Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection (Unannounced)

Cygnet St Teilo House

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:	Provide an independent view on the quality of care
Promote improvement:	Encourage improvement through reporting and sharing of good practice

Influence policy and standards:	Use what we find to influence policy, standards and practice

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection of Cygnet St Teilo House on the evening of 28 March 2022 and following days of 29 and 30 March 2022.

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

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

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

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

2. Summary of our inspection

We found a dedicated staff team that were committed to providing a high standard of care to patients. Staff interacted with patients respectfully throughout the inspection.

Safe and therapeutic responses were in place to manage challenging behaviour and promote the safety and wellbeing of patients.

Established governance arrangements were in place and we found the service was being well managed to help provide safe care to patients.

However, staffing levels during the night shifts must be reviewed to increase support available to registered nursing staff.

This is what we found the service did well:

- The physical health and nutritional needs of patients were assessed on admission and monitored through weekly clinics
- Advocacy services were available to support patients with aspects of their care
- Patient care plans were being maintained by staff to a good standard
- Procedures were in place for the safe management of medicines
- Suitable protocols were in place to manage risk, health and safety and infection control
- The statutory documentation we saw verified that the patients were legally detained.

This is what we recommend the service could improve:

- Sufficient numbers of staff must be available to allow scheduled activities to take place

- Staff must be kept aware of the COVID-19 status of the hospital at all times
- The capture of patient information must be streamlined to remove duplication

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

3. What we found

Background of the service

St Teilo House is registered to provide an independent mental health service at Goshen Street, Rhymney, Gwent, NP22 5NF.

The hospital is a 23 bedded setting that provides a rehabilitation service to female patients only. At the time of the inspection, there were 21 patients. The service was first registered with HIW on 23 March 2007.

The service employees a staff team which includes a hospital manager, head of care, and a team of registered mental health nurses and healthcare support workers. The multi-disciplinary team includes a responsible clinician, psychologist and occupational therapists.

The hospital is overall supported by the management and organisational structures of Cygnet Behavioural Health Ltd.

Quality of patient experience

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

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

Patients could engage and provide feedback to staff on the provision of care at the hospital in a number of ways.

Patients had access to a range of suitable activities and therapies to aid their rehabilitation. However, the hospital must ensure that there is a sufficient number of staff on each shift to allow activities to take place as scheduled.

Health promotion, protection and improvement

During the inspection we saw evidence that suitable physical assessments had been undertaken on patients upon their admission. A 'well-woman clinic' has been routinely held every weekend for patients to undergo routine physical health checks and receive health monitoring interventions where necessary. We saw evidence that regular refusals by patients to participate in routine health checks were escalated by the nursing staff to the multi-disciplinary team (MDT) to consider. All patients are registered with the local GP practice to ensure patients have access to NHS screening programmes, such as breast and cervical screening.

Patients had access to a range of therapy facilities at the hospital to support and maintain their health and wellbeing, including a craft room, hair salon and occupational therapy kitchen. Gym equipment was also available for patients to exercise. The occupational therapy team helps patients participate in a range of group and individualised activities at the hospital and within the local community. However, we were informed by patients during the inspection that sometimes activities are cancelled due to staff shortages.

The hospital facilities are spread across two floors. A communal lounge was available on each floor which provided patients with a number of useful

resources, such as board games, DVDs and books. Large outdoor spaces were accessible within the hospital grounds, and we observed patients using these spaces regularly during the day times.

We were informed that plans were being finalised to make the hospital site smoke-free. The patients we spoke to during the inspection informed us they had been provided with information about smoking cessation services available to them to provide support ahead of the change coming into force.

Improvement needed

The registered provider must ensure that there is a sufficient number of staff on each shift to allow activities to take place as scheduled.

Dignity and respect

Throughout the inspection we observed staff treating patients appropriately and with dignity and respect. Staff seemed to have developed good relationships with patients and took time to understand their needs or any concerns patients raised. The staff we spoke with demonstrated a good level of understanding of the patients they were caring for.

Patient bedrooms were located on both floors of the hospital. Patients that required more support had their bedrooms on the ground floor, while patients with higher levels of independence had bedrooms on the first floor.

