Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Cygnet St Teilo Hospital, Rhymney

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at St Teilo House Hospital, Rhymney on 18, 19 and 20 August 2025.

The only ward at the hospital was reviewed during this inspection. There were 23 beds providing high support inpatient rehabilitation (level two) for women between 18 and 65.

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

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

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Although the number of responses in the patient questionnaires was limited, most rated the care as “good” or “very good,” with patients feeling involved in their treatment planning. Comments praised the environment and staff, though some raised concerns about communication and safety.

The hospital demonstrated a strong commitment to health promotion, offering resources on healthy living, smoking cessation and exercise. Facilities such as a gym, relaxation rooms and outdoor spaces supported physical and mental wellbeing. Advocacy services were actively promoted, though information on external support groups was limited.

Respect and dignity were consistently upheld. Staff interactions were kind and respectful. Privacy was maintained through en-suite rooms, lockable doors and secure handling of confidential information. Gender diversity among staff improved patient engagement and behaviour management.

Clear and accessible communication was a priority, with materials available in Welsh and other languages. Staff adapted communication styles to individual needs and digital safety was managed through care planning. Patients were supported in understanding treatments and making informed decisions.

Care planning was personalised and activity-focused, with strong community links and vocational opportunities. Multidisciplinary team (MDT) meetings showed collaborative decision-making, with patients actively involved. Positive Behaviour Support (PBS) plans were integrated into care and family involvement was evident.

Equality, diversity and inclusion (EDI) were embedded in practice, with training and supervision supporting staff awareness. EDI was also embedded in practice, with respectful care for transgender patients.

Citizen engagement was facilitated through surveys, meetings, suggestion boxes and digital tools. However, low survey participation and inconsistent complaint feedback were noted as areas for improvement. The surveys were not frequent and there was a need for timely responses to complaints to enhance patient experience and ensure their voices were heard.

This was what we recommend the service can improve:

- Hold more regular patient surveys
- Ensure responses to complaints are timely and consistent.

This was what the service did well:

- Displaying health promotion initiatives
- Uphold patient privacy and dignity
- Personalised care planning for patients
- Embedded EDI.

Delivery of Safe and Effective Care

Overall summary:
The environment was clean, well-maintained and designed to promote safety and dignity. Facilities included therapy gardens, a salon and communal areas. Risk management was robust, with regular assessments, incident reporting and reflective practice. Ligature risks, fire safety and infection control were actively monitored and staff were trained in safety protocols.

Nutrition and hydration were well-managed, with varied menus and patient choice. Improvements were recommended in food storage and waste segregation. Medicines were securely stored and administered, supported by regular audits and pharmacist oversight.

Safeguarding policies were clear and accessible, with staff confident in procedures. Patients understood safeguarding through accessible materials and advocacy support. Children visiting were protected through designated areas.

Restrictive practices were minimised and proportionate, with restraint used only when necessary. Observations were well-managed and staff upheld privacy and dignity. The hospital did not use seclusion.

Quality improvement was ongoing, with audits, staff training and patient engagement. The hospital received the Triangle of Care award and involved patients in community projects. Information management complied with General Data Protection Regulations (GDPR) and records were securely maintained.

Overall, the hospital demonstrated a safe, effective and patient-centred approach, with recommendations for improving outdoor access, complaint feedback and food safety practices.

This was what we recommend the service can improve:

- Consider the access to the second garden and the height of the walls in this area

- Replace the chairs in the nurse's station and the board room to reduce the IPC risk presented by these chairs
- Open food and beverage items are clearly labelled with dates when opened.

This was what the service did well:

- Clean well-maintained environment
- Well managed nutrition and hydration
- Person centred care planning
- Quality improvement was ongoing, with audits, staff training and patient engagement.

Quality of Management and Leadership

Overall summary:
The inspection highlighted strong governance, leadership and staff satisfaction at the hospital. Staff feedback, though limited in number, was overwhelmingly positive. Respondents praised the supportive team environment, good work-life balance and commitment to patient care. Most staff felt there were sufficient resources to perform their roles effectively and patient dignity was consistently maintained.

Governance structures were well-established, with regular local and regional meetings addressing patient safety, training and clinical effectiveness. The hospital complied with HIW regulations and unannounced visits by the Responsible Individual occurred biannually. Incidents and complaints were logged via Datix, with lessons learned shared through bulletins, handovers and reflective sessions. Staff described senior management as approachable and responsive.

Complaints were managed well, with clear policies outlining timelines for resolution. Patients and carers could raise concerns through various channels, including anonymous suggestion boxes. In the past year, five complaints and 50 compliments were recorded. Themes from complaints were reviewed regularly and staff were supported during investigations.

