Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Delfryn House and Lodge

Inspection date: 07, 08 and 09 October 2024
Publication date: 09 January 2025

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-83715-175-2

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 5

2. Summary of inspection 6

3. What we found 9

- Quality of Patient Experience 9
- Delivery of Safe and Effective Care 13
- Quality of Management and Leadership 19

4. Next steps 23

Appendix A – Summary of concerns resolved during the inspection 24

Appendix B – Immediate improvement plan 25

Appendix C – Improvement plan 26

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at Delfryn House and Lodge on 07, 08 and 09 October 2024.

The following hospital wards were reviewed during this inspection:

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

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

During the inspection we spoke to patients or their carers to find out about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 18 questionnaires were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We observed friendly and respectful interactions taking place with staff communicating with patients in a kind, proactive and engaging manner. The patients we spoke with during the inspection provided positive feedback.

Each ward provided a comfortable environment with appropriate fixtures and fittings for the patient group. Each patient had their own bedroom which we found to be clean and tidy and had been personalised to provide a homely feel. We noted that not all bedroom doors throughout the hospital had viewing panels. A patient in one of these rooms commented that they were often disturbed when staff undertook observations, particularly at night. Staff informed us that plans were in place to ensure all bedroom doors had observation panels, and we recommended that this work should be completed in a timely manner.

Tailored therapeutic activities were available for patients and we observed patients participating throughout the inspection. Two new social hubs had recently been created which were welcoming and safe areas for patients. It was disappointing to hear feedback that their opening hours were limited due to a lack of staff available to oversee the hubs. We recommended the service reviews the arrangements in place to ensure the social hubs can be kept open for as long as possible for patients to be able to use them.

This is what we recommend the service can improve:

- The range of information available to patients must be reviewed to ensure it is consistent and accurate
- Care and treatment plans must be reviewed in a timely manner to ensure they identify and meet the ongoing needs of patients.

This is what the service did well:

- Patients could engage and provide informal feedback to staff on the provision of care at the hospital in several ways
- The physical health needs of patients were being assessed and managed in a timely and appropriate manner
- The hospital held a family and carers day each quarter to increase engagement, develop positive relationships and keep families informed.

Delivery of Safe and Effective Care

Overall summary:
We found that staff at the hospital were committed to providing safe and effective care. Suitable protocols and policies were in place to manage risk, health and safety and infection control. Medication was being managed and stored appropriately within each clinic. We found effective processes in place to help ensure that staff at the hospital safeguarded patients appropriately. Regular checks were being undertaken of resuscitation and emergency equipment.

Patients had Positive Behaviour Support or 'My safety' plans in place which were detailed and included personalised strategies for preventing and managing challenging behaviour. The number of incidents of physical restraint was minimal, which indicated that physical interventions appeared to be being used as a last resort.

We were told that a recent NHS Wales Joint Commissioning Committee inspection had identified some issues with the quality of the patient records being maintained at the hospital. Work has been ongoing since that inspection to review and update their quality. However, the care and treatment plans we reviewed showed that some improvements were still required. We recommended that the service must continue its efforts to review and improve the quality of the care and treatment plans to ensure they meet the requirements of the Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010.

This is what we recommend the service can improve:

- Daily clinical manager walkaround checklists must be completed as required to identify any issues with the environment
- Staff must regularly check, document and take action to remove any out-of-date patient food and ensure that fridge temperatures are checked and recorded daily to ensure food and drink are stored safely
- All audits must be completed as specified and that an appropriate number of patient records are reviewed to ensure any issues or themes can be identified.

This is what the service did well:

- The Mental Health Act documentation we reviewed during the inspection showed that patients at the hospital had been legally detained
- The dietary needs of patients had been assessed on admission and specific dietary requirements had been identified and acted upon where necessary.

Quality of Management and Leadership

Overall summary:
Staff responses to the HIW questionnaires were generally positive. All but one respondent would recommend the hospital as a place to work, and all respondents agreed they would be happy with the standard of care provided by the service for themselves, friends or family.

We found established governance arrangements in place to provide oversight of clinical and operational issues. Staffing levels appeared appropriate to maintain patient safety within the wards at the time of our inspection. However, staff comments within the questionnaires suggested that current staffing levels may be impacting upon the ability of patients to participate in therapeutic activities and to take their Section 17 leave. We also noted that the staffing levels for the House at night only included one registered nurse. We felt this could provide additional adverse responsibility and pressure for the one registered nurse, particularly in the event of an incident. We recommended that the service reviews whether the current staffing establishments are sufficient and appropriate for the health and welfare of the patients and to fully meet their needs.