Every patient had their own en-suite bedroom, which provided a good standard of privacy and dignity. Patients were able to store possessions and personalise their rooms with pictures and posters. During the inspection we saw many examples of staff respecting the privacy of patients by knocking on bedroom and bathroom doors before entering. Patients could lock their rooms, but staff could override the locks if required. Each bedroom door had an observation panel, which enabled staff to undertake observations without having to open the door and potentially disturb patients that may be asleep.

Suitable rooms were available for patients to meet staff and other healthcare professionals in private. The majority of patients had use of their own mobile phone to contact friends and family, but a telephone was available in the corridor of the main building for patients to use if required. We were told that visitors are allowed inside the hospital and within the hospital grounds following the relaxation in the national COVID-19 guidelines. Visitors must provide a negative

lateral flow test (LFT) and wear Personal Protective Equipment (PPE) before being admitted.

During the inspection we found the environment on the wards to be loud and noisy. This was mainly in relation to staff carrying large bunches of keys that jangled when unlocking and locking doors, and self-closing doors to some rooms which often slammed shut with force. The registered provider may wish to consider the impact this may have on the wellbeing of patients in their environment of care.

Patient information and consent

A patient information guide was available to patients and their relatives / carers that described what they can expect from their stay at the hospital. The registered provider's statement of purpose[1] also described the aims and objectives of the service. We saw that both documents were up to date and contained all the relevant information required by the regulations. Registration certificates from HIW were on display in the entrance area of the main building.

There was a patient status at a glance board[2] in the nursing office that displayed sensitive information regarding each patient being cared for at St Teilo House. The board was covered when not in use which helped protect patient confidentiality.

We saw that relevant information for patients was on display throughout the ward. This included details about how patients could contact, and access, advocacy services and about how patients could raise a complaint. Information about the role of HIW was also available and informed patients that they could contact the organisation should they wish.

[1] A statement of purpose is a legally required document that includes a standard set of information about a provider's service.

[2] A board that provides staff with a quick reference to essential information about the individual patients being cared for at the hospital.

A timetable of weekly activities was available for patients to see by the downstairs communal lounge. We also saw that the times and attendees required for MDT meetings during the week of the inspection were on display to inform patients of when their care and treatment was being reviewed.

Communicating effectively

We observed a positive rapport on display between staff and patients. Staff communicated appropriately and effectively with patients, and patients were confident in approaching staff to engage in discussions. The patients we talked to during the inspection spoke positively about their interactions with staff during their time at the hospital.

Daily planning meetings were held every morning to discuss upcoming activities within the hospital and the community, and other relevant information, such as tribunals and medical appointments.

A handover meeting was being held every weekday morning for nursing staff to update the multi-disciplinary team (MDT) on any concerns, issues or incidents that had taken place the day before. We attended a handover meeting during the inspection and saw that staff demonstrated a good level of understanding of the patients they were caring for and that discussions focused on what was best for the individual patient.

Care planning and provision

During the inspection we reviewed the care plans of three patients. We found that care plans were person centred with each patient having their own programme of care that reflected the needs and risks of the individual patients. We saw evidence that care plans had been developed and agreed with the patient and that they were being regularly reviewed and updated by the MDT.

We saw that the contact details of relatives / carers had been identified and that they had been involved in the development of the patient's care plan where appropriate to do so.

Further information on our findings on the legal documentation is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Equality, diversity and human rights

During the inspection we looked at the patient records of three individuals that had been detained at the hospital under the Mental Health Act (the Act). We found that 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). This meant that the rights of patients admitted to the hospital had been protected and maintained.

The hospital had policies in place to help ensure that patients' equality and diversity were respected. We noted that some patients at the hospital had informed staff that their gender identity was now different from their sex assigned at birth and we observed staff referring to patients using their preferred pronouns.

During the inspection we observed a mental health advocate visiting the hospital to provide information and support to patients with any issues they may have regarding their care. We spoke with the advocate who informed us that they visit the hospital every week and said they had a positive relationship with the management team at the hospital. The patients we spoke with confirmed that they are aware of the advocate that visits the hospital.

