not assured that the health, safety and welfare of patients, staff and visitors at Coed Du Hall was being actively promoted and protected. We saw examples of potential risks to patient safety as follows:

- We were advised that there were sufficient personal alarms for staff but found they were not being used during our inspection, which compromised the safety of staff and patients. We were further told there was no personal alarm policy in place in the hospital. After advising staff of our concerns, we continued to witness staff not using the alarms during the inspection. Staff did not address the seriousness of the issue and the remedial action required. Therefore, we were not assured that patients and staff were being fully protected from harm within the hospital
- The wards were extremely cluttered and presented numerous risks for patients liable to self-harm or harm others. Within drawers, cupboards and in communal patient areas throughout the hospital, we found high-risk items including electrical cables, broken electrical items, batteries, pens, high heeled shoes and carrier bags

- On Ash ward, the cupboard containing the consumer unit was filled with blankets, clothing and clutter, which posed a fire safety risk
- The Ash ward accessible bathroom contained an open, insecure cupboard housing the trip switch and pipework, which was accessible to patients and contained unnecessary clutter
- There were exposed pipe fittings supporting the accessible bath, which posed a risk of injury to staff and patients
- We noted that the fire extinguishers within the communal corridors had been suitably stored in cabinets since our previous inspection, but found some cabinets were damaged or partially insecure
- The televisions on Beech and Cedar wards were both heavily damaged. The television on Cedar ward was shattered and there was loose broken glass present. Both televisions were replaced during the inspection, but we were told they had been damaged for a number of weeks
- Staff were using a damaged blood pressure monitor which was sellotaped together. This posed a risk to patient safety
- The glass fire door of Cedar ward was completely shattered, and a glass fire door within the main hospital corridor was cracked. The Cedar ward fire door was repaired during our inspection, but the fire door in the main corridor was not.

We highlighted these issues to staff and noted that some improvements were made to declutter the hospital, replace damaged items and remove the patient safety risks during the inspection. However, many patient safety risks were still present at the time the inspection was completed.

Our concerns were dealt with under our non-compliance process. This meant that we wrote to the service immediately following the inspection issuing a non-compliance notice requiring that urgent remedial actions were taken. Details of the actions taken by the service are provided in Appendix B.

Arrangements were in place to ensure fire safety within the hospital and we saw suitable fire safety equipment such as fire extinguishers and fire blankets. However, the cluttered state and poor storage arrangements within the hospital did not support the reduction of fire risk. During our discussions with staff, it was concerning to note that some staff demonstrated a lack of understanding regarding the hospitals fire evacuation procedures and fire exit operation.

The service must reinforce the fire safety and evacuation procedure with all staff.

During the inspection we noted there were measures in place to prevent unauthorised access to the hospital. However, we noted that the entrance/exit

from Cedar ward to the hospital grounds was unrestricted during the day, which posed a risk of patients absconding from the hospital, or of staff not being able to account for their whereabouts during an emergency.

The service must explore ways to ensure patient whereabouts are accurately accounted for at all times.

Infection prevention and control (IPC) and decontamination
During the inspection we considered the environment of the patient and clinical areas within the hospital. The fitness of the premises we observed was not reflective of a modern inpatient mental health service. We identified poor standards of cleanliness evident throughout the hospital and found some areas of the premises were not being kept in a good state of repair. For example:

- The entrance and garden areas of the hospital were strewn with cigarette butts and general litter
- The dining room was untidy and unclean, with food on the tables and floor, and dirty dishes and cutlery present. This also presented a slip/trip hazard
- The bathroom areas of the hospital were generally in an unclean state. It was evident that the patient communal bathing facilities were not being cleaned after each use. We saw evidence of long-standing grime which included dirty baths, showers and floors, and unflushed toilets
- The bathroom on Beech ward was particularly odorous and contained a bin full of clinical waste. We were informed that the fan ventilation system was not working in this bathroom
- The majority of bins throughout the hospital were dirty, and some had no lids
- The floors and surfaces throughout the hospital required cleaning
- The clinic room was found to contain unnecessary clutter and required cleaning
- The laundry room was unclean, odorous and contained unnecessary clutter. A pile of patient clothing was discarded on the floor outside the door. One of the washing machines appeared to be leaking
- Some patients appeared to be unclean and unkempt during the inspection
- The ceiling light outside the laundry room contained numerous dead insects
- Some of the hospital's furniture, fixtures and fittings were in a state of disrepair and not fit for purpose
- Many of the hospital's radiators were dirty and highly rusted
- A large number of patient chairs throughout the hospital were unclean, in an extreme state of disrepair and worn to an extent which prevented effective infection prevention control

- The patient communal areas required redecoration to make these areas more pleasant. This was also identified during our previous inspection of the hospital in 2022
- The doors, floors and walls throughout the hospital appeared worn, marked and dirty. This was also identified during our previous inspection of the hospital in 2022
- The hospital kitchen areas and fridges contained patient foods which were opened but unlabelled, so the expiry date and date of opening could not be ascertained. We saw many examples of food items which had passed their expiry or best before dates
- The fridge on Ash ward was damaged and was sitting at a tilted angle within the kitchen unit
- The hospital's microwaves and main kitchen stove were dirty
- The microwave on Beech ward was extremely rusted and contained a plate of cooked, unsealed food.

We highlighted these issues to staff and noted that some improvements were made to clean and tidy the hospital and order replacements for the damaged items over the course of the inspection. However, some of the above issues were still present at the time the inspection was completed.

We were provided with recent audit reports and environmental checklists undertaken throughout the hospital. Following review of these documents, we were concerned about the accuracy and quality of data being recorded because they had not identified the same issues and therefore did not provide a true reflection of the environment observed during the inspection. For example:

- The Hospital Improvement Plan completed in January 2024 outlined that daily walkarounds were being conducted by housekeeping staff, and weekly walkarounds were being conducted by hospital managers, to review the cleanliness of the hospital. There was no documentary evidence of this
- We were informed that the March IPC audits were not yet completed. During the inspection we were provided with a clinical IPC audit dated 12 January 2024 and a non-clinical IPC audit dated 20 February 2024. The non-clinical audit had confirmed the following statements to be true and correct:

    - "Fixtures/floors/surfaces/handrails and appliances are free from grease, dirt, dust, deposits, marks stains and cobwebs"
    - "Microwave/ovens/toasters/utensils are visibly clean"
    - "Shelves, cupboards and drawers are clean inside and out and free from damage, dust, litter or stains"
    - "Laundry area clean and tidy, free from contaminating equipment."