Workforce recruitment followed structured policies, with pre-employment checks and professional registrations managed centrally. Staff supervision and appraisals were consistently conducted, though some departmental meetings had lapsed and were recommended to resume monthly. Emergency preparedness was supported by a business continuity plan and relevant training.

Staff expressed high job satisfaction, citing strong leadership, teamwork and opportunities for development. Training compliance exceeded 80%, with most areas above 90%. Staffing levels were maintained, with adjustments made for

unplanned absences. Staff were encouraged to pursue additional training, including autism awareness.

Overall, the hospital demonstrated a proactive and supportive approach to workforce management, underpinned by clear governance, effective communication and a culture of continuous improvement.

This was what we recommend the service can improve:

- Hold regular monthly staff meetings.

This was what the service did well:

- Strong governance, leadership and staff satisfaction
- Regular staff supervision and appraisals
- Staff expressed high job satisfaction.

3. What we found

Quality of Patient Experience

Patient feedback
We received questionnaire feedback from five patients and one member of the family or carers of the patients, responses were generally positive, but due to the low number of replies, we were unable to draw any definitive conclusions. However, all rated the care and service provided by this hospital as 'good' or 'very good' and that they were aware and involved in the care and treatment planning.

Patient comments included:

> ***"Its not really about the setting its about my family, i miss them a lot. As for the setting I am really pleased."***

> ***"I feel new staff and bank staff should be properly introduced to patients as soon as they start working. It is the best place i have been."***

> ***"I think communication could be better when something is being said at the morning meeting you don't get told and its usually not on the notice board and this has led to miscommunication."***

> ***"I feel happy and safe and i believe the setting is doing all they can to support me."***

> ***"I don't really feel safe. I have been affected by another patient before and another patient's made me feel unsafe. I have raised a complaint to the management and its being well handled."***

A patients' family or their carer commented:

> ***"Would like to see more than one visitors room."***

Health promotion, protection and improvement
There was a strong commitment to health promotion, protection and improvement. Patients had access to a wide range of information and resources that supported healthy living, including materials on healthy eating, smoking cessation, exercise and immunisation. However there was limited information for support services which patients could self-refer to such as alcohol or drug abuse groups.

The registered manager must ensure that more information on support services is available to patients.

The environment was clean, well-maintained and conducive to wellbeing, with several patients expressing satisfaction with the setting. Facilities include a gym, relaxation rooms and a hairdressing room, all of which contributed positively to patients' physical and mental health. Additionally, patients could engage in various activities such as reading, watching TV or DVDs, playing games, using the internet and enjoying outdoor spaces. This promoted independence and supported patients in maintaining and improving their health and wellbeing.

Advocacy details were given in leaflets in the visitor's room and on the notice boards in patient areas. Advocacy was actively promoted, with regular visits and an in-house advocate available.

Dignity and respect
Observations and patient feedback confirmed that staff interactions were consistently kind and respectful, and patients felt valued and supported. The physical environment was designed to uphold privacy, autonomy and comfort.

During the inspection, staff were consistently observed engaging respectfully with patients, addressing concerns and supporting personal care needs in a dignified manner. Staff facilitated access to outdoor spaces and social activities and were present during communal engagements such as watching films, demonstrating attentiveness and compassion.

All patient rooms were en-suite and patients were encouraged to personalise their rooms and maintain their belongings, supported by risk assessments which evidenced privacy and individuality. Staff were observed knocking before entering rooms and patients had keys to lock their doors, although staff could override locks when necessary for safety. Observation windows on bedroom doors were equipped with blinds.

Confidential information was securely managed. Patient status boards were electronic and kept out of sight, with sensitive data stored in locked areas. The ward was a single-gender female ward, with en-suite facilities and a communal bath that was clean and well-used.

Gender diversity among staff had improved, with male staff employed recently, positively impacting patient behaviour and de-escalation. Staff demonstrated strong knowledge of individual patients, using this understanding to provide tailored support and manage challenging behaviours effectively.

Patient information and consent
Clear, accessible and well-structured information was provided to patients, enabling them to make informed decisions about their care. We noted a consent to treatment policy which aimed to ensure that consent was obtained and managed in accordance with legal and professional requirements.

Patients received an Interest Assessment and a weekly activity plan, offering a varied and engaging schedule. Written information was prominently displayed and easily accessible throughout, including details about advocacy services, visiting times, the Mental Health Act and how to raise concerns or complaints.

Information about the role of Healthcare Inspectorate Wales (HIW) and contact details was displayed, alongside a leaflet titled *"Review Service for Mental Health and its Work – Information for Patients."* A picture board at the entrance and activity area helped patients and visitors identify staff. A list of legal representatives for detained patients was also provided.