Further information on our findings on the legal documentation is detailed in the Mental Health Act Monitoring section of this report.

Citizen engagement and feedback

We found strong evidence that patients could engage and provide informal feedback to staff on the provision of care at the hospital in a number of ways. As well as the daily morning meetings, weekly community and monthly patient council meetings were being held for patients to discuss any developments or concerns they may have. We saw minutes of such meetings which showed that staff were keeping patients informed of what actions had been taken in response to issues that had been raised.

A suggestion box had been installed on the ward to allow patients to provide any informal feedback or suggestions for improvement. A poster was displayed in the visitor room encouraging feedback from family, friends and relatives of patients. We saw evidence that annual patient and carer surveys have been undertaken to capture feedback more formally. However, we were told that these surveys have a low response rate, and the registered provided may wish to consider ways of encouraging more engagement with the annual surveys.

Delivery of safe and effective care

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

Patient care plans were being maintained to a good standard and in line with the criteria set out in the Mental Health (Wales) Measure.

There were established processes in place to suitably manage potential risks, health and safety and infection control.

Legal documentation to detain patients under the Mental Health Act was compliant with the requirements of the legislation.

The hospital must ensure that all staff are aware of the COVID-19 status of the hospital at all times.

Managing risk and health and safety

Overall, we were assured that St Teilo House had processes in place to manage and review risks to help maintain the health and safety of patients, staff and visitors at the hospital.

The hospital entrance was secured to prevent unauthorised access. The main building was split over two floors, and a lift was available to assist people with mobility difficulties. The hospital provided a clean and comfortable environment for patients. Furniture and fixings were appropriate for the patient group and in a good state of repair apart from two washing machines that had been out of order since the previous weekend. We were told that a maintenance request had been raised and that they would be repaired shortly. At the time of the inspection a programme of work was being undertaken on the first floor to replace carpets and improve the en-suite bathrooms in the patient bedrooms.

We saw that a range of up-to-date health and safety policies were available for staff. Daily environmental checklists and monthly health and safety audits were being completed and submitted to the corporate Cygnet health and safety team to monitor compliance.

There were up-to-date ligature point risk assessments in place. These were comprehensive and identified potential ligature points and detailed actions that

had been taken to manage these. There were a number of ligature cutters located throughout the hospital for use in the event of a self-harm emergency.

Staff wore personal alarms which they could use to call for assistance if required. There were also nurse call points within patient bedrooms so that patients could summon assistance if required.

We saw evidence of regular checks being undertaken of resuscitation and emergency equipment. Staff had documented when these had occurred to ensure that the equipment was present and in date.

Infection prevention and control (IPC) and decontamination

We saw evidence that relevant policies were in place that detailed the various infection control procedures at the hospital to keep staff and patients safe. Regular audits had been completed to check the cleanliness of the environment and monitor compliance with best practice hand hygiene procedures.

It was evident that housekeeping, nursing and support staff were clear about their individual responsibilities in relation to infection control measures at the hospital. The hospital was clean on our arrival. We were told that keeping the outside smoking area clean and tidy has been the biggest challenge for staff. We saw evidence of cleaning schedules that were in place to promote regular and effective cleaning of the hospital. Cleaning equipment was stored and organised appropriately.

We noted that sharps boxes located in the treatment room were not overfilled and were labelled appropriately. We saw that the cleaning of medical equipment and devices was the responsibilty of nursing staff to help reduce the risk of cross infection between each use.

We found procedures were in place to help control the risk of transmitting COVID-19 throughout the hospital. Staff had access to hand washing facilities and multiple hand gel dispensers were available for both staff and patients to use. We observed staff wearing face masks on the wards, and staff did not highlight any issues relating to access to other PPE during our discussions. Staff have been required to undertake LFTs every other day in line with company policy.

At the time of the inspection the COVID-19 status of the hospital was ‘red’ which meant that the hospital had recently declared an outbreak of COVID-19 among staff members. We saw that the status was displayed on the window of the reception area. However, on the first night of the inspection we were informed by staff that the COVID-19 status of the hospital was ‘green’. This meant that some

staff were unaware that the hospital was currently dealing with a COVID-19 outbreak. The registered provider must ensure the COVID-19 status of the hospital is communicated clearly to all staff members at all times to ensure the correct procedures are followed to help protect staff and patients from transmission.