During the inspection we felt that each ward was being governed separately rather than as one organisation. For example, several recommendations we have made in this report apply to one of the wards only, rather than both, which did not provide assurance to us that good practice was being communicated and shared appropriately. We had noted the same during our previous inspection at the hospital in July 2022, and we have again recommended that the service reflect on this and review its governance arrangements to help bring consistency across both wards in relation to good practice and compliance with relevant standards.

This is what the service did well:

- The hospital had up-to-date policies and procedures in place to help staff provide safe and effective care
- Overall compliance among staff with mandatory training was high.

3. What we found

Quality of Patient Experience

Health promotion, protection and improvement
We saw evidence that the physical health needs of patients were being assessed and managed in a timely and appropriate manner. During the inspection we observed comprehensive discussions taking place in relation to the physical healthcare needs of one patient whose condition had recently changed significantly. We were told that all patients receive regular physical health screening on a rotational basis. The service had recently recruited a physical healthcare nurse to provide further support to help patients improve their health and manage any long-term conditions.

Patients on both wards had access to enclosed garden areas. We noted that both gardens were well maintained and appeared clean and tidy. Some of the patients we spoke with commented that having some more plants and flowers in the garden areas would provide additional interest and make them more appealing. We suggest that the service engages with patients to find out more about their views on improving the garden spaces.

Dignity and respect
We observed good standards of care being displayed by staff throughout the inspection. It appeared that staff had formed positive relationships with patients.

Patients were able to wear their own clothing and appeared well-kempt. All patients had their own bedrooms with ensuite facilities. We observed staff knocking on bedrooms doors before entering to maintain the privacy of patients. We viewed some of the bedrooms on each ward, and it was positive to see they were generally clean and tidy and had been personalised to provide a homely feel.

We noted that not all bedroom doors throughout the hospital had viewing panels. This meant that staff were not able to undertake enhanced observations without frequently opening the door to check on the patient. A patient in one of these rooms commented to us that they were often disturbed when staff undertook observations, particularly at night. Staff informed us that plans were in place to ensure all bedroom doors had observation panels.

The service should ensure the work to install observation panels on all bedroom doors is completed in a timely manner.

All staff members who completed a HIW questionnaire felt that the privacy and dignity of patients was maintained.

Patient information and consent
We saw a variety of patient information displayed throughout both wards. This included information on advocacy, activity timetables and a pictorial guide of staff members. Information leaflets were also available to patients. However, we noted some improvements were required:

- We saw different versions of the same leaflet at times which made it difficult to identify which information was correct or the most up-to-date
- Some leaflets referred to the Care Quality Commission in England rather than Healthcare Inspectorate Wales
- Some leaflets contained incorrect address details for Healthcare Inspectorate Wales.

The service must review the range of information available to patients to ensure it is consistent and accurate.

We also noted that some patient information was displayed in the reception areas rather than on the wards. The service may wish to consider whether the location of its current patient information is most accessible to patients.

We saw that 'Patient status at a glance' boards containing confidential information was kept out of sight of patients on each ward.

Communicating effectively
We observed friendly and respectful interactions taking place with staff communicating with patients in a kind, proactive and engaging manner.

We saw some information was available bilingually, and a poster was displayed which informed patients that other information could be provided in Welsh on request. We were told that some staff members could speak Welsh if required.

Patients are risk assessed for access to their mobile phone. Suitable rooms were available for patients to meet staff and other healthcare professionals in private. Visiting arrangements were in place for patients to meet friends and family at the hospital where appropriate.

We were told that the hospital holds a family and carers day each quarter to increase engagement, develop positive relationships and keep families informed, which we noted as good practice.

Care planning and provision
During the inspection we reviewed the care and treatment plans of four patients from each ward. We found that care plans were person centred, with each patient having their own programme of care that reflected their individual needs and risks. All staff who completed a questionnaire also felt that patients were kept informed and were involved in decisions about their care.

More findings on the care plans can be found within the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

We found the occupational therapy team were engaging well with patients on both wards. A weekly timetable of tailored therapeutic activities was available for patients to access and we observed patients participating throughout the inspection.