Communicating effectively
The hospital provided clear, accessible and respectful communication tailored to patient needs, with a generally positive approach to communication and information provision. This ensured patients were supported in making informed decisions about their care. There were posters displayed throughout the hospital advising patients and visitors to contact the manager for Welsh translations.

The service ensured inclusivity by offering information in both Welsh and English, with translation services available as needed. A recent example involved translating materials for a Polish-speaking patient, indicating the system was used when needed.

Staff communicated with patients using appropriate language, avoiding jargon and adapting their pace to suit individual needs. There were dedicated spaces for private discussions.

Whilst there were currently no Welsh-speaking patients or staff, the clinical manager was learning Welsh. Staff communicated with patients using kind, respectful and jargon-free language, tailored to individual comprehension levels. Observations confirmed that staff were engaged and professional in their interactions.

Most patients had personal devices with computers also available in the activities room. Private rooms were available and accessible for confidential conversations with family, advocates, or professionals. Staff and activity coordinators assisted

patients with device use when necessary and any concerns were addressed through care planning and MDT involvement. Digital device safety was managed through monitoring and care planning, ensuring appropriate use.

We also noted an example where a patient asked the nurse concerned about a new medication and the side effects. There was a clear and positive explanation given about the medication and why the medication was necessary, by the nurse, in an easy-to-understand way, demonstrating a positive manner and interaction with the patient.

Care planning and provision
Activity co-ordinators were highly motivated and creative in the wide programme of activities provided. Each patient had an Interests Assessment completed on admission and had an individual activity programme developed, which was reviewed regularly and flexible in its implementation.

The activities co-ordinators had developed positive relationships within local communities and regularly accessed community activities with local sports, leisure centres and community hubs, for example swimming, archery and kayaking. There were also indoor activities such as the use of the salon and sensory lounge, known as the community social hub.

Activities were discussed during daily sessions with patients, whilst patients did not always engage with the process, the activities went ahead and efforts were made for more patient participation in activities.

The occupational therapist (OT) also described the positive work with patients and activities including unsupervised access to the kitchen. The OT spoke about the work relating to individual skill development, activities of daily living (ADL), road safety and community type activities such as travelling and transitional work to pathways of care such as step down or into the community. There was also vocational work and courses, to support patients whilst at the setting and to use their time to work towards long terms goals. There was also music therapy and animal therapy. Patients were supported with job applications and could receive therapeutic earnings as part of a vocational pathway.

We attended the ward round for two patients, the MDT attending the meeting included the specialist doctor, nursing, OT, psychology and a manager from a potential future placement facility for one patient. Additionally, online at the meeting were the commissioners of care, community nursing and care co-ordinators. There was evidence of team cohesion with staff and a close working relationship with the community teams.

The ward round showed evidence of team working, professional respect and listening. The patient was at the centre of the process and able to contribute on an equal basis to the staff attending, their views and needs were discussed. It was positive to note the attendance and contribution from the community staff and commissioners. The proforma used for recording the treatment reviews was detailed and well ordered. Capacity was reviewed at each ward round by the responsible clinician (RC).

Patients were well looked after and cared for at the hospital. However, it was acknowledged that when there were staff shortages resources would be stretched but safe care was always provided.

Personal behavioural support (PBS) plans were developed by psychology and integrated into care planning. These plans contained individualised care and risk assessments, reflected proactive and reactive strategies to manage individual behaviours of concern. Patients had access to self-soothing environments and therapeutic interventions were embedded in care delivery. Family involvement was evident in care planning, with regular communication and consented sharing of information.

Equality, diversity and human rights
There was a strong commitment to promoting equality, diversity and inclusion (EDI) across the hospital culture and operational practices. The organisation had robust policies in place to protect both staff and patients from discrimination.

Annual EDI training was mandatory for all staff, with additional sessions provided when legislative changes occurred. We were told that EDI was embedded into quarterly supervision, where staff were expected to provide examples of how they had addressed EDI-related issues in practice. This reflective approach ensured ongoing awareness and accountability.

Transgender patients were appropriately placed, with care plans reflecting cultural, spiritual and social needs. A recent example of inclusive practice involved a patient who identified as male and requested to be referred to as “he”. We were told that staff communicated this change respectfully to other patients and reinforced expectations around respectful behaviour. The response from patients was positive and supportive.

Patients had access to private communication facilities, including personal phones and Wi-Fi, as well as the use of a phone in the administrative office. Dedicated visiting rooms were available, including spaces suitable for children. Information about patient rights and how to raise concerns were clearly displayed throughout.

Citizen engagement and feedback
A wide range of engagement methods, including surveys, meetings, suggestion boxes, digital tools and advocacy support were available. These approaches were well-integrated into the daily operations and were visible and accessible to all.