- A visit of the hospital was conducted in October 2023, in accordance with Regulation 28 of The Independent Health Care (Wales) Regulations 2011. The report indicated that the cleanliness of the hospital had required significant improvement since the last visit and that during this visit, the cleanliness of the hospital had significantly improved
- The January/February clinical governance meeting minutes indicated that all improvements identified during our previous inspection of the hospital in 2022 had been completed
- The hospital had only one housekeeper and the cleaning schedules we viewed during the inspection indicated that some of the required cleaning tasks were not always being undertaken
- We were told that when the housekeeper was off duty or on annual leave, the hospital cleaning was contracted to an outside company, during which time no cleaning schedules were completed. Therefore, it was not possible to identify which cleaning tasks were completed during this time
- Staff confirmed there was no additional governance oversight of hospital cleaning schedules and audit processes to ensure they were completed.

As a result of these findings, we were not assured that:

- The premises provided a clean, safe and secure environment in line with current legislation and best practice
- The premises were being kept in a good state of repair internally
- Patients and staff were being protected from health care associated infection through the maintenance of appropriate standards of cleanliness and hygiene
- The service was identifying, assessing and managing risks relating to the health, welfare and safety of patients and others.

Our concerns formed part of the non-compliance notice issued to the service immediately following the inspection. Details of the actions taken by the service are provided in Appendix B.

The hospital had an appointed IPC lead. We reviewed the staff mandatory training compliance figures and found that 50 per cent of nursing staff and 89 per cent of support staff were compliant with their IPC training. During our discussions with staff, they told us that there was no housekeeping support during the evening and that they were sometimes unable to complete their cleaning tasks due to staffing pressures and changes in patient acuity and care requirements.

We were informed that the cleaning responsibilities for housekeeping staff were documented within the weekly cleaning schedules, while other areas of the

hospital were maintained by nursing staff. These included the hospital's cupboard and fridge interiors, which were found to be unclean and cluttered during the inspection. We further noted that the nursing staff cleaning schedule was very basic and did not clearly outline a full schedule of their cleaning responsibilities. For example, the schedule only detailed 'Ash Clean', Beech Clean', 'Cedar Clean', and 'Laundry', without providing any additional instructions to staff. The document outlined that the cleaning would be checked by the Nurse in Charge (NIC) and by senior management every morning, but it was evident this was not being done. During the inspection we discussed this matter with senior staff who agreed that the nursing staff cleaning schedules provided insufficient detail and amended the schedules during the inspection.

The service must review the cleaning roles and responsibilities for staff to ensure they do not negatively impact on the ability of staff to care for patients.

The service must implement robust governance oversight to ensure the cleaning roles and responsibilities of nursing staff are enforced and regularly monitored to ensure compliance.

Nutrition
We saw evidence that the nutritional and hydration needs of each patient were being appropriately assessed, recorded and addressed. Patients were assessed on admission and received ongoing weight management checks during their stay. Care plans had been put in place to manage specific dietary needs where required.

Patients were provided with a variety of meals and could access drinks and snacks throughout the day. We witnessed food being served to patients during the inspection and found it appeared to be appetising and of good quality. As well as the meals provided, patients were able to buy and store food in the hospital. We were told that patients could also use the occupational therapy kitchen to prepare their own meals.

We were informed that patients were provided with a choice of meal options, and that staff would accommodate any alternative requests wherever possible. However, we noted that the menus were only displayed in the kitchen where they could not be viewed by patients. We discussed this with staff who confirmed that menus were no longer displayed in the communal patient areas and told us that this also caused confusion for staff when preparing meals. Staff told us that the patients would benefit from having set pictorial menus which rotated on a weekly basis. These would provide patients with clear guidance on the options available to them and avoid confusion for staff.

The service must provide patients with suitable menus which clearly outline the meal options available to them.

Medicines management
Relevant policies, such as medicines management and controlled drugs, were available and staff told us that they knew how to access them.

It was previously mentioned in the report that we found the clinic room at the hospital to be cluttered and unclean. During the inspection we also noted that the medication fridge was unlocked and highlighted these issues to staff. Both issues were rectified during the inspection, in that the clinic room was cleaned and decluttered, and the fridge was locked.

We reviewed the hospital's clinic arrangements and found robust procedures in place for the safe management of medicines. Daily temperature checks of the medication fridges and clinic rooms were being completed to ensure that medication was stored at the manufacturer's advised temperature. All prescribed patient medications were securely stored in locked cupboards within the clinic room. The records evidenced that stock was accounted for when administered and that stock checks were being undertaken.

We saw appropriate internal auditing systems in place to support the safe administration of medication. These included a monthly Medication Administration Record (MAR chart) audit and a three-monthly clinic room audit. The patient MAR charts we viewed were being maintained to a good standard. The MAR charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. Consent to treatment forms were appropriately completed and stored with the corresponding MAR charts.

We observed safe, sensitive and appropriate prescribing of medications in accordance with patient needs. Regular medication reviews were completed to ensure patient medications continued to be safe and appropriate. Medication side effects were measured and appropriately escalated using the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS), which we identified as an example of good practice.

We saw strong evidence that patients were involved in decisions about their medications wherever possible. We were told that patients and their representatives routinely attended MDT meetings during which any updates or changes to their medication were discussed and recorded.

Staff we spoke with during the inspection demonstrated appropriate knowledge and understanding of medications management procedures. We found good systems in place to ensure medication errors were appropriately recorded, investigated and supervised, and any learning opportunities were shared with all staff.

Safeguarding children and safeguarding vulnerable adults
There were established processes in place to ensure that the hospital safeguarded vulnerable adults, with referrals to external agencies as and when required. A comprehensive safeguarding policy was in place and up to date, and a register of safeguarding incidents was being maintained. The hospital's management structure included a dedicated safeguarding lead who was supported by the senior management team to ensure the hospital's safeguarding responsibilities were met. Hospital staff attended clinical governance meetings where safeguarding concerns were discussed as a standing agenda item, to share trends and learning opportunities.