Two new social hubs had recently been created and opened on each ward. We found these to be welcoming and safe areas which provided numerous opportunities for therapeutic engagement with patients. However, we noted feedback from patients in the minutes of a previous people's council meeting that they would like the social hubs to be open for longer. We spoke with staff members during the inspection who echoed this, but said the opening hours were limited due to a lack of staff available to oversee the hubs.

The service should review the arrangements in place for the operation of the social hubs to ensure they can be kept open for as long as possible for patients to be able to use them.

Equality, diversity and human rights
The hospital had suitable policies in place to help ensure that patients' equality and diversity were respected. We saw evidence that most staff had completed mandatory Equality and Diversity training as part of their role.

The care and treatment plans we reviewed generally evidenced that the social, cultural and spiritual needs of patients had been considered upon admission. However, we found that some care plans were not being reviewed regularly which meant we could not be assured that patients were having their current cultural or spiritual needs met.

The service must ensure all care and treatment plans are reviewed in a timely manner to ensure they identify and meet the ongoing needs of patients.

The Mental Health Act documentation we reviewed during the inspection showed that patients at the hospital had been legally detained. We saw evidence that

patients had been kept informed about their rights while at the hospital and had been appropriately supported to apply to the Mental Health Review Tribunal to have their detention reviewed.

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

Citizen engagement and feedback

We found that patients could engage and provide informal feedback to staff on the provision of care at the hospital in several ways. These included daily planning meetings and weekly community meetings. We saw minutes of previous community meetings which showed that staff were keeping patients informed of what actions had been taken in response to issues that had been raised.

Patients could also complete satisfaction questionnaires to provide feedback on their experiences and help identify improvements to the service. However, we noted that the QR codes that linked to the satisfaction questionnaires did not work.

The service must ensure the information leaflets contain QR codes that work so patients can provide their feedback.

Delivery of Safe and Effective Care

Safe Care

Environment
We saw that regular risk assessments and audits were being carried out to identify any issues with the environment. However, we noted several gaps in the daily clinical manager walkaround checklists for the Lodge.

The service must ensure the daily clinical manager walkaround checklists are completed to identify any issues with the environment.

Each ward provided a comfortable environment with appropriate fixtures and fittings for the patient group. We did note exposed plaster on a wall outside the patient lounge in the Lodge which needed to be repaired.

The service should ensure any damage to the fixtures and fittings is repaired in a timely manner.

On the first night of the inspection the external lighting was not working outside the House, which made access to the ward very difficult in the dark. It was positive that the lighting was repaired the following day.

Managing risk and health and safety
Overall, we were assured that the service had suitable and effective processes in place to manage and review risks to help maintain the health and safety of patients, staff and visitors at the hospital. The ward entrances were accessible to everyone and were secured throughout the inspection to prevent unauthorised access.

Nurse call points were located within patient bedrooms so that patients could summon assistance if required. Staff wore personal alarms which they could activate in the event of an emergency. There were up-to-date ligature point risk assessments in place and several ligature cutters located throughout each ward for use in the event of a self-harm emergency. Suitable fire safety measures and precautions were being taken to protect patients and staff in the event of a fire.

Infection prevention and control (IPC) and decontamination
We found suitable IPC arrangements in place at the hospital. An up-to-date IPC policy was available that detailed the various procedures in place to keep staff and patients safe. All areas of the wards appeared to be visibly clean and tidy.

A designated IPC lead had been appointed and there appeared to be a collective approach towards implementing IPC procedures among nursing, housekeeping, and maintenance staff. Regular audits, such as hand hygiene audits, had been completed to check compliance with IPC procedures.

All staff members who completed a questionnaire agreed that there were effective infection prevention and control practice measures in place. We saw evidence that staff had completed appropriate IPC training and the staff we spoke with during the inspection showed good awareness of their responsibilities around infection prevention and control.

On the first night of the inspection, we noted that laundry detergent was being stored in the laundry room in the House. While patients are risk assessed to have entry to the laundry room, it may be more appropriate for the laundry detergent to be moved and stored securely elsewhere.

Nutrition
We saw evidence that the dietary needs of patients had been assessed on admission and that specific dietary requirements had been identified and acted upon where necessary. All patients received ongoing weight management checks during their stay where required.