There was an inclusive approach to citizen engagement and feedback, using a variety of methods to ensure patients, families and carers could share their views and experiences. The annual patient and carer surveys ending January 2025 only had three patients involved. Increasing the frequency of these surveys could enhance responsiveness and provide more timely insights.

Weekly community meetings took place, which were minuted and covered topics such as meals, activities and service changes. Patients confirmed their involvement in these discussions and staff reported that feedback was also gathered during morning meetings. There were also regular meetings of the People Council where information was shared amongst patient and staff.

A patient representative attended governance meetings, ensuring that the patient voice was heard.

Information about how to provide feedback was clearly displayed throughout the setting, including on notice boards and in visitor areas. The complaints procedure was accessible and user-friendly. There were easy-read leaflets explaining the complaints process and how to give compliments or raise concerns. Quick response (QR) codes were available for anonymous feedback and the website provided email contact options for patients, families and carers.

Patients were encouraged to speak with carers, raise issues in meetings, or use digital methods to submit feedback. Staff confirmed that feedback was addressed during meetings and management provided evidence of written responses to patient concerns. However, some patients noted that feedback following complaints was not consistently communicated.

The registered manager must ensure that

- **There are more regular family and patient surveys to provide more timely insights**

- **Responses to complaints are timely and consistent.**

Delivery of Safe and Effective Care

Safe Care

Environment
The hospital appeared well organised on arrival at the start of the inspection with staff independent and knowledgeable undertaking their roles. There was a secure external door into an airlock reception area with swipe card and key access to various rooms.

The patients appeared calm and relaxed moving around the ward and accessing individual patient bedrooms and communal areas. The ward appeared in a good state of decoration and repair. The ward was clean and tidy and free from clutter. toilets were suitable, clean and tidy.

The environment appeared safe and accessible for patients, with several positive features that supported comfort and dignity. The environment was designed to be as ligature-free as possible. A lift was available and operational, allowing patients to access first-floor bedrooms and the community social hub. There was level access throughout the building, with a ramp to the garden, which enhanced mobility for patients with physical needs. Whilst staff noted that the setting may not be fully suitable for individuals with significant physical disabilities, this was considered during pre-assessment.

Restricted items were stored in a managed area on the ward where items were signed in and out, dependant on individual patient risk assessment. We were advised that patients could access the laundry room based on individualised risk assessment, whilst others had to be accompanied, this also applied to the OT kitchen and therapy rooms fostering life skills and autonomy.

Additional facilities included a therapy garden, where patients could grow vegetables with support from the occupational therapy team and an in-house salon, which was well-used by patients, with staff assisting patients in hair care. These features promoted independence, self-care and therapeutic engagement.

Patients had access to outdoor spaces, although access to one garden area was restricted due to a low wall and associated absconding risks. Patients could only use this space following a risk assessment and with staff supervision or when section 17 leave had been authorised, which limited their independence. Patients we spoke with said that if the walls were higher, they felt they would be able to

access the garden more and spend more time out there. It is recommended that the hospital reviewed this area to improve access whilst maintaining safety.

The registered manager must consider the view of the patients regarding access to the second garden and the height of the walls in this area and inform the patients of any actions they would take to address this.

The setting included quiet rooms and a multicultural room, offering patients private spaces for reflection or conversations with staff, family or legal representatives. These rooms supported emotional wellbeing and privacy. Call bells were installed in patient bedrooms and staff were observed responding promptly to alarms, demonstrating a strong safety culture. Staff were equipped with personal alarms and keys, which were signed out from reception.

Environmental safety was further supported by up-to-date risk assessments, including fire, ligature and violence and aggression assessments. Weekly environmental checks were conducted by the hospital manager and maintenance team, with issues escalated and addressed as needed.

Managing risk and health and safety
The service had a comprehensive approach to managing health, safety and wellbeing, with clear processes in place to assess, monitor and respond to risks, particularly those related to ligatures, incidents and fire safety. There was a risk management and escalation policy and guidance in place that described Cygnet's approach to risk management. In addition, there was a Health and Safety Policy to promote compliance with legal requirements and to promote a proactive safety culture within the organisation.

Ligature risks were assessed every six months by the hospital manager, with immediate reviews following any incidents. Patients were assessed daily for individual risks. Ligature cutters were stored in accessible locations and all staff were aware of their location. When used this would be documented and checks undertaken to see if they needed to be replaced.