Training figures we viewed during the inspection indicated that overall staff compliance with mandatory Safeguarding Adults training was 100 per cent for nursing staff and 83 per cent for support staff. During our discussions with staff, they demonstrated a good understanding of the risks and vulnerabilities of the patients being cared for in the hospital. We were assured that staff fully understood the hospital's safeguarding procedures and reporting arrangements. We saw evidence that safeguarding concerns were being recorded and referred to external safeguarding agencies in line with the registered provider's policy.

Senior staff told us that the service worked closely with the Flintshire County Council Safeguarding Team to ensure the hospital's safeguarding responsibilities were met. However, they expressed concern that the Safeguarding Team had advised that they must gain patient consent before making safeguarding referrals, which was causing confusion for staff. At the time of our inspection, discussions were ongoing between hospital staff and the local authority regarding this matter, as hospital staff were not in agreement with the advice they had been given by the Safeguarding Team.

The service must continue to engage with the local authority to seek clarification regarding this matter, to ensure that safeguarding referrals are appropriately submitted.

Safe and clinically effective care
We found the staffing levels met hospital templates throughout the inspection and were proportionate to provide safe and effective patient care. At the time of our inspection the hospital manager was supported by a committed ward and

multidisciplinary team. We were informed that a full-time deputy manager had been appointed and was due to begin working in the hospital, which would strengthen the support and governance systems in place. Staff we spoke with during the inspection told us that the team provided good professional support to each other and felt that there were enough staff to provide safe patient care. The patients we spoke with during the inspection confirmed that they felt safe at the hospital. However, two of the four patients who responded to our questionnaire stated that they felt unsafe. We did not identify a common cause for this, and we were not able to obtain feedback from all patients during our visit. We therefore recommend that the service must reflect on this feedback and conduct further discussions with patients in respect of this matter.

The service must engage with patients to identify ways of making all patients feel safe during their stay at the hospital.

We found an established system in place for recording, reviewing and monitoring incidents via electronic systems and paper records. However, improvements were required to ensure the effectiveness of patient care in relation to governance and oversight of audit activities, IPC arrangements and reducing environmental risks, as outlined throughout this report.

The hospital had policies and procedures in place to help protect the safety and wellbeing of patients and staff. Staff we spoke with during the inspection confirmed that they knew how to access the relevant clinical policies, procedures and professional guidelines to assist them in their roles. The policies we were given during the inspection were all found to be in date, however, we saw a policy folder in the nursing office which contained a number of outdated policies. We also noted that some of the 'in date' policies in the folder were not the latest version as was provided to us during the inspection. We discussed this matter with senior staff who advised that the folder would be removed from the nursing office and staff would be advised to access all relevant policies on the intranet.

The service must ensure staff are provided with current, up to date policies and procedures to support them in their roles.

During the inspection we observed staff responding to patient needs in a timely manner and managing patient risks through therapeutic observation and engagement. We saw that risk assessments were being completed by nursing staff and individual patient observation levels were discussed during the daily risk review meetings. The Guidelines for Clinical Observations Policy outlined that staff undertaking therapeutic observations should take 'an active role in engaging positively with the patient'. We witnessed staff undertaking safe therapeutic patient observations during the inspection, which were recorded in line with

hospital policy. However, we observed some staff members undertaking therapeutic observations who were not engaging with the patients concerned.

The service must ensure all staff engage and interact in a positive way with patients when undertaking therapeutic observations.

It was positive to note that during our conversations with staff they showed understanding of the restrictive practices available to them as well as appropriate preventative measures which can reduce the need for restrictive responses to challenging behaviour. We saw examples of good practice in relation to staff and patient interactions, particularly in respect of de-escalation, diversional approaches and managing challenging patient behaviours.

We found an established governance structure in place to review and monitor patient restraint incidents during daily meetings and bimonthly clinical governance meetings. We reviewed a sample of patient safety incidents and noted that incidents of restrictive practice were appropriately recorded within individual patient care records and on the RADAR healthcare system. We noted that most of the recorded incidents were lower level 'touch support' and 'arm holds', which demonstrated that restrictive practices were used as a last resort after other methods of de-escalation had proved unsuccessful. We were told that debriefs took place with staff and patients following incidents to check on their welfare, reflect, and identify any areas for improvement.

During the inspection, we were informed that 74 per cent of nursing staff and 94 per cent of support staff had completed their mandatory physical intervention training. Staff advised that the service had a dedicated physical intervention trainer and that any non-compliant staff members were booked onto forthcoming courses. Senior staff confirmed that robust measures were in place to ensure agency staff had received appropriate physical intervention training before they commenced working in the hospital.

During the inspection we requested a breakdown of restraint incidents to identify whether any staff who were not compliant with their restraint training had been involved in incidents of restraint during the previous six months. However, staff advised that the system could not be filtered to produce this information and that each individual incident would have to be scrutinised, which was a time-consuming and laborious task. At our request, staff collated this information for the previous three months prior to our inspection and confirmed that all patient restraints were conducted by appropriately trained staff during this period. Given the difficulty staff faced in collating this information, we identified that the current recording systems for restraint incidents presented barriers for supervisory staff to review and provide robust governance oversight of restraint incidents.

The service must implement processes to ensure that restraint incidents can be filtered to support effective investigation, supervision and governance oversight.

Participating in quality improvement activities
It was apparent from our discussions with staff that senior managers were reviewing the provision of service with a view to improving patient care. There were various meetings being held to identify issues, points of learning, themes and trends in order to share information with staff. We noted many audit activities were being appropriately completed to support the safe care of patients. However, immediate improvements were required in respect of the IPC and environmental risks we found during the inspection, as outlined throughout this report.

Throughout the inspection we noted that staff were receptive to our findings and recommendations. The process of cleaning and decluttering the hospital and addressing the environmental risks present was commenced at the time of the inspection. Following the inspection, we received additional updates from senior staff regarding further actions they had undertaken to improve the environment and rectify the issues we observed.