There were suitable facilities available for patients to have hot and cold drinks and we saw patients accessing these throughout the inspection. Staffed kitchens are located on site to provide patients on each ward with a variety of meals throughout the day. We observed mealtimes and the food appeared appetising, and we noted that healthier options were available.

Patients were able to securely store their own snacks and food should they wish to do so. Staff told us that they regularly monitor patient food and discard any items that are out of date. However, we did not see any evidence of completed food monitoring forms, and we found some out-of-date patient food in the Lodge.

The service must ensure that staff regularly check, document and take action to remove any out-of-date patient food.

We also saw gaps in the fridge temperature recording checklist in the Activities of Daily Living (ADL) kitchen in the Lodge. For example, there were six gaps in September 2024 and five gaps in October 2024.

The service must ensure that fridge temperatures are checked and recorded daily to ensure food and drink are stored safely.

Medicines management
During the inspection staff told us that they were currently working towards improving their medicines management processes at the hospital due to issues identified in a recent NHS Wales Joint Commissioning Committee inspection. These included additional oversight from the clinical managers on each ward and refresher training to staff about their responsibilities. It was positive that during our inspection we found suitable procedures were in place for the safe management of medicines on each ward.

Relevant policies, such as medicines management and rapid tranquillisation, were in date and were available to staff. The clinic rooms were clean and tidy and well organised. Medication fridges were locked when not in use. We saw that daily temperature checks of the medication fridges and clinic rooms were being completed accurately to ensure that medication was stored at the manufacturer's advised temperature.

Appropriate arrangements were in place for the storage and safe use of controlled drugs and drugs liable to misuse. Drugs were stored securely and the records we viewed evidenced that stock was accounted for when administered and that stock checks were being undertaken. There was good support available from an external pharmacist who visited the hospital weekly to undertake audits and provide general support to the clinical staff.

We viewed a sample of Medication Administration Records (MAR charts) and found they were being maintained to a good standard on both wards. The MAR charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. We also found that relevant consent to treatment forms were being appropriately stored alongside the MAR charts to make them accessible to nursing staff.

We saw evidence that NEWS charts were being completed where required to record physical observations. A fluid intake chart was being completed for one patient and we saw that there was a requirement for the patient to drink two litres of fluids a day due to their health condition. However, when we reviewed the fluid intake chart, we noted that on some days the patient had taken on as little as 400ml a day. It did not appear that staff had escalated this to the doctors, and staff were not able to tell us whether this was an oversight, or whether the fluid intake charts were inaccurate and that the patient had taken on more fluids than recorded.

The service must ensure that fluid intake charts are maintained accurately to ensure minimum intake has been achieved, and that failures to meet the minimum intake are escalated to the doctors as appropriate.

Safeguarding children and safeguarding vulnerable adults
We found suitable measures in place to safeguard vulnerable adults. An up-to-date safeguarding policy was in place which set out the procedures for staff to follow in the event of a safeguarding concern. The staff members we spoke with during the inspection were clear on how to apply these procedures in the context of their duties. This included identifying and acting upon safeguarding matters. We reviewed training data and found that staff received regular training relevant to their roles.

There was good oversight of safeguarding matters at a management level and we saw evidence that any issues were discussed at relevant clinical governance and MDT meetings for review and monitoring.

We did note that the patient information leaflet for the House needed to be updated as it incorrectly identified the clinical manager as a safeguarding lead.

The service must ensure that the patient information leaflets at the hospital refer to the correct safeguarding leads for patients and staff to approach if they have any concerns.

Medical devices, equipment and diagnostic systems
We saw evidence of weekly checks being undertaken on resuscitation and emergency equipment held on each ward. Staff had documented when these had occurred to ensure that the equipment was present, in date and safe to use in the event of an emergency such as patient collapse.

Safe and clinically effective care
The hospital had up-to-date policies and procedures in place to help staff provide safe and effective care. Almost all staff members who completed a questionnaire felt that patient care is the organisation's top priority and that they are content with the efforts of the organisation to keep them and patients safe.

Principles of positive behaviour support (PBS) were being used to determine level of risk and encourage positive risk taking. Patients had PBS plans or ‘My safety’ plans in place which were detailed and included personalised strategies for preventing and managing challenging behaviour.

