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 St Teilo House on the evening of 7 October and days of 8 and 9 October 2019. The following sites and wards were visited during this inspection:

- St Teilo House

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

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. We observed that staff interacted with patients respectfully throughout the inspection.

Staff were positive about the support and leadership they received.

We found that improvements were required in respect of some aspects of the service and in particular the administration of the Mental Health Act, ligature risk assessments needed to be reviewed, and the standard of cleanliness in some parts of the hospital required improving.

This is what we found the service did well:

- Staff interacted and engaged with patients respectfully
- Patients were provided with a good range of therapies and activities
- Good team working and motivated staff
- Established governance arrangements that provided safe and clinically effective care
- High compliance rates for mandatory staff training, supervision and appraisals.

This is what we recommend the service could improve:

- Menu planning
- Cleanliness of hospital
- Review of Ligature Risk assessments
- Mental Health Act administration
- Additional staff training and resources to support Mental Health Act administration process
- Ensure all first aid kits are complete and in date

We identified the service was not compliant with regulations 30 & 31 of the Independent Healthcare (Wales) Regulations 2011. The registered provider

must comply with their duty under the Independent Healthcare (Wales) Regulations 2011 to notify the registration authority, Healthcare Inspectorate Wales (HIW), of incidents that fall under those defined by the regulations. These incidents related to patients needing to attend hospital as a result of self-harm, the attendance of which should have been reported to HIW. The registered provider has since provided assurance that all staff involved in the incident reporting process are aware of the regulatory requirements for notification to HIW. Further details can be found in Appendix B. Whilst this has not resulted in the issue of a non-compliance notice, there is an expectation that the registered provider takes meaningful action to address these matters, as a failure to do so could result in non-compliance with regulations.

3. What we found

Background of the service

Cygnet Behavioural Care Limited is registered to provide an independent hospital service at St Teilo House, Goshen Street, Rhymney, Gwent NP22 5NF.

The service has 23 registered beds and provides female locked rehabilitation service. At the time of inspection there were 20 patients.

The service employs a staff team which includes the Hospital Manager, Head of Care and Responsible Clinician. The multidisciplinary team includes a psychologist and psychology assistant, two occupational therapists and two activity co-ordinators, a team of registered mental health nurses and health care support workers. There was an established team of housekeepers, kitchen staff and maintenance person.

The service was first registered on 23 March 2007.

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 we observed staff treating patients with dignity and respect.

Patients we spoke to told us they were happy and receiving good care at the hospital. Relatives also told us that there was good communication between the hospital and families.

There were a range of suitable activities and therapies available throughout the hospital, and within the community, to aid patients' rehabilitation.

However, some improvements were required in relation to raising awareness around smoking cessation and women's health issues.

Health promotion, protection and improvement

The hospital had a range of well-maintained facilities to support the provision of therapies and activities. The hospital had two full time occupational therapists and two activity co-ordinators. There were a range of facilities within the hospital to provide patients with activities such as the hair and beauty salon which also incorporated a nail bar, the computer room which had internet access, the occupational therapy kitchen, and other activity rooms. There was a visitor room off reception which was also suitable for child visiting. Patients also had access to a hospital gym which had a good range of cardio exercise equipment, such as a treadmill and an exercise bike.

Patients had open access to a large garden area that was well maintained and both staff and patients we spoke with told us they were proud and pleased with the therapeutic garden they'd helped to develop.

The occupational therapists created bespoke activities based on the individual patient's interests. This made sure that all patients had the opportunity to participate in activities they enjoyed and were interested in.

During our inspection we observed a number of patients participating in a variety of activities which included a smoothie making group, baking and patients were due to visit a cat café. A review of the minutes taken at the patient council meeting revealed that these activities had been requested by the

patient group, it was positive to see that the patients' requests had been met and already introduced on the therapy programme. We observed staff encouraging and motivating patients to attend activities and it was noteworthy to see staff praising and thanking patients for their input and attendance at the activities.

Patients were able to access GP, dental services and other health professionals as required. Patients' records also provided evidence of detailed and appropriate physical assessments and monitoring. Staff had access to two designated hospital vehicles which enabled staff to facilitate patients' activities and medical appointments in the community.

Smoking was not allowed within the hospital, however patients did have access to a smoking area located in the garden area. We were told that patients were able to access a smoking cessation programme via the local GP services. However, the registered provider should take a more proactive approach and provide more information and support to the patients in regard to smoking cessation and women's health issues.

Although Information on healthy eating was on display in the dining room, this poster was very small and difficult to read.

There were also no bilingual posters or information displayed in Welsh within the hospital. Given that the service operates in Wales, arrangements should be made to provide information in Welsh.

Improvement needed

The registered provider should proactively encourage and support patients to access health promotion services, including smoking cessation and women's health advice.

The registered provider must display further information on healthy eating and women's health issue within the hospital.

Dignity and respect

We noted that all employees; ward staff, senior management and administration staff, interacted and engaged with patients appropriately and treated patients with dignity and respect. We observed positive professional engagement and interaction between patients and staff with the patient at the

centre of each part of the process. It was positive to hear and observe patients being spoken about in a professional and respectful way.