We were told that the service was reviewing the training and qualifications of existing staff members with a view to developing, upskilling and retaining staff. At the time of our inspection, senior staff were in the process of developing a monthly supplementary training programme which will provide additional support for staff on relevant topics such as medicines management and mental health.

It was positive to hear of the future plans for the hospital during the inspection. We were told that the entire hospital site would be completely refurbished in 2026, which would resolve many of the environmental issues identified in this report. Senior staff confirmed that discussions were already ongoing in respect of this matter, with a view to causing minimal disruption for patients during the refurbishment process.

Information management and communications technology
We found that paper records and data were being maintained in line with General Data Protection Regulation (GDPR) legislation and securely stored in locked areas. Information was accessible to all relevant staff and there were established processes to share information with partner agencies in a safe and secure way. We saw high support staff compliance with mandatory Information Governance training at 89 per cent but noted that nursing staff compliance was low at only 25 per cent.

Records management
The hospital had a paper record system and an electronic record system which was password protected. We found well-organised paper records throughout the hospital, which were easy to navigate through clearly marked sections. Information was being captured comprehensively within the records and they were appropriately and securely stored. However, staff advised that the dual paper and electronic records systems presented challenges for them, as they were often required to duplicate complex patient information within both systems. Staff we spoke with during the inspection told us this process was time consuming and repetitive, and prevented them from performing their other duties within the hospital. Staff expressed that their working practices would be improved with the introduction of an entirely electronic health record system which would resolve these issues. We discussed this matter with senior staff who advised that an alternative records management system was being trialled at two other Coed Du Hall Group sites, and the service was considering options to implement a fully electronic health record system in future.

The service must review the current records management systems with a view to implementing a single system which captures information in a streamlined and consistent way, to ensure efficiency and avoid duplication for staff.

During the inspection we noted that the hospital's electronic record system was faulty. Whilst reviewing an individual patient's records, the system glitched and opened a different patient's record without any indication. This error occurred on three separate occasions whilst we reviewed patient records and could easily go unnoticed. We also saw an example whereby staff had mistakenly recorded information into the wrong patient's record. We raised our concerns to staff that this issue could impact on the safety of patients in the hospital. Senior staff advised that they would engage with the service's Information Technology Team regarding this matter.

The service must ensure that the hospital's current electronic record system is fully functional and fit for purpose.

Mental Health Act monitoring
We reviewed the Mental Health Act (MHA) 2007 statutory detention documentation of five patients being cared for in the hospital. The records verified that the patients were being legally detained and were well supported to access Independent Mental Health Advocacy services. Patient rights information was clearly documented in accordance with section 132 of the Act.

We found robust monitoring and audit processes in place in relation to MHA documentation and record keeping. The MHA records we viewed were well

organised and compliant with the requirements under the act. We saw high support staff compliance with mandatory Mental Health, Dementia and Learning Disabilities training, but noted that nursing staff compliance was low at 50 per cent.

During the inspection we identified several areas of good practice in relation to MHA monitoring as follows:

- The hospital had a dedicated Mental Health Act Administrator (MHAA) who provided robust governance oversight to ensure staff compliance with MHA processes. Staff spoke positively of the supportive role of the MHAA within the hospital
- We were told that the MHAA had undertaken additional training to expand their knowledge of MHA processes and share valuable learning with staff
- The MHAA confirmed that there were appropriate support systems in place for them within the service, which contributed to their continuous personal development.

We found good processes in place to document Section 17 leave appropriately. Patient leave was being suitably risk assessed and the forms determined the conditions and outcomes of the leave for each patient. There was evidence that patients had been provided with, or offered, a copy of their leave form. However, we saw examples where the patient had signed but not dated the form. Within the forms we also noted that the 'circulation list' tick boxes had not been fully completed to indicate who had been provided with a copy of the form.

The service must ensure that MHA Section 17 leave forms are fully completed to include the date and details of all recipients, as a matter of good practice.

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

Alongside our review of statutory detention documents, we considered the application of the Mental Health (Wales) Measure 2010. We reviewed four patient Care and Treatment Plans (CTPs) and found that they were completed in accordance with the Mental Health (Wales) Measure 2010. Overall, we observed a good standard of clinical record keeping which reflected the needs and risks of the patients. The paper records were well organised, easy to navigate and included all relevant information. Within all the records we saw evidence of comprehensive assessments and risk assessment. Patient physical healthcare needs were appropriately assessed on admission and the hospital liaised with primary and secondary NHS services to ensure any ongoing care needs were being met.

We found strong evidence that patients, family and carers were involved in the development of the CTPs wherever possible. The patient voice and wishes were well-reflected in the patient records. The CTPs were person-centred and included a good level of patient specific detail.

Monthly ward rounds were being held by the MDT to discuss the progress and care of each patient. The meeting minutes we viewed provided detailed information regarding the patients' progress, ongoing treatment plans and discharge planning arrangements. The MDT review process included the involvement of the patient, external agencies and community professionals where required. We noted that the service had developed a formal care records audit process and a schedule to record forthcoming MDT and care planning meetings, which we recognised as examples of good practice.

Quality of Management and Leadership

Governance and accountability framework

The staff members we spoke with during the inspection provided positive feedback to us about their immediate line managers. They confirmed that they felt supported in their roles and that the leadership team was visible and approachable. The MDT was well established and we observed everyone working well together throughout the inspection.

We found an established governance structure in place to provide oversight of clinical and operational issues. Staff confirmed that the governance arrangements included activities and meetings to discuss incidents, findings and issues related to patient care, which supported improvements and shared learning from incidents and serious untoward events. Agendas for clinical governance meetings showed a wide range of standing items to help ensure that the hospital focussed on all aspects of the service. Further oversight of the performance of the hospital was managed through the Coed Du Hall corporate teams. We saw evidence that the responsible individual had been visiting the setting to produce a written report on the standard of treatment and services being provided at the hospital.

Audit activities and monitoring systems and processes were in place to ensure the hospital focussed on continuously maintaining standards. However, many of the issues we found during our inspection had not been identified within the hospital's audit processes and internal inspections. As a result, we were not assured that the hospital governance arrangements ensured that key risks were being identified, addressed and monitored to prevent reoccurrence.