We were told that staff would observe patients more frequently if patients continued to present with increased risks. We saw that records of observations being undertaken on patients were being completed appropriately by nursing staff. An up-to-date Safe and Supportive Observations policy was in place to help staff manage observations safely.

We saw evidence that staff had completed Safety Intervention training. The number of incidents of physical restraint was minimal, which indicated that physical interventions appeared to be being used as a last resort.

A safety huddle 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.

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

Further information on our findings in relation to patient records and care plans is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Mental Health Act monitoring
We reviewed the statutory detention documents of eight patients currently residing at the hospital. The records were well organised, easy to navigate and demonstrated compliance with the Act. Clear reasons were being documented to evidence why detention under the Act was the most appropriate way of providing care for patients.

We saw evidence that capacity assessments had been undertaken on admission and at regular intervals to determine that patients were able to make decisions for themselves. Consent to treatment documentation was being appropriately completed.

We saw that information was being provided to patients following their admission about their detention and their legal rights. We found Section 17 leave was being documented appropriately. 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.

The Mental Health Act Administrator was knowledgeable and was available on-site to support staff. The administrator also undertook biannual audits of the legal documentation to monitor compliance with statutory requirements. We also saw evidence of clinical staff undertaking regular audits. However, we noted that the

Mental Capacity Act audit template stated that five patient records should be reviewed. We saw occasions where previous audits had been completed and signed off but less than five audits had been reviewed.

The service must ensure all audits are completed as specified and that an appropriate number of patient records are reviewed to ensure any issues or themes can be identified.

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

The recent NHS Wales Joint Commissioning Committee inspection identified some issues with the quality of the patient records being maintained at the hospital. We were told that work has been ongoing since that inspection to review and update the patient records. The eight care and treatment plans we reviewed showed that some improvements were still required. These included:

- We saw in the September 2024 clinical governance meeting minutes that:
    - 11 per cent of care plan outcomes had not been achieved for patients at the House in August 2024
    - 9 per cent of care plan outcomes had not been achieved for patients at the Lodge in August 2024
    - 16 per cent of care plan outcomes had not been recorded for patients at the Lodge in August 2024
- We saw some good examples of care and treatment plans where it was clear that patients had been involved in their development, with the patient voice evident. However, a large proportion of the care and treatment plans appeared to contain the same generic information and had not been individualised for each patient.

The service must continue its efforts to review and improve the quality of the care and treatment plans to ensure they meet the requirements of the Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010.

Despite the improvements required, we also saw examples of good practice within the care and treatment plans we reviewed. The care co-ordinator for each patient had been identified and recorded, and we saw that the therapeutic and social interventions identified for patients reflected evidence-based practice. There was evidence that the care and treatment plans were being discussed in the monthly MDT meetings. We saw information in relation to discharge and aftercare planning, with clear involvement from social workers and community health teams. It was recorded that patients had been provided with, or offered, a copy of their care and treatment plan.

Quality of Management and Leadership

Staff Feedback
Staff responses to the HIW questionnaires were generally positive. All but one respondent would recommend the hospital as a place to work, and all respondents agreed they would be happy with the standard of care provided by the service for themselves, friends or family. All but one respondent felt that their job was not detrimental to their health and that their organisation takes positive action on health and wellbeing.

Staff suggestions for improvement included:

> *"The exchange of information can be improved. Information is mainly shared through emails and pink notes, however not all staff access these online services and do not apply the information shared. There needs to be a better system to make sure that everyone involved in patient care can access information quickly and easily."*

While undertaking our review of patient records, we also found that it was not always easy to find key information due to some documents being available online and some information being kept in paper files.

The service should reflect on this feedback and engage with staff members to review where key information is stored and identify improvements to make it easily accessible to all staff members.

Governance and accountability framework
We found established governance arrangements in place to provide oversight of clinical and operational issues. 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. Audit activities and monitoring systems and processes were in place to ensure the hospital focussed on continuously maintaining standards. However, we have made recommendations in the report that highlight the need to ensure audits and associated checklists are completed accurately and when required to identify issues.

During our last inspection of the hospital in July 2022, we commented that there was a feeling among the inspection team that the Lodge and the House were operating independently. We had the same sense during this inspection. We were told that some staff members have recently moved between the Lodge and House to help bridge this. Key hospital meetings also included representatives from the Lodge and House to help share learning. However, it still felt that each ward was

being governed separately rather than as one organisation. For example, several recommendations we have made in this report apply to one of the wards only, rather than both, which did not provide assurance to us that good practice was being communicated and shared appropriately.