The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients. We observed staff taking time to speak with patients and address any needs or concerns the patients raised, this demonstrated that staff had responsive and caring attitudes towards the patients.

The hospital was secured from unauthorised access by locked doors and an intercom system. Each patient had their own bedroom which they could access throughout the day. The bedrooms provided patients with a high standard of privacy.

The bedrooms offered adequate storage and patients were able to personalise their room with pictures and posters. Patients could also lock their bedrooms, which staff could over-ride if required. Patients told us that staff generally respected their privacy and dignity. During the course of our inspection we saw many examples of staff knocking on patients doors before entering the bedrooms.

One patient reported to us that they had difficulty negotiating the step up to the shower in the en-suite area of their bedroom. As a result staff had moved the patient to a new refurbished room. We viewed the newly refurbished room and noted a significant improvement, we strongly recommend that the provider accelerates the refurbishment to make sure all patients have access to more suitable en-suite facilities.

Facilities were available for patients to spend time with family and friends; a visitor room was available and a family visitor we spoke with, told us that the hospital would always try and facilitate any visits. They also told us that the communication between the hospital staff and families was excellent. Patients were also able to use their own mobile phones to maintain contact with family and friends, in addition to having access to a pay phone located in a private booth within the hospital.

In the nurses office there was a patient status board[1] displaying confidential information regarding each patient being cared for on the ward. The boards were designed in such a way that confidential information could be covered when the boards were not in use. This meant that the staff team were making every effort to protect patient confidentiality.

Patient information and consent

The hospital had a written statement of purpose and a patient information guide which was made available to patients and their relatives/carers. Notice boards were situated just outside the main entrance to the ward. The information displayed was current and included advocacy and visiting time information. It was positive to note that the hospital had a board in the entrance area displaying photos of staff members, these assist patients and visitors in identifying individual staff members.

On the wards, we saw advocacy posters which provided contact details about how to access the service. Registration certificates and information on Healthcare Inspectorate Wales was also on display. Information on the complaints process and how to raise a complaint was also displayed, however the address for HIW included in the leaflets was incorrect.

Improvement needed

The registered provider must display current and up to date contact details for HIW.

[1] A board that provides staff with a quick reference to essential information about the individual patients being cared for on the ward.

Communicating effectively

Through our observations of staff-patient interactions, it was evident that staff made sure they communicated appropriately and effectively with patients. Staff took time to undertake discussions using words and language suitable to each individual patient. Where patients remained unclear, or what they were trying to communicate was misunderstood, staff would patiently attempt to clarify what they had said. We frequently observed patients approaching a variety of staff from the multidisciplinary team, and it was praiseworthy to see staff take time out to speak to the patients irrespective of other commitments staff may have been dealing with at the time.

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

During our attendance at a morning management meeting, individual risk assessments were being discussed and during this meeting we did not observe any meaningful professional discussion and debate taking place amongst the staff. This was disappointing as every member of staff should contribute to this process. The hospital manager should encourage all members of the multidisciplinary team to participate and have meaningful debate and discussions, as this is such an important aspect when staff are making key decisions on patients' levels of risk and needs.

There were regular patient meetings where patients had the opportunity to provide feedback on the care that they receive at the hospital and discuss any developments or concerns.

Improvement needed

The registered provider must make sure that all staff contribute to the discussion and decision making process when debating individual risk assessments.

Care planning and provision

There was a clear focus on rehabilitation with individualised patient care that was supported by least restrictive practices, both in care planning and ward or hospital practices.

We found that there was clear evidence of multidisciplinary involvement in patient care plans which helped support the hospital in being able to deliver comprehensive care to the patients.

Care plans were well structured, comprehensive, and detailed. Progress reports were also dated and signed by the patients. We also saw that care plans were person centred with support provided in a structured way to enable patients to achieve individual goals.

Equality, diversity and human rights

Staff practices aligned to established hospital policies and systems ensured that patients' equality, diversity and rights were maintained. We saw that patients had access to the Independent Mental Health Advocacy (IMHA) service and the Independent Mental Capacity Advocacy (IMCA) service, when required.

Mental Health Act detention papers had been completed correctly to detain patients at the hospital. However, the registered provider must implement improvements to the application of the Act to fulfil its statutory duties under the Act and as set out in the Mental Health Act Code of Practice for Wales 2016. This was brought to the attention of the Mental Health Act Administrators working at the hospital and senior management. This is detailed further within the Mental Health Act Monitoring section of this report.

Citizen engagement and feedback

There were regular patient meetings and surveys to allow for patients to provide feedback on the provision of care at the hospital. It was pleasing to note that the registered provider had received positive feedback from some patients and relatives. The hospital had a system in place to obtain patient feedback and any learning identified from feedback would be shared with staff during staff meetings or through regular staff bulletins.

There was a complaints policy and procedure in place. The policy provided a structure for dealing with all patients’ complaints for services.

A sample of complaints records were looked at during the inspection to ensure completeness and compliance with the complaints policy. Complaints were predominantly managed via an electronic based method of logging and recording. The complaints process and associated actions were overseen by the hospital manager.

Delivery of safe and effective care

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

The hospital environment was generally well maintained and equipped with suitable furniture, fixtures and fittings for the patient group.