We saw that compliance among staff for training in infection prevention and control was high at 89 per cent. However, we saw that the infection prevention and control lead had not undertaken the two day training course developed for that role.

Improvement needed

The registered provider must ensure the COVID-19 status of the hospital is communicated clearly to all staff members at all times.

The registered provider must ensure the IPC lead undertakes the two day IPC Lead training course as soon as possible.

Nutrition

We saw evidence that patients are weighed on admission to the hospital and that their weight is monitored regularly at the weekly well-woman clinics. The Malnutrition Universal Screening Tool (MUST)[3] is used to assess the dietary needs of patients. During our review of the care plans we saw that patients identified as at risk following their MUST assessment were provided with a care and treatment plan to address this risk through additional fluid and nutrition monitoring.

A staffed kitchen is located on site that provides patients with a variety of meals throughout the day. Menu choices for each week are displayed in the dining area and we noted that the menu promoted a good amount of healthy eating options.

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

There were suitable facilities available for patients to have hot and cold drinks and we saw patients accessing these throughout the inspection. Fruit and snacks were provided to patients by the hospital and patients with Section 17 leave[4] were also able to purchase food from the local community. An occupational therapy kitchen was available upstairs for those patients with access to prepare their own food with assistance from a staff member. We saw that individual food items were labelled with use by dates for refrigerated items.

Patients are able to feedback their suggestions and opinions to members of the catering team about the food at the hospital during their weekly community meetings. We saw evidence of the hospital listening to patients by taking action to implement suggestions raised by patients, such as agreeing to offer a cooked breakfast to patients once a week.

Medicines management

We reviewed the hospital's clinic arrangements and found that procedures were in place for the safe management of medicines.

The clinic room was well organised with individual patient medications and stock medications stored appropriately. Medication fridges were locked when not in use. We saw that daily temperature checks of the medication fridge and clinic room were being completed to ensure that medication was stored at the manufacturer's advised temperature.

We looked at the arrangements in place at the hospital 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.

Patients had individualised medication management plans and a range of medication information leaflets were available in the clinic for patients to access.

Relevant policies, such as medicines management and rapid tranquillisation, were in date and available to staff. We were told that a paper copy of the

[4] Section 17 leave allows the detained patient leave from hospital.

medicines management is usually kept in the clinic room for staff to have easy access. However, during the inspection we noted that a paper copy wasn't available in the clinic room. We raised this with staff who immediately printed out a copy of the policy and placed it in the clinic room.

Reviews of medication were being undertaken and discussed and documented in MDT meetings. We saw evidence that patients had been involved in these discussions which we noted as good practice.

We viewed a sample of Medication Administration Record[5] (MAR charts) and found they 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. Each patient had a dedicated medication folder, and all relevant consent to treatment certificates were stored alongside the MAR charts as required. We were told that medicines management audits are undertaken monthly to monitor ongoing compliance.

Safeguarding children and safeguarding vulnerable adults

We found processes in place to help ensure that staff at the hospital safeguarded patients. Safeguarding incidents were being referred to appropriate external agencies as and when required.

We saw evidence that safeguarding incidents were included at monthly clinical governance meetings as a standing agenda item. We saw from the minutes of previous meetings that discussions around incidents were being held to help identify any themes.

We saw that compliance among staff with safeguarding training was high at 95 per cent.

[5] A Medication Administration Record is the report that serves as a legal record of the drugs administered to a patient by a health care professional. The Medication Administration Record is a part of a patient's permanent record on their medical chart.

Safe and clinically effective care

We found safe and therapeutic responses were in place to promote the safety and wellbeing of patients.

Principles of positive behavioural support were being used as a primary method of de-escalation to manage challenging behaviour. We saw that Short Term Assessment of Risk and Treatability (START) assessments[6] were being completed by nursing staff. These were reviewed daily by the MDT and we observed discussions being held in relation to each patient on potential changes to care plans, observation levels and Section 17 leave status.