Incidents were initially managed by staff, recorded in clinical notes and on Datix and reviewed during daily MDT meetings. These meetings included risk assessments and planning, with escalation to HIW as required. Senior staff, including the clinical lead and hospital manager, oversaw incident reports, which were reviewed daily, with psychology reviewing reports to identify patterns or trends. These were discussed in governance meetings and used to inform care improvements. A "START form" system was also in place for behaviours that did not meet the threshold for a Datix report but still required attention. Staff were trained to

escalate concerns appropriately and feedback was provided on the quality of incident submissions.

Lessons learned were shared during governance meetings and reflective practice sessions. A4 posters and bulletins were used to communicate learning as well as newsletters and emails from the wider organisation helped disseminate information across the service.

A robust audit system supported quality and safety monitoring. Monthly clinical audits, weekly pharmacy visits and nightly stock checks were standard. Controlled drugs were checked every morning, defibrillators nightly and emergency bags weekly. Patient records and observational audits were also reviewed monthly. Daily handovers from Monday to Friday included discussions on environmental and clinical issues, ensuring continuous monitoring and communication.

Fire safety was managed through a clear policy framework. There was a fire panel, designated fire marshal and wardens, as well as weekly fire alarm tests. Fire safety was included in staff induction and signage, escape routes and equipment were maintained. A fire pack was available in reception and a map of fire zones was displayed. A fire risk assessment was also carried out in November 2024, with up-to-date actions evidenced on the maintenance system used.

Staff reported no significant concerns about the ward environment, though managing patient conflicts could be time-consuming. Recent changes in patient placements had improved stability of patients at the hospital.

We were told that psychology took the lead on risk assessments and formulation at the site in addition to individual and group therapies. Psychiatric formulation, a systematic framework used to create a summary of a patient's story that reflected a social and clinical history, clinical judgement and the patients experience. This collaborative approach resulted in a comprehensive understanding and a tailored treatment plan between clinicians and the patients, particularly those with complex needs and/or that have not responded to traditional treatment. PBS plans were embedded in practice and in addition to the paper record they were available on the hospital IT system 'MyPath' and reviewed in ward rounds. Psychology also supported the reflective practice sessions on request and provided monthly training sessions for staff in the hospital. Session were topical and informed through the needs identified by staff.

Infection prevention and control (IPC) and decontamination

The hospital demonstrated a strong commitment to maintaining high standards of IPC through its environment, policies, staff practices and governance structures. The physical environment was clean, tidy and well-maintained. Observations

during the inspection confirmed shared areas, patient rooms and bathrooms were visibly clean, with cleaning activities ongoing throughout the day.

Housekeeping staff followed structured cleaning schedules, which were monitored daily by the head of housekeeping and supported by night staff. Although most areas were in a good condition, minor issues such as mould and uneven flooring in one empty bathroom were noted. We were told that the rooms were given a deep clean and refurbish before the next patient and these issues would then be addressed.

We saw staff cleaning regularly during the inspection. Cleaning schedules and audits were in place and improvements had been made since the previous inspection. Lessons from audits and inspections were used to inform improvements. However, some areas required attention such as the chairs in the nursing station and boardroom were found to be damaged, which could pose infection prevention and control (IPC) concerns and in need of replacement. We were told these were on order.

The registered manager must ensure that the chairs in the nurses' station and the board room are replaced to reduce the IPC risk presented by these chairs.

Patient rooms were expected to be maintained by the individuals, with staff support available. The hospital was equipped to support barrier nursing and isolation when required as there were individual en-suite rooms available.

Sharps disposal was managed safely, with designated bins in clinical areas. Personal protective equipment (PPE) was readily available in treatment rooms and cleaning cupboards, staff confirmed they used PPE appropriately. Staff had received training on donning and doffing PPE. There was also an in-date PPE policy to explain how the Cygnet group met the requirements of the PPE at Work (Amendment) Regulations 2022.

Hand hygiene was actively promoted, with hand washing stations located throughout the ward and appropriate signage displayed. Monthly hand hygiene audits were conducted by senior nurses or healthcare support workers (HCSWs) and patients were encouraged to wash hands before and after meals. Visitors were accommodated safely, with designated areas such as the visitors' room and sheltered garden used to minimise IPC risks.

There was a named IPC lead who had attended a two-day IPC course and the IPC policy was in date. Staff were aware of the policy, their responsibilities and all had completed IPC training as part of the mandatory programme, which was updated

annually. Staff knew how to escalate IPC concerns both in and out of hours and appropriate equipment was available to support cleaning and hygiene practices.

Nutrition
The patients' hydration and nutritional needs, ensured quality, choice and safety. Overall, the hospital provided a supportive environment for nutrition and hydration. Whilst the quality of food and patient satisfaction was generally good, improvements were needed in menu review frequency, food storage practices and patient education around waste disposal.