The service should reflect on this feedback and review its governance arrangements to help bring consistency across both wards in relation to good practice and compliance with relevant standards.

The majority of staff members who completed a questionnaire felt that senior managers were visible, and all staff members agreed that senior management are committed to patient care.

Dealing with concerns and managing incidents
There was an established electronic system in place for recording, reviewing and monitoring incidents. Individual incidents were being discussed with members of the MDT and senior staff at the daily safety huddles and the monthly clinical governance meetings.

All staff members who completed a questionnaire told us that they would know how to report unsafe practice, and that their organisation encourages them to report errors, near misses or incidents. All staff also said they would feel secure raising concerns about patient care or other issues at the hospital, and felt their organisation takes action to ensure that they do not happen again.

Workforce recruitment and employment practices
A recruitment, selection and appointment of staff policy was in place that set out the arrangements to ensure recruitment followed an open and fair process. Safety checks are undertaken prior to employment to help ensure staff are fit to work at the hospital. These include the provision of two satisfactory professional and character references from previous employers, evidence of professional qualifications and a Disclosure and Barring Service (DBS) check.

Newly appointed permanent staff receive a period of induction where they are required to complete an induction programme and workbook. Senior managers are responsible for reviewing the workbook to ensure newly appointed staff have demonstrated the required levels of competency to work at the hospital.

A ‘Raising concerns: freedom to speak up’ (whistleblowing) policy was in place to support staff to feel empowered and safe to raise concerns at the hospital. Staff were able to contact a ‘freedom to speak up’ guardian to raise any issues in confidence.

The majority of staff members who completed a questionnaire agreed that their immediate manager can be counted on to help with a difficult task at work and gave them clear feedback on their work.

Workforce planning, training and organisational development
Staffing levels appeared to be appropriate to maintain patient safety within the wards at the time of our inspection. It was positive to hear that the use of agency staff was low. However, one staff member from the Lodge provided the following comment in their questionnaire:

> *"I do feel that this is a very highly active ward and with all the extra support needs of patients, staffing at times can be challenging and as such we have to prioritise legal requirements e.g. observations and medical appointments over therapeutic activities that forms part of the patients care plan. I do strongly believe that we would benefit from having more staff on the floor at times to further improve quality of care patients receive."*

One staff member from the House also provided a similar comment in their questionnaire:

> *"There should be a higher number of staff on shift to allow for more service users to use their Section 17 leave, and for room cleans etc to be completed."*

It is concerning to hear from staff members that staffing levels may be impacting upon the ability of patients to participate in therapeutic activities and to take their Section 17 leave. We were also told that the staffing establishment for the Lodge at night included two registered nurses. However, the staffing establishment for the House at night only included one registered nurse. We felt this could provide additional adverse responsibility and pressure for the one registered nurse, particularly in the event of an incident.

The service should reflect on this feedback and review whether the current staffing establishments are sufficient and appropriate for the health and welfare of the patients and to fully meet their needs.

We saw evidence that staff had received an annual appraisal to discuss their performance and set annual objectives. We saw that suitable processes were in place for senior staff to monitor compliance with mandatory training. It was positive to see that overall compliance among staff with such training was high. Staff members who completed a questionnaire told us that they have had

appropriate training to undertake their role. We asked staff what other training they would find useful, and responses included:

- “Full training on specific therapeutic intervention models, such as Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT) or Compassion Focused Therapy (CFT)”
- “More drug and alcohol training”
- “Nurse prescribing Continuing Professional Development courses “
- “Healthcare leadership Continuing Professional Development courses”
- “Some training for personality disorders could be given because a lot of staff can be ignorant to the symptoms and the condition in general.”

The inspection team also felt that staff could potentially benefit from manual handling and end of life care training due to some of the health conditions and presentation of patients. The service should discuss this feedback in relation to training with staff to explore ways to meet their continuous developmental needs.

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
No immediate concerns were identified on this inspection.			

Appendix B - Immediate improvement plan

Service: Delfryn House and Lodge

Date of inspection: 07, 08 and 09 October 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.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate assurance issues were identified on this inspection.					