We noted that a number of patients were on enhanced observations during the inspection for their own safety. Staff were compliant in undertaking those observations in line with the hospital policy and documented accordingly.

During our tour of the hospital we saw that 'sepsis 6 pathway' information posters were on dispay in the clinical and treatment areas to help staff identify early warning signs.

We saw that any use of restraint was documented which included details such as duration of the intervention and type of restraint used. We were told that debriefs take place with staff following incidents to reflect and identify any areas for improvement. We noted that incidents of restraint are summarised and discussed by the MDT at each monthly clinical governance meeting.

Participating in quality improvement activities

We found arrangements were in place to help assess and monitor the quality of the services and care being provided to patients. Clinical governance information in relation to safety and performance was being collated by staff through a schedule of audit activities and regular risk assessments. We saw that this data formed part of the monthly clinical governance meetings to be scrutinised by

[6] START is a 20 step tool used to evaluate a patient's level of risk for aggression and likelihood of responding well to treatment.

senior managers and the MDT. The data was also required to be submitted to the corporate team at Cygnet to be monitored corporately.

Information management and communications technology

Throughout the inspection we were shown the electronic systems in place for capturing and recording data such as incidents, clinical audits, and human resources documentation. These systems allowed staff to manage information and data effectively to support patient care and assist the management and running of the hospital.

Records management

Patient records were being maintained on paper files and electronically. We observed staff storing the paper records appropriately during our inspection, for example MAR charts were being stored in the clinic which was locked when not in use. The electonic system was password protected to prevent unauthorised access and breaches in confidentiality. We used the electronic system throughout the inspection and found patient records were being completed comprehensively. However, because information was being input across several sources, including a paper 'grab file', physical health file and the electronic system, we found it difficult to navigate the system to quickly identify the relevant information. We also found evidence of duplicated records for the same patient, for example, we found two National Early Warning Score charts had been completed for the same time period for the same patient, but stored in different locations. The registered provider must ensure that information is captured in a more streamlined way to reduce the risk of inaccurate recording and provide clarity on which documents should be used when deciding on care and treatment for patients.

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.

Improvement needed

The registered provider must ensure that information is captured in a more streamlined way to help keep patient data accurate, up-to-date, complete and contemporaneous.

Mental Health Act Monitoring

We reviewed the statutory detention documents of three patients currently residing at St Teilo House. The records we looked at were compliant with the Mental Health Act and the Mental Health Act Code of Practice for Wales 2016 and verified that the patients were legally detained. The documents were being stored securely onsite in individual files.

The records we viewed were of a high standard and were well organised, easy to navigate and contained detailed and relevant information. There was evidence that consideration of the Mental Health Act was well integrated in the care and treatment planning process for patients. We saw comprehensive capacity to consent to treatment forms being completed in line with best practice guidelines.

It was positive to see improvements had been made since our last inspection in relation to the documentation around Section 17 leave arrangements. We saw that leave was being suitably risk assessed and determined the conditions and outcomes of the leave for each patient. Discussions were also being held with patients to evaluate how the leave went. Patients had signed their leave form to indicate their agreement to the terms, and the Mental Health Act Administrator recorded whether the patient had accepted a copy of the form.

Robust systems of audit were in place for the management and auditing of statutory documentation. We saw that there was also oversight of compliance being regularly undertaken by the corporate team at Cygnet. However, the registered provider may wish to consider adding the Mental Health Act as a standard item to the monthly clinical governance meetings to allow for an escalation of any issues and ensure discussions are taking place locally among the MDT team.

The Mental Health Act Administrator for the hospital was new to the role. We advised the administrator that they may wish to consider joining the All Wales Mental Health Act Administrators Forum to develop relationships with other administrators and share knowledge, issues and experiences and keep up to date with any changes in legislation.

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

We reviewed the care plans of a total of three patients. Overall, the documentation we reviewed was being maintained to a good standard.

A summary from previous placements was being kept so staff could understand the reasons for admission and the needs and risks of the patients, their strengths and aspirations for the future. Patients then received a full mental health assessment following admission to St Teilo House.