There was generally a positive approach to meeting patients' nutritional and hydration needs, with systems in place to support personal choice, dietary requirements and healthy eating. Patients' needs were assessed, recorded and addressed appropriately. Staff confirmed that patients were provided with suitable meals and hydration options and patients themselves spoke positively about the consideration given to their dietary preferences.

Patients had access to the food menu displayed in the dining area. However, there was inconsistency in how often the menu was reviewed, whilst some staff stated it changed every three weeks, others noted the last review was in April 2025, with the next due in October. We saw evidence that patients would comment on food and make suggestions for the menu at weekly community meetings. Despite this, the menu offered variety and included healthy options such as fruits and balanced meals.

Patients were able to choose what, when and where they ate. They had access to a patient kitchen and a separate coffee and snack room, both of which were unrestricted. This promoted independence and personal choice. However, food storage practices in the patient kitchen could be improved. General use opened items were not labelled or dated, indicating poor monitoring. Management acknowledged this issue and committed to improving food labelling and storage protocols.

At mealtimes, food appeared appetising and well-presented. A dedicated dining area was available and patients were supported to make individual food choices. It was noted that food and general waste were disposed of in the same bin by patients. Although kitchen staff confirmed separate waste disposal systems existed, it was recommended that patients be educated on proper waste segregation to support independent living skills.

Hydration was well-managed, with regular access to drinks throughout the day. Patients could prepare their own hot and cold beverages and staff ensured drinks were available at set times.

The registered manager must ensure that:

- **The patient menu options are changed on a more frequent basis**

- **Patients are educated on proper waste segregation of food waste and general waste**

- **Open food and beverage items are clearly labelled with dates when opened, using the form of education for the patients suggested by OT, without being too restrictive.**

Medicines management
The management, administration and prescribing of medicines, supported safe and effective patient care. There were systems in place to ensure the safe and effective management, administration and prescribing of medicines. These processes were supported by clear policies, regular audits and active patient involvement, contributing to a high standard of care.

Medicines, including controlled drugs (CDs), were stored securely in locked cupboards and trolleys, with keys held safely. The clinic room was well-organised and clearly signposted. Fridges used for medication storage were locked and temperature-monitored daily. Emergency drugs were stored in line with national and local guidelines, checked regularly and accessible only to qualified staff. A system was in place to monitor stock levels and reorder medication, with a pharmacist visiting weekly to support checks and ordering.

CDs were checked twice daily by staff, whilst the administration followed legal guidance, a discrepancy was noted in the recording of one CD. The hospital team was informed and the issue was investigated and resolved by the pharmacist and CD accountable officer (CDAO) representative. We spoke with the pharmacist who showed us the audit process, which was positive, showing what was done, if an issue was noted.

Emergency equipment, including resuscitation kits and oxygen cylinders, was maintained and checked regularly. Staff had received oxygen cylinder training as part of the hospital's mandatory programme and governance arrangements ensured awareness of associated risks.

Patients were actively involved in decisions about their medication. During ward rounds, patients were given opportunities to discuss their prescriptions with the specialist doctor. Staff supported patients in understanding their medicines,

including side effects and easy-read materials were available. Monthly reviews were standard, with additional reviews accommodated as needed.

Medication administration was recorded accurately using medicines administration records (MAR) charts, with legal status and patient identity clearly documented. Reasons for non-administration were noted. Some patients self-medicated under structured care plans and individualised plans were in place for medications requiring close monitoring.

Medicines management was overseen by nursing staff and audited weekly by the pharmacy used, with monthly high-level audits. Errors were reported through incident forms and investigated, with learning shared through supervision and reflective practice. Policies for medicines management, controlled drugs and rapid tranquilisation were in place, accessible electronically and up to date.

Antipsychotics and sedatives were prescribed by the Responsible Clinician (RC) and discussed with the MDT and patients. High-dose antipsychotic use was monitored using appropriate forms and policies were in place for safe prescribing. Pain management was supported by assessment tools and care plans and as required (PRN) medication was managed through clear protocols. Regular medications for chronic conditions were monitored with appropriate documentation.

Safeguarding children and safeguarding vulnerable adults
Clear and accessible safeguarding policies and procedures promoted a culture of safety and accountability for both patients and staff. Staff were well-informed about their safeguarding responsibilities, with procedures available on the intranet and displayed on posters throughout patient and visitor areas. These posters outlined categories of abuse and provided contact details for the service lead and local protection of vulnerable adult teams.

Safeguarding was discussed during morning risk review meetings, weekly reflective practice sessions, discussed in monthly clinical governance meetings and in three-monthly staff supervisions. Referrals were typically completed by senior staff, ensuring consistency in threshold decisions and liaison with the local authority. Staff were also aware of the whistleblowing process, which was covered during induction and displayed in staff areas. Learning from safeguarding investigations was shared via emails, MDT discussions and supervision.