We discussed this issue with staff and were informed that the service had employed several hospital managers in recent years, resulting in a lack of continuity and changing governance arrangements for staff. At the time of our inspection, the service had recently employed a new hospital manager who was in the process of developing an improved system of audit within the hospital. During our discussions with senior staff, they agreed that there had been a lack of senior management scrutiny of the environmental risks and IPC issues we found during the inspection. We were informed that the hospital's governance systems and audit processes would be immediately improved to provide clear guidance to staff and improved senior management scrutiny of ward-based audits. This process commenced during the inspection and we were provided with additional evidence of improvements made in respect of this matter after the inspection had concluded.

The service must continue to strengthen the leadership systems within the hospital to ensure key issues are identified, addressed and supervised in order to prevent reoccurrence and drive quality improvement.

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

Individual incidents were being discussed with members of the MDT and senior staff at the daily risk review meetings and the bimonthly clinical governance meetings. We saw that incidents, complaints and safeguarding concerns were discussed as a standing agenda item during daily morning meetings, and any learning was shared with all staff.

Workforce recruitment and employment practices
An appropriate staff recruitment, selection and appointment process was in place at the hospital. Prior to employment, external pre-employment checks were conducted which included enhanced Disclosure and Barring Service (DBS) checks. Staff confirmed that newly appointed permanent staff members received a fourteen-day period of induction during which they were supernumerary to the usual staffing establishment at the hospital. We were told that staff employment records were regularly reviewed to ensure that staff were fit to work at the hospital.

A whistleblowing policy was in place should staff wish to raise any concerns about any issues at the hospital. We were informed that all complaints were appropriately investigated and that any staff member who was subject to a complaint was appropriately supported during the investigation process.

We were told that the hospital had a dedicated staff meeting process to share concerns and feedback and strengthen staff working relationships. We were informed that when staff meetings were held, the minutes were collated and circulated for staff awareness. However, we found that the staff meetings did not take place on a regular basis and the evidence we reviewed indicated that only two meetings had taken place within the six months prior to our inspection. Staff we spoke with during the inspection were unable to provide further clarity on how often the meetings took place.

The service must ensure staff meetings are conducted on a regular basis to engage with staff and encourage staff feedback.

Workforce planning, training and organisational development
Staffing levels appeared to be appropriate to maintain patient safety within the hospital at the time of our inspection. During our discussions with senior staff, we were told there were vacancies for three support staff members in the hospital, but no permanent nursing staff vacancies. Senior staff confirmed that bank and agency staff were usually used to cover any staffing shortfalls and the hospital actively sought to block-book agency staff who were familiar with the hospital and the patient group wherever possible.

Most staff we spoke with during our inspection agreed they could meet the demands of the role and that there were enough staff to deliver care to patients safely. However, we identified that during the night shifts only one registered nurse would be working with a team of healthcare support workers. This meant that the nurse working the night shift could not take a break without leaving the hospital without nursing cover during this period. We highlighted our concerns to staff that being unable to take a break could potentially affect their wellbeing and compromise their professional judgements. We also found this same issue during our previous inspection of the hospital in 2022.

The service must ensure there is sufficient cover for nursing staff to take breaks during their shift without leaving the ward unsupervised.

We found suitable processes were in place for senior staff to monitor compliance with mandatory training. Senior staff confirmed there were processes in place to ensure bank and agency staff were appropriately trained to work in the hospital. During the inspection we reviewed the mandatory training statistics for staff and found that overall support staff compliance with mandatory training was generally high. However, improvements were required in respect of overall nursing staff compliance with the following mandatory training courses:

- Basic Life Support - 25 per cent
- Mental Health Act, dementia and learning disabilities - 50 per cent
- Safe administration of medication, including rapid tranquilisation - 75 per cent
- Level 1 Health and Safety - 50 per cent
- Level 1 Information Governance - 25 per cent
- Level 1 Fire Safety - 75 per cent
- Infection Prevention and Control - 50 per cent
- Physical Intervention - 74 per cent.

We discussed these areas of low compliance with senior staff and were told that that the service had employed a dedicated training and development support officer within the last twelve months, as well as two additional staff trainers. As a

result, training courses were readily available, and we saw evidence that staff were already booked or would be booked on to the next available training courses.

The service must ensure that that all outstanding mandatory training is completed, regularly monitored and that staff are supported to attend the training.

The service must ensure that there are systems in place to prevent low compliance with mandatory training requirements.

We were told that opportunities were available for staff to develop within the service. Staff received regular supervisions and annual performance development reviews to discuss their performance and set annual objectives.

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 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
On Ash ward, the cupboard containing the consumer unit was filled with blankets, clothing and clutter, which posed a fire safety risk.	This posed a risk to staff and patient safety.	We highlighted our concerns to staff.	The cupboard was appropriately cleaned during the inspection.
The televisions on Beech and Cedar wards were both heavily damaged. The television on Cedar ward was shattered and there was loose broken glass present.	This posed a risk to staff patient safety.	We highlighted our concerns to staff.	Both televisions were replaced during the inspection.
Staff were using a damaged blood pressure monitor which was sellotaped together.	This posed a risk to and patient safety.	We highlighted our concerns to staff.	The blood pressure monitor was replaced during the inspection.
The glass fire door of Cedar ward was completely shattered	This posed a risk to staff and patient safety.	We highlighted our concerns to staff.	The Cedar ward fire door was repaired during our inspection

The entrance and garden areas of the hospital were strewn with cigarette butts and general litter	This posed a risk to staff and patient safety.	We highlighted our concerns to staff.	Improvements were made to clean and tidy and declutter the hospital grounds over the course of the inspection.
The dining room, bathrooms, floors and surfaces of the hospital were generally untidy and unclean	This posed a risk to staff and patient safety.	We highlighted our concerns to staff.	Improvements were made to clean and tidy the hospital over the course of the inspection.
The clinic room was found to contain unnecessary clutter and required cleaning. The medication fridge within the clinic room was unlocked.	This posed a risk to staff and patient safety.	We highlighted our concerns to staff.	Both of these issues were rectified during the inspection, in that the clinic room was cleaned and decluttered, and the fridge was suitably locked.