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

However, some improvements were required in relation to ligature risk assessments, cleaning arrangements, and further improvements were required in relation to the implementation of the Mental Health Act.

Managing risk and health and safety

St Teilo House had processes in place to manage risk and maintain health and safety. The hospital provided individualised patient care that was supported by managed positive risk taking, both in ward practices and care planning.

Access to the hospital building was direct from the car park level which provided appropriate access for persons with mobility difficulties. The hospital entrance was secured to prevent unauthorised access. Patient areas were on the ground floor and first floor of the hospital; there was a lift available to assist people with mobility difficulties.

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

The hospital's estate team were part of the daily staff handover meetings, this meant that any maintenance would be discussed during the meeting and estates would be in a position to deal with any issues in an efficient and effective way. Throughout the inspection, we saw the estates team responding and undertaking maintenance work to rectify environmental issues. However, a member of the inspection team found an item left on the floor following a recent repair that could have been used by a patient to harm themselves or others. This was immediately removed and reported to the hospital manager. It was confirmed that this was reported on the incident reporting system and action and learning would be taken from this incident.

We found the decking area in the patients' garden extremely slippery and hazardous. The safety notice was also very small and couldn't be read without actually standing on the decking. The registered manager needs to make sure that the decking area is made safe for patients and that appropriate signage is visible and easy to read.

We identified that there were several ligature points throughout the hospital. We reviewed the most recent ligature point risk assessments which had been completed on 10 September 2019, and there were ligature points within the hospital that were not included on the risk assessment. These must be added to the ligature point risk assessment and clear actions recorded on how these ligature points will be rectified or managed.

There was an established electronic system in place for recording, reviewing and monitoring patient safety incidents. Incidents were entered on to the system that included the names of patient(s) and staff involved, a description, location, time and length of the incident. Any use of restraint was documented, including who was involved and the body positions of each person involved in the restraint. Incident reports were automatically linked to the individual patient's electronic care notes which ensured that these were up-to-date. We found evidence that individual patients had individualised restraint reduction plans in place which identified the least restrictive options for risk management. Staff confirmed that they undertake MAPA[2] training which emphasises de-escalation and physical restraint as a last resort.

Through attendance at meetings and from discussions with the hospital manager it became apparent that there had been instances of patient self-harm that had not been submitted as a notifiable event to HIW under Regulation 31 of the Independent Health care (Wales) Regulations 2011[3]. Whilst we

[2] MAPA® is a behaviour management system that teaches skills for assessing, managing, and responding to risk behaviour. The focus is on verbal de-escalation, prevention, and early intervention. Safe physical intervention options are also taught, to be used only as a last resort.

[3] Regulations 30 and 31 of the Independent Health Care (Wales) Regulations 2011 require the registered person to notify HIW about prescribed events (they can be found at Appendix A). The events in question relate to patient safety and whilst there is a legal requirement to notify HIW of their occurrence, it is also expected that the registered person has the necessary policies and procedures in place to reduce the risks of their occurring in the first instance;

acknowledge that 'serious injury' isn't absolutely defined within the regulations, within our published guidance[4] we request to be notified of any incidents of self-harm which result in the patient attending a hospital or where such attendance has been so advised as a consequence of the patient's actions regardless of whether or not the patient attended.

Improvement needed

The registered provider must ensure that there is a comprehensive ligature risk assessment in place

The registered provider must ensure that incidents of self-harm are notified to HIW in line with our published guidance.

Infection prevention and control (IPC) and decontamination

Dedicated housekeeping staff were employed at the service. Staff had access to Personal Protection Equipment (PPE) when required. Cleaning equipment was stored and organised appropriately. However we observed that whilst areas of the hospital appeared superficially clean, we noted that there was an accumulation of dust on top of doors and curtain rails, the ground floor bathroom smelt of urine and we also noticed that some of the light diffusers in the hospital required cleaning due to an accumulation of dead flies. The patients' kitchen floor also appeared dirty and we saw used tea bags dropped onto the floor, bins were overflowing and although there were signs for recycling, we did not see any facilities for recycling in this area of the kitchen.

In addition there was poor compliance with cleaning schedules and domestic cover at the weekends was limited. The lack of domestic cover over the weekend often meant that nursing staff would have to step in to cover domestic duties. The reliance on nursing staff to step in to cover domestic duties is not a

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appropriately manage the situation if and when it occurs; and ensure the occurrence of the identified risk is appropriately managed so as to avoid future occurrences.

[4] http://www.legislation.gov.uk/wsi/2011/734/contents/made

https://hiw.org.uk/sites/default/files/2019-06/160627notifiableeventsguidanceen.pdf

suitable solution and the hospital manager needs to review staff coverage over the weekend to make sure that the hospital cleaning schedules are consistently maintained to a high standard.

On the first night of our inspection the clinical room was quite untidy, the bin was full and the inside of the clinic door was dirty. We also identified areas within the occupational therapy kitchen that required cleaning and improvements. We found a large amount of out of date crisps, snacks and biscuits located in draws and cupboards in the therapy kitchen. The freezer wasn't working in this kitchen and both of the ovens were unclean. The hospital manager must make sure that the occupation therapy kitchen is maintained to an appropriate level of cleanliness and that food items are suitably stored and within their expiry date. It was positive to note that actions were taken during the inspection to rectify these issues.