Patients were supported to understand safeguarding through a charter displayed on notice boards, which explained safeguarding in accessible language with examples relevant to their environment. Advocacy services were available weekly, with additional support provided on request. Patients generally said they felt safe on the ward and knew who to speak to if they had concerns.

Safeguarding concerns were managed through the MDT, with each patient having a dedicated folder for safeguarding referrals. Referrals were tracked via an internal spreadsheet and incidents were reported to HIW when required. Risk between patients was managed through enhanced observations, room placements and safeguarding referrals. The observations were made in accordance with the Safe and Supportive Observations Policy.

Children visiting the service were safeguarded through pre-arranged visits in designated areas.

Safeguarding concerns and HIW notifications were recorded on Datix, with specific forms known as 'START' forms used for lower-level behaviours to track patterns. Staff were trained and confident in safeguarding procedures, with posters and clear referral pathways. Records were stored securely and issues were reviewed daily in risk meetings to ensure timely action.

Safe and clinically effective care

There was a strong commitment to delivering safe and effective care through well-established staffing practices, clinical governance and patient-centred approaches. Overall, the hospital maintained a safe, effective and person-centred care environment, underpinned by strong teamwork, responsive staffing and a culture of continuous improvement.

Staff reported having sufficient time to carry out their duties, including one-to-one meetings, care plan updates and risk assessments, without compromising patient care. While staffing was described as 'tight' during periods of increased observation, additional support was sourced from bank, agency, or other group staff to maintain safe levels.

The staff mix had improved with the recent addition of male nurses and HCSWs, enhancing gender balance and positively impacting patient engagement and de-escalation. Staff felt supported and respected within their teams, describing a collaborative and communicative culture. We were told that weekly reflective practice contributed to professional development and team cohesion.

Clinical policies and guidelines were accessible via the intranet and updates were communicated through emails, newsletters and handovers. Safety and advice bulletins were also shared through these channels. Clinical audits were conducted regularly, with findings discussed in supervision and reflective sessions to inform practice improvements. Record-keeping audits and observational audits further supported quality assurance.

Patients were actively supported in developing self-care and re-enablement skills. They had access to aids such as communication tools and mobility supports and were encouraged to participate in daily tasks. Personal choice was respected in care delivery and patients were involved in decisions about their routines and preferences.

The hospital worked with external agencies, including third-sector organisations and social services, to support care planning and discharge arrangements. This integrated approach ensured continuity of care and promoted rehabilitation.

Participating in quality improvement activities
There was a proactive approach to quality improvement through regular audit activity and staff engagement. Audits included patient records, environmental checks, observation records and medicines management, with findings discussed in clinical governance meetings to drive improvements. The MDT used clinical audits as a tool for learning and development, with lessons shared via supervision, reflective practice and internal communications.

Improvement initiatives focussed on promoting outdoor access, healthy lifestyles and reducing restrictive practices. Patients were actively involved in these efforts through weekly meetings and therapeutic activities such as music therapy, animal visits and community projects.

Adverse incidents, complaints and near misses were used as learning opportunities, with outcomes disseminated through emails and daily risk meetings. Staff were encouraged to reflect and adapt practice accordingly. There was a culture of continuous improvement, collaboration and patient involvement to enhance care quality.

We noted that the hospital was awarded the carers Triangle of Care award for excellence in carers setting. The registered manager stated that they had focussed on improving the environment for patients and staff. Patients had been involved in a tree planting project in the Caerphilly area. Future plans were for a carers open day where carers would be invited to the hospital and events such as a barbecue and social events being held.

We were also shown a self-isolation pack for patients, designed by OT, with ideas for them to fill their time if isolating due to an illness, learning new skills and self-care, yoga and virtual tours.

Information management and communications technology
There were safe and secure data management practices aligned with GDPR and the Data Protection Act 2018. All computers were password-protected with individual

logins. The service user privacy notice gave information on why the group collected information, why it was used and how it was used.

Sensitive paperwork was scanned into patient records and securely shredded. Information sharing with external partners was via password-protected emails and only essential data was sent.

Patient profiles were securely maintained and moved with the patient when they moved within the Cygnet group.

Records management
There was evidence that the hospital stored and maintained records in a safe and secure way. Patient records were stored on a mixture of paper and electronic records and staff records electronically. All records were accessible to all relevant staff including the administrative manager for staff records.

There were up to date records management and data quality policies which included retention periods of patients records and staff records. The policy complied with the relevant regulations.