Appendix B - Immediate improvement plan

Service: Coed Du Hall

Date of inspection: 25, 26 and 27 March 2024

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.

Description of Non-Compliance/ Action to be taken	Timescale for completion	Regulation number	Provider Action
The service must ensure that all staff use personal safety alarms. An alarm policy must be implemented to support staff in their roles.	Immediately and then ongoing	15(1)(b), 19(1)(b) 47(1)(c)	A new policy has been written and is available for scrutiny policy was implemented on 02.04.2024. Staff are supported to and encouraged to wear their personal Alarms; this is monitored daily at handover by the nurse in charge of the building to ensure all staff are compliant. Staff have had a group supervision which explains about the importance of wearing the personal safety alarms on 05.04.2024 and 07.04.2024.
The service must ensure that suitable and effective measures are in place to ensure potential risks to patient safety are identified, assessed and mitigated.	Immediately and then ongoing	15(1)(b), 19(1)(b), 26(2)(a), 47(1)(c)	All areas are checked and monitored for any potential risks daily, these risks are then mitigated and any risks/hazards are identified and if anything is found it is removed. There has been a daily walk around implemented by the manager who will check drawers, cupboards, main kitchen and the satellite kitchens,

			as well as the laundry on 08.04.2024. Ongoing and with management oversight daily. There is a daily checklist for the support staff to complete which includes all the kitchen areas and communal area checks, commenced on 08.04.2024, ongoing with management oversight daily. The blankets in cupboards have been removed and discarded, as have the broken electrical items, batteries, pens, shoes, carrier bags - completed on 04.04.2024 with ongoing management oversight daily. The bath in Ash is a little more complicated as the need for the area to be clear (wires) underneath is for the bath to rotate, so these wires cannot be blocked in, however, there has been a review to take out the bath and put a new one in, but this will be completed by the end of May 2024. In the meantime, the only people using that bathroom are supervised, to ensure risk is reduced. The lock has been placed on the bathroom door where there was an opened cupboard in Ash bathroom 04.04.2024.

			All fire extinguisher boxes have been repaired, completed on the 19.04.2024, and ongoing daily management oversight is now in place. All TV's have been replaced and had been broken but were on order and had been in the building waiting to go up, this is ongoing and will be monitored by management oversight daily. Blood pressure monitors were available in the clinic as seen in the inspection and the old broken one was discarded; completed at the time of inspection. Ongoing oversight by the management on a monthly basis on the medication audit. The glass fire door that was broken has been reported and was waiting to be repaired this was actually repaired on one of the days of the inspection, ongoing monitoring will continue.
The service must ensure all areas of the hospital are thoroughly deep cleaned and decluttered. Maintenance work must be undertaken to ensure all areas of the hospital are in a good state of repair and appearance to adhere with best practice infection prevention and control (IPC) standards.	Immediately and then ongoing	15(7) 15(8)(c) 26(2)(a) 26(2)(b)	All areas of the hospital have been deep cleaned and this is an ongoing process, this is monitored by a daily walkaround at different times of the day. There is a new schedule in place and is monitored through the audit process that matches the schedule, which makes for a more vigorous robust process.

			The seating area at the front of the hospital is cleaned every morning and monitored daily. New planters have been added to the front of the hospital and new plants added. The bench has been deep cleaned. There is now a patient environment action team to go around the hospital on a daily basis to ensure it is clean and tidy. This is monitored by the staff that are with them and the information is added to the observations charts. The Beech fan ventilation system works with the lights, when the lights go on the system works. This has been checked and is working. There are checks by staff on a regular basis on the wards at least twice daily. This has been resolved and forms part of the daily walkaround. The staff at the end of the day shift now have a rota where they clean all the communal areas before they leave shift, and this is monitored by the nurses in charge of the hospital both day and night. A new cleaning system is in place to ensure that all areas of the hospital have been cleaned on a rota basis.

			We have changed all the bins throughout the hospital, to adhere to the IPC audit. We have completed a deep clean of all bathrooms on each ward. This is an ongoing process which is monitored on a daily basis by management oversight. To support the housekeeper and increase capacity the hospital has advertised for another domestic to recruit to the housekeeping department. There has been significant interest in the position and we hope to announce the successful candidate very soon. The lights have now been added to the maintenance program to be cleaned and there is oversight by the management team on a daily walkaround. All radiator covers have been taken off and cleaned, all old radiators will be replaced by the end of May 2024 to ensure all the rusty ones have been disposed of. All chairs have been ordered and all old furniture has been removed and replaced with new chairs. The dining room tables and chairs have been

			ordered and will be delivered week commencing 22.04.2024. There is now a painting schedule in place for the whole of the building. Included in this will be the wooden furniture which needs to have a coat of varnish. This has commenced 25.04.2024 and is ongoing, with this being managed by the management. Microwaves have been replaced and a new one for Beech ward is on order. Fridges and microwaves form part of the cleaning schedule of the support staff and the housekeeper, this is also monitored on a daily walkaround by management.
The service must implement robust governance oversight to ensure IPC audits and reviews are accurately completed and are effective in identifying improvements that are required in relation to cleanliness and good hygiene.	Immediately and then ongoing	19(1)(b)	All audits have been reviewed and are relevant and reflective of the hospital ICP procedures and the management has oversight of these areas on a daily basis with walk arounds of the hospital and grounds, but also through auditing processes. To ensure we identify any issues and rectify them as soon as possible, this oversight will include a new set of audits for the wards, kitchen, maintenance and management to do and to oversee, to ensure the cleanliness of the inside and outside of the hospital.

			All audits will be reported to the clinical governance meeting for scrutiny and monitoring.