There were hospital laundry facilities available so that patients could undertake their own laundry with appropriate level of support from staff based on individual need. We noted that the tumble dryer had broken down on the day of our inspection and had been removed, the hospital manager confirmed that a new tumble dryer had been ordered.

Hand hygiene products were available throughout the hospital, however old hand dispensers were still on the walls. These need to be removed as they were no longer in use, were gathering dust and could be a possible safety hazard. We also noted that a chairs located in the visitor's room and in the upstairs corridor were both ripped. These must be replaced as they pose a risk to possible infection and present a risk to patient safety.

We saw that arrangements were in place for the safe disposal of medical sharps (needles) into appropriately coloured bins. However, safety lids were not closed on sharp boxes and not all tracking labels had been filled in. Safety lids must be closed to prevent injury and harm and the tracking label must be filled in prior to first use, and completed when the bin is full to ensure appropriate and safe tracking at the point of disposal.

Improvement needed

The registered provider must make sure that systems are in place and completed to maintain the cleanliness of the hospital and upkeep of the occupational therapy kitchen.

The registered provider must make sure that the damaged chairs are replaced.

The registered provider must make sure that the old hand dispensers are

disposed of.

The registered provider must confirm that the tumble dryer has been replaced and is available for patients to use.

The registered provider must make sure that sharps boxes are stored and that the tracking label is completed correctly.

Nutrition

We spoke with kitchen staff and looked at patient menus and found that a menu plan had been devised, however we felt that many of the choices were repetitive and patients also commented on the lack of variety and choices on the menu. During our inspection we did not observe patients having free and available access to fresh fruit. We were informed that patients can request this from the kitchen and that the hospital is unable to leave fruit in the dining room due to there being a number of patients who are deemed high risk of choking. The registered provider should consider displaying information to remind patients that fruit is available on request. Whilst patients are given advice regarding healthy eating during Well Woman Clinic it was disappointing to see that snacks available to patients in the therapy kitchen were predominantly unhealthy options. The registered provider should consider how to encourage patients to purchase healthy snack options whilst shopping.

As part of patient rehabilitation care, patients were encouraged and supported to cook their own meals. Where patients had Section 17 leave[5] authorisation they could also undertake food shopping as part of their community focused rehabilitation activities.

There were suitable facilities available to patients for hot and cold drinks and we observed patients accessing the patient kitchen facilities throughout the inspection.

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

Improvement needed

The registered provider must make sure that menus provide a suitable varied range of options to meet the preferences of the patient group at the hospital.

Medicines management

Whilst medication was stored securely at the hospital, improvements are required in the management of medicines. Medication was stored securely with cupboards and medication fridges being locked and secure. There was evidence that there were regular temperature checks of the medication fridge to ensure that medication was stored at the manufacturer's advised temperature.

There was regular pharmacy input and audits undertaken that assisted the management, prescribing and administration of medication at the hospital.

During our inspection we made a request for the medication fridge to be opened, we witnessed the nurse in charge struggling for some time to identify the correct key from a very large bunch of keys they were carrying. This demonstrated that if medication such as lorazepam was required urgently in an emergency situation, staff would have difficulty in quickly identifying the key. Therefore it is important that the hospital manager reviews this process and finds a solution where staff are not carrying large bunches of keys, so staff will be in a position to quickly identify keys in an emergency situation.

There were appropriate arrangements for the storage and use of Controlled Drugs and Drugs Liable to Misuse, however there were gaps in staff signatures identified on the Medication Administration Record (MAR). There were many instances of the charts having a letter in the area where there should be a signature the main one being that of the prescribing doctor was not signing the charts and just using an initial.

We also noted that MAR charts had been written up days prior to being started. In one case a prescription for an intramuscular injection showed the incorrect start date written as the date of the prescription rather than the original start date of the medication. The prescription was written five days prior to the date that the next required intramuscular injection was due, because of the incorrect start date for the medication there was a risk that a registered nurse would be unaware that this was a continuation of intramuscular injection and administer the medication early, which could have a detrimental effect on the patient.

There were numerous examples in the controlled drugs record book where initials had been used instead of a full signature when medication had been administered. In addition not all the daily checks had been signed for. Staff we spoke to told us that often on night shifts there is only one qualified nurse on duty, when asked about the process on nights for signing for controlled drugs some staff were unclear, whilst others told us that a support worker had been trained to act as a witness, but they would not be present every night.

Improvement needed

The registered provider must review the large bunch of keys carried by staff to make it easier for staff to identify keys in an emergency situation.

The registered provider must make sure that all completed MAR charts contain signatures.

The registered provider must ensure the correct start date is recorded for all prescribed medication.

The registered provider must ensure that Controlled Drugs and Drugs Liable to Misuse are at all times accurately signed for by staff that are qualified and trained to do so.

Safeguarding children and safeguarding vulnerable adults

There were established processes in place to ensure that the hospital safeguarded vulnerable adults and children, with referrals to external agencies as and when required. Training records we examined showed 100% compliance with safeguarding training.