We found the care plans reflected the domains of the Welsh Measure and clearly stated the treatment plan to be followed. Interventions described in the care plans were appropriate to meet the needs of the patients and clearly stated who was responsible for delivering each intervention.

We saw that the views of the patients had been taken into account and were reflected in the care plans we reviewed. However, we did not see evidence that the patients had agreed to their care plan and recommended treatment or received a copy.

A range of appropriate risk assessments were being completed that described the mitigations in place to manage identified risks. There was evidence of regular MDT involvement in the development and ongoing review of the care plans we saw. Weekly individual reviews were being held between patients and members of the MDT which fed into discussions internally at monthly MDT meetings and externally with care-coordinators at care and treatment plan reviews.

Improvement needed

The registered provider must document whether patients have indicated their agreement with, and received a copy of, their care and treatment plan.

Quality of management and leadership

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

Established governance arrangements were in place to provide effective oversight of clinical and operational issues.

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

Staff were committed and we observed the multidisciplinary team working well together to provide individualised care.

The hospital should review its nursing cover establishment during night shifts to ensure staff are fully supported at all times.

Governance and accountability framework

It was positive that throughout the inspection staff were receptive to our views, findings and recommendations. Staff we spoke with were passionate about their roles and we saw staff working as a team during our time at the hospital.

We received positive feedback about the leadership and management displayed by the hospital director since they started in the role. Similarly, we found a very visible and accessible MDT who demonstrated during the inspection that their focus was on working together to meet the individual needs of the patients at St Teilo House.

We found established governance arrangements in place at the hospital level 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.

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 is managed corporately through the Cygnet corporate teams.

Dealing with concerns and managing incidents

There was a complaints policy and procedure in place for patients to raise concerns with the head of care. Any unresolved issues would be escalated to the hospital director.

As stated earlier in the report, appropriate procedures were in place for recording, reviewing and monitoring incidents. Regular incident reports were produced and reviewed at the hospital level at clinical governance meetings, and at a corporate level, to help identify trends and patterns of behaviour.

We also noted that compliments from patients, relatives / carers and staff were captured and discussed at clinical governance meetings to share positive feedback and recognise good practice.

Workforce planning, training and organisational development

Staffing levels were appropriate to maintain patient safety at the hospital at the time of our inspection. The hospital director confirmed that there were only a small number of nursing vacancies at the hospital and that there was an ongoing recruitment campaign to fill these positions.

During our last inspection of St Teilo House in October 2019 we found that during the night shift there was only one registered nurse working with a team of health care support workers. We recommended that the registered provider reviewed the night time staffing levels to ensure sufficient nursing cover is provided at all times. Disappointingly, we found again during this inspection that only one registered nurse was working on the night we arrived. Due its remote location, and the number of patients at the hospital, we felt the registered nurse required more support during the night shift in case an incident occurred. One registered nurse also meant that when that nurse took a break, the hospital was left with no registered nursing cover. We discussed this with the hospital manager who told us that wherever possible two registered nurses are allocated to the night shift, but that it hasn't always been possible to fulfil both roles. We recommend that the registered provider again reviews its night time staffing levels and implement changes to reduce the likelihood that only one registered nurse is working during the night shift.

We noted that there was no social worker presence on the MDT. We felt a social worker would provide added benefit and perspective to the MDT discussions

about care and treatment plans for patients as well as support patients that are working towards discharge from the hospital.

We found systems were in place to monitor compliance with mandatory training and appraisals for staff. We saw that completion rates for training were generally high. However, we noted that compliance among staff for training on START assessments was low at 47 per cent. Due to the importance of using the START assessment tool to identify risks and lead discussions with the MDT, we recommend that staff complete their outstanding training as soon as possible. 88 per cent of staff had received their annual appraisal which was positive. We were told that staff have regular clinical and management supervision sessions with senior members of staff to help them reflect and identify areas for improvement.

Improvement needed

The registered provider must review its night time staffing levels to reduce the likelihood of only one registered nurse working during a night shift.

The registered provider must consider employing a social worker to work as part of its MDT team.