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): **Donna Woodruff**

Job role: **Hospital Manager**

Date: **19 April 2024**

Appendix C - Improvement plan

Service: Coed Du Hall

Date of inspection: 25, 26 and 27 March 2024

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.	There were no observation panels on the patient bedroom doors. This issue was also identified during our previous inspection of the hospital in 2022.	The service must consider installing vision panels in patient bedroom doors to ensure therapeutic observations can be conducted with minimal disruption to patients.	Dignity and respect Regulation 18	The MDT have discussed the use of vision panels with the RC, who is not assured the vision panels will allow for close observation and monitoring. We need to ensure that observations take account that the patients are breathing and that they are not able to ligature in bed where a risk is identified.	Manager	31 July 2024

				Observation panels would reduce the quality of observation and the efficacy of intervention. We will continue to ensure staff provide observations as per policy and respect the patient's privacy and dignity at all times with minimum disruption.		
2.	There was no privacy glass to prevent patients from being seen within their bedrooms from the external areas of the hospital.	The service must ensure patient bedrooms cannot be seen from the external areas of the hospital, to protect their privacy and dignity.	Dignity and respect Regulation 18	To promote patients' privacy and dignity all external windows will be fitted with screening film.	Maintenance and Manager	28 June 2024
3.	During our tour of the hospital, we noted that the nursing office blinds were left open and confidential patient information	The registered provider must ensure that staff maintain patient information confidentiality within the nurse's office.	Dignity and respect Regulation 18	The Registered Provider will review the policy and procedures for the management of confidential information. Privacy	Maintenance and manager	28 June 2024

	was visible from outside the office.			board will be installed in the nurse's station to promote the staff storage of confidential information.		
4.	There were no pictorial information boards to identify the hospital staff for patient or visitor awareness.	The service should install pictorial information boards to identify the hospital staff for patient and visitor awareness.	Patient information and consent Regulation 15	Pictorial information boards will be updated to include staffing pictorial identification.	Occupational Therapist and Manager	28 June 2024
5.	The staff attire posed difficulty for patients, visitors and unfamiliar staff to distinguish between staff and patients.	The service must ensure that hospital staff are appropriately attired and easily identifiable, to avoid confusion and support patient safety.	Patient information and consent Regulation 15	All staff have been advised of the dress code and hospital policy. ID Badges are available for all staff and the senior management team will maintain daily observation to ensure that staff have ID and it is appropriate and visible to patients, colleagues and visitors to support patient safety.	Manager	30 April 2024

				To further support identification an information board will contain the structure of staffing by name and role.		
6.	Some staff we spoke with during the inspection felt that the daily risk review meeting process would be improved with the attendance and involvement of healthcare support workers as well as multidisciplinary staff members.	The service must conduct further discussions with staff in with a view to involving healthcare support workers in hospital meeting processes.	Care planning and provision Regulation 19	The support staff are invited to the MDT meetings so they are updated with all the risk reviews. They are also given this information in handover.	MDT	30 April 2024
7.	The weekly patient meetings were not minuted and there was no recorded evidence of the meetings taking place.	The service must ensure patient meetings are appropriately minuted to capture patient feedback and evidence any issues raised.	Citizen engagement and feedback Regulation 19	The patients' meetings will minuted and a record to be kept of all meetings to ensure patients feedback, any required actions and activity are delivered promptly.	Occupational Therapist	31 May 2024

8.	There was no 'You Said, We Did' board in the hospital to inform patients and family/carers of changes made as a result of their feedback.	The service must implement suitable processes to update patients and family/carers of actions taken as a result of their feedback.	Citizen engagement and feedback Regulation 19	'You Said, We Did' has been added to the notice board displayed in the OT area of the hospital.	Occupational Therapist	31 May 2024
9.	Some maintenance issues were not being routinely recorded in the logbook and we saw examples where recorded issues were not signed off to indicate they had been completed.	The service must conduct a full environmental audit of the hospital to ensure all maintenance issues are identified and recorded.	Environment Regulation 26	Environmental audit to be completed on a monthly basis and all actions to be evidenced and signed as completed by the maintenance team. This will be monitored through our clinical governance systems.	Maintenance	31 July 2024
10.	We saw examples whereby recurrent maintenance issues were reviewed during monthly maintenance meetings but remained unresolved	The service must implement a robust programme of continuous governance oversight to ensure outstanding maintenance issues are appropriately addressed and monitored.	Environment Regulation 26	This is being monitored by management and maintenance team, it is also added to the clinical governance meeting agenda. All remedial action and activity to be	Manager and maintenance	31 July 2024

				recorded in the meeting notes.		
11.	Some staff demonstrated a lack of understanding regarding the hospital's fire evacuation procedures and fire exit operation.	The service must reinforce the fire safety and evacuation procedure with all staff.	Managing risk and health and safety Regulation 20	Fire safety and emergency evacuation drill training dates have been set for the 17th of July and the 24th of July 2024. This is to ensure all staff have a comprehensive understanding of the evacuation process and procedures and to ensure a good understanding of the hospital policy. This will be monitored by feedback and supervision.	Maintenance Snowdonia fire services management	31 July 2024
12.	The entrance/exit from Cedar ward to the hospital grounds was unrestricted during the day, which posed a risk of patients absconding from the hospital, or	The service must explore ways to ensure patient whereabouts are accurately accounted for at all times.	Managing risk and health and safety Regulation 19	All patients are monitored throughout the day and night, the hospital make use of an observation booklet and this records the patients' movements in line	Nurse care and support workers Observation booklets	31 May 2024

	of staff not being able to account for patient whereabouts during an emergency.			with their prescribed observations.		
13.	Staff told us there was no housekeeping support during the evenings and they were sometimes unable to complete their cleaning tasks due to staffing pressures and changes in patient acuity and care requirements	The service must review the cleaning roles and responsibilities for staff to ensure they do not negatively impact on the ability of staff to care for patients.	Infection prevention and control (IPC) and decontamination Regulations 15, 19, 26	As a service we have been actively recruiting for another cleaner to support the housekeeping department. We have a cleaning schedule in place for both days and nights to help support the housekeeping department.	Housekeeping and Manager	30 April 2024
14.	The staff cleaning schedule outlined that the staff cleaning would be checked by the Nurse in Charge (NIC) and by senior management every morning, but it was evident this was not being done.	The service must implement robust governance oversight to ensure the cleaning roles and responsibilities of nursing staff are enforced and regularly monitored to ensure compliance.	Infection prevention and control (IPC) and decontamination Regulations 15, 26	Housekeeping to provide a comprehensive cleaning schedule to the manager on a weekly basis. All action and activity in relation to the cleanliness of the hospital will be provided to the	Housekeeping Manager/deputy daily walkaround	31 July 2024