During our inspection a safeguarding issue was raised in the middle of a multidisciplinary meeting. Following discussions with the hospital manager and clinical lead it became apparent that the safeguarding issue had not been addressed as promptly as expected, when considering the nature of the incident reported. As a result of our discussions the matter was immediately reported to the local authority and prior to leaving the inspection we were satisfied that all the relevant safeguarding protocols had been implemented. It was reassuring to note that the hospital manager and clinical lead took ownership of the incident following our discussions. A more in depth review of the current ongoing safeguarding issues revealed no concerns and highlighted

that the hospital was complying with their duties and responsibilities in respect of raising and reporting safeguarding issues.

Improvement needed

The registered provider must make sure that all safeguarding incidents are dealt with in a prompt and effective manner.

Medical devices, equipment and diagnostic systems

Weekly audits of resuscitation equipment were taking place and staff documented when these had occurred to ensure that the equipment was present and in date. However, we found that cleaning schedules were poorly completed, staff we spoke with were unclear as to whose responsibility it was to clean medical devices and equipment and therefore we were not assured that devices and equipment were being cleaned regularly which could pose a risk to patients' safety. The registered manager must make sure that staff know who is responsible for the cleaning of medical equipment and devices and that the equipment is regularly cleaned.

We also found that some items within the first aid kits in the therapy kitchen were missing. Checks had been undertaken, but the missing equipment had not been replaced. This was brought to the attention of the hospital manager who took immediate steps to replace the kits whilst we were still carrying out the inspection.

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

Improvement needed

The registered provider must make sure that staff know who is responsible for the cleaning of medical equipment and devices and ensure that the equipment is regularly cleaned.

The registered provider must make sure that the first aid kits are stocked appropriately and checks are undertaken to make sure all items are in date.

Safe and clinically effective care

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

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

During the course of our inspection it became apparent that the hospital uses a system of graded one to one observations where a patient is under constant observations for 45 minutes of a 60 minute period, and then not for the remaining 15 minutes. We reviewed the hospitals engagement and observation policy to determine the rationale for supporting this practice. We found no reference or guidance for staff in the hospital's policy to support this practice, and the rationale for using it is unclear. This practice must stop until the hospital manager undertakes a thorough review to determine if this is a suitable and safe observation method to use with patients. Where a patient requires one to one observations this must remain continuous.

Improvement needed

The registered provider must ensure that one to one observations remain continuous to maintain the safety of the patient.

Participating in quality improvement activities

Links with local colleges, leisure centres, and community initiatives ensured that patients had access to courses and activities, enabling patients to participate in meaningful activities during their time at the hospital and when they are also on leave.

The hospital had a folder in the visiting room which contained monthly news events on activities the patients and hospital staff had participated in, this was up to date and included a recent McMillan coffee morning.

Information management and communications technology

The computerised patient record systems were well developed and provided high quality information on individual patient care. The system was comprehensive, accessible and patient orientated.

Weekly hospital Key Performance Indicators (KPIs) were collated for senior management. The KPIs included data such as patient occupancy levels, patient care statistics, incident reporting, staffing establishment, staff absenteeism, staff training and supervision. The phased introduction of the electronic MyHub system supported the hospital' existing systems and helped to further strengthen the administration and records management systems at the hospital.

Records management

Patient records were electronic and password protected to prevent unauthorised access and breaches in confidentiality.

We reviewed a sample of patient records across the hospital. It was evident that staff from across the multidisciplinary teams were writing detailed and regular entries which provided a live document on the patient and their care.

We saw that staff were completing care documentation and risk assessments in full. Overall the nursing documentation viewed was very good and physical assessments were well completed. The quality of the care and treatment plans were also very good.

Mental Health Act Monitoring

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

The statutory documentation reviewed verified that the patients were legally detained, and the patient statutory folder were easy to navigate, with dividers for different areas clearly shown. However through reviewing the patients' records we identified the following areas that require compliance and improvements:

- Patients are not receiving a leaflet providing information on what the Act says about treatment for their mental disorder in accordance with chapter 4.23 of the Code of Practice for Wales.
- The hospital must ensure that there is medical scrutiny of statutory documents when patients are transferred into the hospital in accordance with chapters 35.12-13 of the Code of Practice for Wales.
- No evidence was recorded within the statutory folder that a risk assessment had taken place prior to the granting of leave in accordance with chapter 27.7 of the Code of Practice for Wales.

Improvement needed

The following areas of improvement are required :-

- The registered provider must make sure patients are receiving a leaflet providing information on what the Act says about treatment for their mental disorder in accordance with the Code of Practice for Wales.
- The Registered provider must make sure that section 17 leave forms have been risk assessed
- The registered provider must make sure that detention papers are medically scrutinised before admission.

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

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

The Care and Treatment Plans reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed. Care plans were developed with members of the multidisciplinary teams and the patient care records we viewed were organised, well completed and comprehensive. The records contained numerous assessments of the patient's functioning and well-being, and these were reviewed regularly. There was evidence demonstrating that the care and treatment plans were evaluated and that review dates had been set, all of which was recorded within the patient's plans.