The registered provider must ensure that staff complete their outstanding training on START assessments as soon as possible.

Workforce recruitment and employment practices

A recruitment, selection and appointment of staff policy was in place that set out the arrangements to be followed to ensure recruitment followed an open and fair process. Prior to employment, potential staff must provide references and evidence of professional qualifications. Disclosure and Baring Service (DBS) checks are also carried out, and then renewed every three years, to ensure staff are fit to work at the hospital.

We were told that all staff have contracts of employment and up-to-date job descriptions, which are reviewed during annual appraisals to ensure they remain accurate.

Staff were able to contact a ‘freedom to speak up guardian’ to confidentially raise any issues or concerns they may have about issues at the hospital. The guardian was an external Cygnet employee but the hospital director informed us that the guardian is invited to the hospital regularly to be visible for staff to speak to if necessary. A freedom to speak up (whistleblowing) policy was also in place

should staff wish to raise any concerns directly with the hospital director, registered provider or an alternative appropriate body if required.

We were told that a member of staff at the hospital was a nominated wellbeing champion for staff to speak to regarding any concerns they may have about their own health or wellbeing. Staff also had access to a company wide employee assistance programme which can assist staff with many aspects of work and personal life.

4. What next?

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

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

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

The improvement plans should:

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

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

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

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

5. How we inspect independent mental health services

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

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

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

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

We also consider other professional standards and guidance as applicable.

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

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

Appendix A – Summary of concerns resolved during the inspection

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

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

Appendix B – Improvement plan

Service: St Teilo House

Date of inspection: 28 – 30 March 2022

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

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The registered provider must ensure that there is a sufficient number of staff on each shift to allow activities to take place as scheduled.	3. Health promotion, protection and improvement	Registered Provider has had significant recruitment drive to ensure all vacancies are filled. There has also been meetings conducted with staff to improve management of the daily activities.	Byron Mtandabari & Roxanne Wright	Completed and Ongoing
Delivery of safe and effective care				
The registered provider must ensure the COVID-19 status of the hospital is communicated clearly to all staff members at all times.	13. Infection prevention and control (IPC) and decontamination	Registered Provider has displayed the Hospital Covid status notice on the window panel in entrance reception door.	Byron Mtandabari	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Staff and visitors see the status upon entering the hospital.		
The registered provider must ensure the IPC lead undertakes the two day IPC Lead training course as soon as possible.	13. Infection prevention and control (IPC) and decontamination	Registered Provider to enrol the IPC lead on the next available two day training course.	Byron Mtandabari	4 months
The registered provider must ensure that information is captured in a more streamlined way to help keep patient data accurate, up-to-date, complete and contemporaneous.	20. Records management	The Registered Provider is taking steps to collate patient information into a single file. This will reduce the amount of paperwork and also provide one access point for staff and external agencies alike.	Byron Mtandabari and Roxanne Wright	Ongoing- 3 months
The registered provider must document whether patients have indicated their agreement with, and received a copy of, their care and treatment plan.	20. Records management	The Registered Provider has included section on the ward round document to indicate patient's agreement and receipt of their care plan.	Byron Mtandabari and Roxanne Wright	Completed
Quality of management and leadership				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must review its night time staffing levels to reduce the likelihood of only one registered nurse working during a night shift.	25. Workforce planning, training and organisational development	The Registered Provider reviewed the night shift staffing matrix. The night shifts now have x2 registered nurses where possible. A twilight shift which finishes at midnight has been introduced.	Byron Mtandabari and Roxanne Wright	Completed and ongoing
The registered provider must consider employing a social worker to work as part of its MDT team.	25. Workforce planning, training and organisational development	Registered Provider will review this recommendation with Operations Directorate of Cygnet Health.	Byron Mtandabari	9 months
The registered provider must ensure that staff complete their outstanding training on START assessments as soon as possible.	25. Workforce planning, training and organisational development	Registered Provider has assigned staff to complete this outstanding training.	Byron Mtandabari and Roxanne Wright	Completed and ongoing

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): **Byron Mtandabari**

Job role: **Hospital Manager**

Date: **25 May 2022**