				regular governance meetings to ensure compliance.		
15.	Staff confirmed that patient menus were no longer displayed in the communal patient areas and told us that this also caused confusion for staff when preparing meals	The service must provide patients with suitable menus which clearly outlines the meal options available to them.	Nutrition Regulation 15	The catering department have delivered menus that detail the meal options available. The menus indicate a healthy and nutritious balanced diet.	Kitchen staff	30 April 2024
16.	During the inspection, safeguarding discussions were ongoing between hospital staff and the local authority as the advice they had been given by the Safeguarding Team was causing confusion for staff.	The service must continue to engage with the local authority to seek clarification regarding this matter, to ensure that safeguarding referrals are appropriately submitted.	Safeguarding children and safeguarding vulnerable adults Regulation 16	The service will continue to actively engage with the local safeguarding team, the referrals will continue to be made and we will continue to engage with the team by having regular monthly meetings.	All staff	30 April 2024
17.	Two of the four patients who responded to our questionnaire stated	The service must engage with patients to identify ways of making all patients feel safe during their stay at the hospital.	Safe and clinically effective care Regulations 16, 19	Patient satisfaction surveys will be distributed, responses analysed and an action plan developed	Psychology Occupational Therapist and management	28 June 2024

	that they felt unsafe in the hospital.			to ensure all patients feel safe during their stay. All action and activity will populate the 'You Said, We Did' noticeboard.		
18.	A policy folder in the nursing office which contained a number of outdated policies and some of the 'in date' policies were not the latest version as was provided to us during the inspection.	The service must ensure staff are provided with current, up to date policies and procedures to support them in their roles.	Safe and clinically effective care Regulation 9	All policies have been reviewed and updated. They have all been made available to all staff. The service has implemented policy of the month for circulation.	All staff	28 June 2024
19.	We observed some staff members undertaking therapeutic observations who were not engaging with the patients concerned.	The service must ensure all staff engage and interact in a positive way with patients when undertaking therapeutic observations.	Safe and clinically effective care Regulations 15, 18	Clinical observations training has been provided to support staff to ensure therapeutic engagement and positive outcomes for patients.	Deputy Manager	31 May 2024
20.	Staff advised that the hospital records systems could not be filtered to produce	The service must implement processes to ensure that restraint incidents can be filtered to	Safe and clinically effective care Regulations 15, 19, 23	Develop and deliver a system to filter and analyse data. All data to be delivered	Manager	31 July 2024

	specific restraint data, which presented barriers for supervisory staff to review and provide robust governance oversight of restraint incidents.	support effective investigation, supervision and governance oversight.		through our governance arrangements to ensure a thorough and comprehensive analysis for developing and delivering robust actions and activity.		
21.	Staff advised that the dual paper and electronic records systems presented challenges, as they were often required to duplicate complex patient information within both systems	The service must review the current records management systems with a view to implementing a single system which captures information in a streamlined and consistent way, to ensure efficiency and avoid duplication for staff.	Records management Regulations 15, 19, 23	The hospital will review and develop an electronic recording system that is comprehensive, robust and fit for purpose.	MDT	29 August 2024
22.	During the inspection we noted that the hospital's electronic record system was faulty.	The service must ensure that the hospital's current electronic record system is fully functional and fit for purpose.	Records management Regulations 15, 19, 23	The hospital will develop and deliver a fully functioning recording system that is fit for the purpose of the hospital.	MDT	29 August 2024
23.	We saw examples where the patient	The service must ensure that Section 17 leave forms	Mental Health Act monitoring	All section 17 leave forms to be audited	MHAA and Manager	30 April 2024

	Section 17 leave forms had been signed but not dated. The 'circulation list' tick boxes within the Section 17 leave forms were not fully completed to indicate who had been provided with a copy of the form.	are fully completed to include the date and details of all recipients.	Regulation 23	for accuracy and any actions to be completed where required.		
24.	Because the issues we found during our inspection had not been identified within the hospital's audit processes and internal inspections, we were not assured that the hospital governance arrangements ensured that key risks were being identified, addressed and monitored to prevent reoccurrence.	The service must continue to strengthen the leadership systems within the hospital to ensure key issues are identified, addressed and supervised in order to prevent reoccurrence and drive quality improvement.	Governance and accountability framework Regulation 19	All audits have been reviewed and updated to ensure that key risks were being identified, addressed and monitored to prevent reoccurrence. All audit activity will be reported through our governance arrangements to ensure continuous quality improvements.	Manager	28 June 2024

25.	The staff meetings did not take place on a regular basis and the evidence we reviewed indicated that only two meetings had taken place within the six months prior to our inspection.	The service must ensure staff meetings are conducted on a regular basis to engage with staff and encourage staff feedback.	Workforce recruitment and employment practices Regulation 19	Meetings have been scheduled for 2024. All meetings to be recorded for monitoring purposes and to provide action and activity following staff feedback.	Management team	28 June 2024
26.	During the night shifts only one registered nurse would be working with a team of health care support workers, so could not take a break without leaving the hospital without nursing cover.	The service must ensure there is sufficient cover for nursing staff to take breaks during their shift without leaving the ward unsupervised.	Workforce planning, training and organisational development Regulation 20	Ensure sufficient competent staff on nights to ensure nurses have the opportunity and availability to take their breaks as required.	Manager, deputy	31 May 2024
27.	Improvements were required in respect of overall nursing staff compliance with several mandatory training courses.	The service must ensure that that all outstanding mandatory training is completed, regularly monitored and that staff are supported to attend the training.	Workforce planning, training and organisational development Regulations 20,21	Manager to ensure that all mandatory training is completed by all staff, including nursing staff. Regular monthly reports will be provided to the	Manager, deputy	30 April 2024

	The service must ensure that there are systems in place to prevent low compliance with mandatory training requirements.		governance meetings to ensure appropriate action and activity is taken where required to improve compliance.		

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): Donna Woodruff

Job role: Manager

Date: 13.6.24