Individual Care and Treatment Plans drew on the patient's strength and focused on recovery, rehabilitation and independence. Risk assessments were well structured and effectively reviewed. However, in one patient file we saw evidence that the MUST assessment tool[6] rated a patient as red risk and

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The MUST is a simple 5 step screening tool which helps to identify adults who are underweight and at risk of malnutrition. Although the term malnutrition can refer to both under and over nutrition.

recommended a plan, however the content of this plan along with a weight chart and graph was not included in physical health documentation and was held in separate file. This meant that there was no comprehensive physical health record available to easily review.

Improvement needed

The registered provider must ensure that all physical health documentation is held in care and treatment plan folders.

Quality of management and leadership

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

We saw good management and leadership from the multidisciplinary team at St Teilo House. There was a committed staff team who appeared to have a very good understanding of the needs of the patients at the hospital.

Recruitment was undertaken in an open and fair process with employment checks on recruitment and throughout employment.

The completion rates of training, managerial supervision and annual appraisals was very good.

Governance and accountability framework

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

There was dedicated and passionate leadership displayed by the hospital manager who was supported by committed multidisciplinary teams. We found that staff were committed to providing patient care to high standards.

Weekly hospital Key Performance Indicators (KPIs) were reported to senior management of the registered provider.

Staff spoke positively about the leadership and support provided by the heads of care and hospital manager. Staff also commented that team-working in the hospital was very good and they told us that they were happy in work and looked after by the management team. It was positive that, throughout the inspection, the staff at the hospital were receptive to our views, findings and recommendations.

Dealing with concerns and managing incidents

As detailed earlier in the report, there was a complaints policy and procedure in place at the hospital. The policy provides a structure for dealing with all patients' complaints for services within the hospital.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the system that included the name of patient(s) and staff involved, a description, location, time and length of the incident. This provided staff with appropriate data to identify trends and patterns of behaviour.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and reviewed at hospital and organisation level so that the occurrence of incidents could be reviewed and analysed. We reviewed a sample of records relating to concerns and incidences and found that these had been dealt with in line with the hospital's policies.

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. It was also pleasing to see that all occupational therapists from the wider Cygnet group would meet up at regional level and discuss lessons learnt and share ideas and resources in order to improve and enhance the patient experience.

Workforce planning, training and organisational development

We reviewed the mandatory training and clinical supervision statistics for staff at the hospital and found that completion rates were high. There was a programme of training so that staff would receive timely updates. The electronic records provided the senior managers with details of the course completion rates and individual staff compliance details.

Some staff were trained in some 'train the trainer' which enabled the trainers to provide onsite training to staff. Staff told us they could access additional and relevant training with line manager approval which was recorded on the training spreadsheets that we saw. It was positive to see that external training opportunities were given to staff which enabled staff to gain additional qualifications.

All staff had regular professional development meetings with senior management and we saw evidence of meaningful and relevant professional development discussions and plans which were documented in individual staff records.

Staff told us that the hospital management team were approachable and visible and during interviews with staff they told us they had confidence to speak with management if they needed to raise issues or concerns. In addition, regular staff meetings were taking place which provided staff with opportunities to have discussions and share information amongst the teams. There was a supervision structure in place and staff confirmed that they had regular supervision sessions. Staff also spoke positively about group supervision and reflective practice sessions.

Staff spoken with stated that the staffing levels were sufficient given the level of dependency at the time of the inspection. At the time of our visit, there were only a small number of vacancies and staff sickness rates were low. The hospital manager described the hospital's future workforce planning arrangements to fill these positions and at the time of the inspection the hospital manager was actively looking to fulfil the current nurse vacancy. However, we identified that during the night shift only one registered nurse would be working with a team of health care support workers; Sufficient nursing staff must be in place at all times including covering for staff breaks; the current arrangement would mean that the nurse working the night shift either does not take a break or the ward is left without nursing cover when breaks are taken. Not taking a break may lead to fatigue and could potentially affect their well-being and/or compromise their professional judgements and leaving the ward without nursing cover is wholly inappropriate for this type of hospital. The registered manager must review the night time staffing levels and ensure sufficient nursing cover is provided at all times.

On the first night of our inspection we noted a lack of staff presence within the upstairs area where the majority of the patients were located. There was no nurse's station located upstairs and we had concerns as to where staff actually base themselves when in this area of the hospital. We recommend that the hospital manager reviews the provisions and identifies a suitable location for staff to base themselves when upstairs. In addition the hospital manager must make sure that this area is sufficiently resourced to make sure that patients' safety is maintained.

Discussions with the mental health act administrators highlighted the need for additional Mental Health Act training to ensure that the staff have up to date knowledge and skills. We also highlighted the need for additional resources to be freed up in order that the staff concerned are able to dedicate sufficient time to the role.

Through looking at patient records, specifically when considering the administration process around the mental health act, we would strongly

recommend that the register provider ensures that further training is provided to staff on this subject.

Improvement needed

Measures must be set in place to ensure that the staff with formal responsibility for the administration of the Mental Health Act within the hospital have received appropriate training and have sufficient resources and time to carry out their duties.

The registered provider must make sure that there are sufficient staff in the upstairs area during the day and night.