Appendix C - Improvement plan

Service: Delfryn House and Lodge

Date of inspection: 07, 08 and 09 October 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.	We noted that not all bedroom doors throughout the hospital had viewing panels.	The service should ensure the work to install observation panels on all bedroom doors is completed in a timely manner.	Dignity and Respect	Estates – quotes have been requested – rolling estates plan in situ. – Local Expert by experience to collate feedback from patients.	Estates/Hospital Manager/Regional Facilities Manager	3 Months
2.	Some patient information leaflets contained inaccuracies and appeared inconsistent across the wards.	The service must review the range of information available to patients to ensure it is consistent and accurate.	Patient Information and Consent	Notice boards have been updated following review by clinical managers completing a peer review of each of the services. Site in process of designing updated	Clinical managers/Administration staff	Complete

				ward information boards, coproduced with patients.		
3.	We were told that the social hubs on each ward have limited opening hours due to an insufficient number of staff available to operate them.	The service should review the arrangements in place for the operation of the social hubs to ensure they can be kept open for as long as possible for patients to be able to use them.	Care planning and provision	Open 24 hour access now in situ post 10pm by request – Local Expert by experience to collate feedback from patients.		1 month
4.	Some care plans were not being reviewed regularly which meant we could not be assured that patients were having their current needs met.	The service must ensure all care and treatment plans are reviewed in a timely manner to ensure they identify and meet the ongoing needs of patients.	Equality, diversity and human rights	A site level review of care plans is being undertaken along with a bi Monthly care plan meeting for full MDT to take responsibility and accountability. A care plan ambassador has also been appointed - Actions/outcomes will be tracked in clinical governance meeting for oversight at executive level.	Key Nurses and MDT	3 months

				All patients are able to review their personalised care and support plans formally and informally with their named nurses in their named nurse sessions and in their monthly MDT reviews.		
5.	The QR codes that linked to the patient satisfaction questionnaires did not work.	The service must ensure the information leaflets contain QR codes that work so patients can provide their feedback.	Citizen engagement and feedback	Hospital manager immediately addressed with Cygnet Group Head Carer & Service User Engagement, Operations to address. New posters have been sent and are now displayed at site.	Hospital Manager	Complete
6.	We noted several gaps in the daily clinical manager walkaround checklists for the Lodge.	The service must ensure the daily clinical manager walkaround checklists are completed to identify	Environment	This was due to annual leave and absence – to add a layer of cover the clinical manager from Delfryn house	Clinical Manager	Complete

		any issues with the environment.		and Delfryn Lodge will peer review and conduct in each other absences moving forward to ensure no missed checks – this can also be delegated to the NIC if required.		
7.	We did note exposed plaster on a wall outside the patient lounge in the Lodge which needed to be repaired.	The service should ensure any damage to the fixtures and fittings is repaired in a timely manner.	Environment	The plastering around the area was raised with Estates and they have sealed the area. The Clinical Manager (Laura Massey along with the maintenance lead Justin Burke will be jointly completing of weekly walk around the ward to quality check any areas that needs cleaning and/or repairing.	Estates Lead	Complete
8.	We found some out-of-date patient food in the Lodge.	The service must ensure that staff regularly check, document and	Nutrition	When food is brought on to the wards, ward staff with the	Senior Support team/ senior nurses/clinical manager	complete

		take action to remove any out-of-date patient food.		patient label the food with opening date & patients name. Protocol is now displayed in the services for all staff to read. Senior support workers and ward staff check items in the fridge when completing temperature checks during the shift and dispose of any items not clearly marked and documented in a file when check is undertook and who by this is also rechecked by night ward staff. Patients would be informed of items which have to be discarded.		
9.	We saw gaps in the fridge temperature recording checklist	The service must ensure that fridge temperatures are checked and recorded	Nutrition	This has been discussed with the Senior Support Workers to ensure	Senior Support team/ senior nurses/clinical manager	complete

	in the Lodge ADL kitchen.	daily to ensure food and drink are stored safely.		this is allocated to an individual to complete on each day and night shift and documented. This will also be audited by the clinical manager at Delfryn lodge in their daily walk around – this will also be checked in morning meeting and documented.		
10.	We saw instances where a patient had not achieved their minimum intake of fluid in a day and it appeared that this had not been escalated to the doctors.	The service must ensure that fluid intake charts are maintained accurately to ensure minimum intake has been achieved, and that failures to meet the minimum intake are escalated to the doctors as appropriate.	Medicines Management	Physical health policy has been recirculated to all staff. Fluid chart to be reviewed at 08.15, 14:00 and 22:00 by RGN/RMN daily to ensure minimum intake/output has been achieved – If the drink/fluid box is not ticked with intake amount or	Nursing team/Medics	Complete