The registered manager must review the night time staffing levels and ensure sufficient nursing cover is provided at all times.

Workforce recruitment and employment practices

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

Therefore we were assured that recruitment was undertaken in an open and fair process.

Newly appointed staff undertook a period of induction under the supervision of heads of care.

The hospital had a clear policy in place for staff to raise any concerns, this was displayed in the staff room area, and during our discussions with staff they confirmed they felt comfortable with raising any concerns that that they would be listened to. Occupational health support was available to all staff and staff spoke highly of the welfare support provided by the management team.

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
We found that instances of patient self-harm had not been submitted as a notifiable event to HIW under Regulation 31 of the Independent Health care (Wales) Regulations 2011.	The impact of this on the patients is that the registered provider is not compliant with the requirements of their registration that are in place to provide HIW with information on whether the service is providing safe and effective care for its patients. These findings mean that HIW cannot be assured that reportable incidents are being investigated fully and lessons learned to ensure any failings are not repeated which could	The hospital manager and Clinical director was made aware of our findings and further discussions and inspection of documents took place regarding notifiable events.	The hospital manager provide assurance that all staff involved in the incident reporting process are now aware of the regulatory requirements for notification to Healthcare Inspectorate Wales.

We found that some of the first aid kits in the therapy kitchen were missing and had not been replaced.	lead to harm coming to patients in the future. This meant that there was a risk of infection or harm to patients.	This was brought to the attention of the hospital manager.	Arrangements were made for the missing items to be replaced.

Appendix B – Improvement plan

Service: Cygnet

Ward/unit(s): St Teilo

Date of inspection: 7 - 9 October 2019

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

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The registered provider must display further information on healthy eating and women's health issue within the hospital. The registered provider must consider a proactive smoking cessation programme within the hospital.	3. Health promotion, protection and improvement	The registered provider has displayed further information on healthy eating and women's health issue within the hospital. Well Woman Clinic. Each patient attends Well Woman Clinic monthly during which smoking cessation advice is given and discussed. Patients are supported to access the smoking cessation group at the GP surgery.	Lynne Ngaaseke and Nursing Team	Completed Complete and ongoing

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must display current and up to date contact details for HIW.	9. Patient information and consent	The registered provider can confirm that current and up to date contact details for HIW are on display.	Lynne Ngaaseke	Completed
The registered provider must make sure that all staff contribute to the discussion and decision making when debating individual risk assessments.	18. Communicating effectively	Discussion with the MDT to explore ways to improve discussion and decision making in relation to individuals risk management has taken place.	Lynne Ngaaseke and Byron Mtandabari	Completed
Delivery of safe and effective care				
The registered manager needs to make sure that the decking area is made safe for patients and that appropriate signage is visible and easy to read.	22. Managing risk and health and safety	The signage for the decking area has been enlarged and displayed. The registered manager will discuss with Regional Estates department to explore alternative flooring.	Lynne Ngaaseke	Completed 3 months.
The registered provider must ensure that there is a comprehensive ligature risk assessment in place	22. Managing risk and health and safety	The registered provider together with the Quality Manager has reviewed and updated the existing Ligature Risk Assessment to include highlighted	Lynne Ngaaseke	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that incidents of self-harm are notified to HIW in line with our published guidance.	22. Managing risk and health and safety	areas. The registered provider will ensure that all incidents of self-harm are notified to HIW.	Lynne Ngaaseke	Completed and ongoing
The registered provider must undertake a thorough review of the graded observation method used at the hospital and review and update the current engagement and observation policy.	22. Managing risk and health and safety	The organisation is currently reviewing the observation and engagement policy. There will be training for all staff for the new policy. All patients' level of observations are documented in their Risk Management and Care Plan.	Lynne Ngaaseke and Cygnet Health Care	3 months
The registered provider must make sure that systems are in place and completed to maintain the cleanliness and upkeep of the occupational therapy kitchen.	13. Infection prevention and Regulation 16 Infection and control (IPC) and decontaminati on	The registered provider has updated the current system to include a daily check of the oven for cleanliness. This will be completed by the therapy team.	Lynne Ngaaseke	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must make sure that the damaged chairs are replaced.	13. Infection prevention and Regulation 16 Infection and control (IPC) and decontamination	The registered manager can confirm the damaged chairs have been removed.	Lynne Ngaaseke	Completed
The registered provider must confirm that the tumble dryer has been replaced and is available for patients to use.	Infection and control (IPC) and decontamination	The registered manager can confirm that the tumble dryer was replaced on the 10th October 2019.	Lynne Ngaaseke	Completed
The registered provider must make sure that the old hand dispensers are disposed of	13. Infection prevention and Regulation 16 Infection and control (IPC) and decontamination	The registered manager can confirm that the old hand dispensers have been removed.	Lynne Ngaaseke	Completed
The registered provider must make sure that Sharp boxes are stored and completed correctly.	13. Infection prevention and Regulation 16 Infection and control (IPC)	The registered provider will ensure that sharp boxes are stored and completed correctly. This has been added to the Clinic and Treatment room daily and	Lynne Ngaaseke and Byron Mtandabari	Complete and ongoing

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	and decontaminati on	weekly check. The Head of Care will review the checks weekly.		
Menus should be reviewed in order to ensure that a variety of meals are made available to the patients.	14. Nutrition	Menus have been reviewed and are in place.	Lynne Ngaaseke	Complete
The registered provider must make sure that Controlled Drugs and Drugs Liable to Misuse are appropriately signed for	15. Medicines management	The registered provider will ensure that Controlled Drugs and Drugs liable to misuse are appropriately signed for. In addition to Nurses Support Workers will complete training in competency assessment to ensure that they are able to check controlled drugs for administration. Controlled Drugs Officer carries out a weekly check. SPEEDS visiting pharmacist has been asked to complete a weekly check during their visit.	Lynne Ngaaseke and Nursing team	1 month Ongoing
The registered provider must review the large bunch of keys carried by staff to make it easier for staff to identify keys in an emergency	15. Medicines management	The register provider has reviewed the large bunch of keys carried by nurses.	Lynne Ngaaseke	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
situation				
The registered provider must make sure that all completed MAR charts contain signatures.	15. Medicines management	The registered provider will ensure that all completed MAR charts contain signatures.	Lynne Ngaaseke and Nursing team	Complete and ongoing
The registered provider must ensure the correct start date is recorded for all prescribed medication.	15. Medicines management	The registered provider will ensure the correct start date is recorded for all prescribed medication.	Lynne Ngaaseke and Dr Koumaris	Complete and ongoing
The registered provider must make sure that staff know who is responsible for the cleaning of medical equipment and devices and ensure that the equipment is regularly cleaned.	16. Medical devices, equipment and diagnostic systems	The registered provider will ensure that staff know who is responsible for the cleaning of medical equipment. This has been added to the Clinic and Treatment room daily and weekly check. The Head of Care will review the checks weekly.	Lynne Ngaaseke, Nursing team and Byron Mtandabari	Complete and ongoing
The registered provider must make sure that the first aid kits are stocked appropriately and	16. Medical devices, equipment and diagnostic	The registered provider will ensure that first aid kits are appropriately stocked and checked. The Head of Care will	Lynne Ngaaseke and Byron Mtandabari	Complete and ongoing

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
checks are undertaken to make sure all items are in date.	systems	complete further weekly check.		
The registered provider must ensure that one to one observations remain continuous to maintain the safety of the patient.	Safe and effective care	The registered provider will review one to one observations. Nurse in Charge at the end of each shift checks and signs off the observation charts. The Head of Care will complete further weekly check.	Lynne Ngaaseke, Nursing team and Byron Mtandabari	Complete and ongoing
The registered provider must make sure that detention papers are medically scrutinised before admission	Mental Health Act	The registered manager will ensure that detention papers are medically scrutinised. Revised scrutiny document and check list now in place.	Lynne Ngaaseke	Complete
The registered provider must make sure patients are receiving a leaflet providing information on what the Act says about treatment for their mental disorder	Mental Health Act	The registered provider will ensure that patients receive a leaflet providing information on what the Act says about their treatment for their mental disorder. Welsh Government leaflets are now given out when rights are read.	Lynne Ngaaseke, Nursing team	Complete and ongoing
The registered provider must make sure that	Mental Health Act	The registered provider will ensure that section 17 leave forms are being risk	Lynne Ngaaseke	Complete

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
section 17 leave forms have been risk assessed.		assessed. Section 17 leave document has been amended to include confirmation that the leave has been risk assessed.		and ongoing
The registered provider must ensure that physical health documentation must be held in care and treatment plan folder	20. Records management	The registered provider will review the physical health documentation and where it is held.	Lynne Ngaaseke	1 month
Quality of management and leadership				
Measures must be set in place to ensure that the staff with formal responsibility for the administration of the Mental Health Act within the hospital have received appropriate training and have sufficient resources and time to carry out their duties.	25. Workforce planning, training and organisational development	Staff responsible will attend peer group sessions within the Welsh trusts and the Welsh MHA forums twice a year. The mental health act administrator has attended Mental Health Act and the Law which was provided by Peter Edwards on the 7th September 2019. Any additional training will be discussed in supervision.	Lynne Ngaaseke and Mental Health Act Administrator	Complete
The registered manager must review the night time staffing levels and ensure sufficient nursing cover is provided at all times.	25. Workforce planning, training and organisational	St Teilo has an ongoing recruitment drive for Registered Nurses. In the interim the hospital has looked at more flexibility of the qualified Nurses to	Lynne Ngaaseke and Cygnet Health care	Complete

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	development.	enable 12 midday to midnight cover until fully recruited.	Recruitment team	
The registered provider must make sure that the upstairs area is sufficiently resourced during the day and night.	25. Workforce planning, training and organisational development	Following supper at 9pm a member of staff has now been allocated to the upstairs from 10pm. The Head of Care reviews the allocation sheets on daily basis. The registered manager will discuss with Regional Estates department to explore CCTV in communal areas.	Lynne Ngaaseke and Byron Mtandabari Lynne Ngaaseke	Complete 3 months

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): LYNNE NGAASEKE

Job role: Hospital Manager

Date:25/11/2019