				output box is not ticked within the review timeframe, this must be escalated to the nurse in charge or the medics and documented in the patients clinical notes. notes/handover documentation		
11.	The patient information leaflet for the House incorrectly identified the clinical manager as a safeguarding lead.	The service must ensure that the patient information leaflets at the hospital refer to the correct safeguarding leads for patients and staff to approach if they have any concerns.	Safeguarding children and safeguarding vulnerable adults	Notice boards have been updated following inspection – safeguarding leads	Administration team/clinical managers	Complete
12.	We saw occasions where Mental Capacity Act audits had been completed and signed off but less than the required five audits had been reviewed.	The service must ensure all audits are completed as specified and that an appropriate number of patient records are reviewed to ensure any issues or themes can be identified.	Mental Health Act monitoring	Clinical managers complete monthly audits and have been advised guidance per policy should be completed in full – oversight by Hospital Manager monthly	Clinical Manager	Complete

				going forward to ensure guidance is followed.		
13.	The eight care and treatment plans we reviewed showed that some improvements were required to improve their quality.	The service must continue its efforts to review and improve the quality of the care and treatment plans to ensure they meet the requirements of the Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	A site level review of care plans is being undertaken along with a bi Monthly care plan meeting for full MDT to take responsibility and accountability. A care plan ambassador has also been appointed - Actions/outcomes will be tracked in clinical governance meeting for oversight at executive level. All patients are able to review their personalised care and support plans formally and informally with their named nurses in their named nurse sessions and in their	Key Nurses and MDT	3 months

				monthly MDT reviews.		
14.	A staff member suggested that there needed to be a better system in place that ensured everyone involved in patient care can access information quickly and easily. We also found information difficult to find during our review of the patient records.	The service should reflect on this feedback and engage with staff members to review where key information is stored and identify improvements to make it easily accessible to all staff members.	Staff feedback	To minimise duplication and to ensure an easier/better process - a pen picture documented has been reviewed and has been implemented for easy access - this offers key information and can direct staff to where further appropriate information can be obtained in an effort to prevent the need for staff to review multiple files and documentation. Also, any information that is recorded in the handover, clinical records and incident	Psychology Dept. and MDT	1 Month

				form is streamlined and consistent.		
15.	During the inspection it felt that each ward was being governed separately rather than as one organisation.	The service should reflect on this feedback and review its governance arrangements to help bring consistency across both wards in relation to good practice and compliance with relevant standards.	Governance and accountability framework	All key meetings which include Clinical Governance, Quality Improvement, Full Staff Meeting, and Medication Management & Head of Departments are collaborative of all services (House and Lodge). There are no separate meetings. We have started discussions with operations director and SLT to discuss plans to move forward.	Hospital Manager	3 Months
16.	Staff members commented that staffing levels may be impacting upon the ability of patients to	The service should reflect on this feedback and review whether the current staffing establishments are sufficient and	Workforce planning, training and organisational development	Safe staffing levels are reviewed every morning as part of the MDT meeting to ensure that the wards have sufficient	Hospital Manager/clinical managers	2 Months

	participate in therapeutic activities and to take their Section 17 leave. We were also felt that the staffing establishment for the House at night may provide additional adverse responsibility and pressure for the one registered nurse, particularly in the event of an incident.	appropriate for the health and welfare of the patients and to fully meet their needs.		numbers as per statement of purpose. Clinical Managers/senior nurses will check the daily allocation board to ensure escorted section 17 leaves are fairly allocated. Regular group leave is allocated for each ward and patients decide where they would like to go as part of community meeting. Clear discussions held regarding provision of resources to be agreed with MDT during planning week. Each patient has an individual planned timetable of activities based on their assessed needs.		

				There are at all times 3 nurses on the site to support in the event of an incident, where possible the rota will allocate 2 nurses at Delfryn house. A twilight shift which finishes at midnight has been introduced for staff to pick up.		

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): **Jade Davies**

Job role: **Hospital Manager**

Date: **10 December 2024**