Mental Health Act monitoring
All 19 patients at the hospital were detained under varying sections of the Mental Health Act (MHA). We reviewed the statutory documentation of three patients (two on section three and one on section 37) and all the documentation was fully compliant with the MHA and MHA Code of Practice.

Paper records were well organised, each section indexed and easy to navigate and stored securely. Robust systems of audit, medical scrutiny and monitoring were in place. Audit outcomes were shared with managers and relevant clinical staff, actioned and recorded appropriately.

The MHA Law Practitioner (Administrator) provided an efficient service that effectively supported the implementation of the MHA and MHA Code of Practice. It was also positive to note that the MHA Law practitioner was a member of the All-Wales MHA Administrators Forum, where problems and solutions, good practice and legal precedence can be shared across the NHS and the Independent sector in Wales. The MHA Law Practitioner fed in issues relevant to the MHA at the daily meetings with managers and clinical staff. Actions for improvement were agreed and reviewed and this was recorded in the daily communications book. The practitioner felt well supported in their role and feedback from staff at all levels clearly indicated that the practitioner was very helpful and supportive.

There was a forum for all practitioners within the wider hospital group where MHA information, good practice and legal precedence was shared.

It was positive to note that the practitioner had regular management supervision and appraisal and was supported with any training and development needs identified.

Information for patients relevant to the MHA was of a noteworthy quality and easy to understand. The relationships between patients and the MHA department was observed to be very accessible, supportive and helpful.

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

We checked five sets of patient records which were of a good standard inclusive of patient and representative views. Minutes of ward rounds and Care and Treatment Planning (CTP) reviews were comprehensive.

Records were maintained across both paper and electronic systems, including 'MyPath', shared drives, physical health files and paper-based patient records. Whilst records were securely stored in locked and restricted areas, the use of multiple formats and storage locations made navigation and information retrieval challenging. Staff could access the necessary information with support, but triangulating data across sources required effort. 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. This was also reported in the 2022 report where we were told that the hospital was 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.

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

Despite these logistical challenges, the quality of the records was high. They were regularly reviewed and updated, incorporating input from patients, their representatives and both internal and external professionals. 'MyPath' served as a central record for MDT entries, whilst psychology maintained a separate confidential record.

Care plans were detailed, person-centred and proportionate to individual needs and risks and included interventions across the MDT. PBS plans were comprehensive, offering preventative strategies for managing challenging

behaviours. Risk assessments were evidence-based and reviewed daily to promote independence.

Physical health was robustly monitored, with patients accessing both primary and secondary care services. Ward round records were particularly good, reflecting collaborative, patient-focused treatment planning. Overall, the service demonstrated a comprehensive and effective approach to care planning, despite the complexity of record systems.

Care planning and review processes were patient centred and patient views were central to the whole process. Also, there was positive engagement with families, efforts to maintain family relationships were evident.

It was positive to note that risks were reviewed daily and the level of restrictions were reduced at the earliest opportunity. Risks reviewed collectively with the MDT also involved patients and their representatives' views.

Challenging behaviour and restrictive practices
We saw a comprehensive and person-centred approach to the prevention, planning and use of restrictive practices. Measures were in place to reduce the need for restrictions. This included access to therapeutic gardens, structured activity programmes led by occupational therapy and opportunities for community engagement through section 17 leave, which was reviewed daily by the MDT.

Restrictive practices were used only when necessary and proportionate to individual risk. Blanket restrictions, such as controlled egress and smoking access, were audited and reviewed through clinical governance. Individual restrictions were managed through daily MDT risk review meetings. Staff were trained to respond to physical interventions if required, although restraint was not a planned intervention. Restraint incidents were documented in Datix, with 11 incidents recorded over three months. These typically involved safe holds rather than floor or seated restraint and were aligned with patient needs, considering age, health, trauma history and cultural factors.

Post-restraint monitoring included physical health checks and emotional support. Debriefs were conducted with patients and staff. More complex incidents were reviewed by clinical leads and psychology. Families were informed of incidents where consent was provided and all incidents were analysed for trends and learning through governance processes.

Observation practices were well-managed, with patients on 1:1 or intermittent observation supported by appropriate staffing levels. Observations were recorded on paper and staff were trained via induction and shadowing with observation

policies in place and reviewed regularly. Staff used discretion to uphold privacy and dignity, particularly in gender-sensitive situations.

The service did not use seclusion and there were no facilities for this. Locked doors were used to manage access based on risk, with all patients detained under the Mental Health Act. However, there was a seclusion and long term segregation policy which applied to all Cygnet Group settings with seclusion facilities.

Governance and oversight of restrictive practices were robust. Policies had been updated in line with the Reducing Restrictive Practices Framework (July 2021). Staff were aware of where to access policies and receive mandatory training.

Staff-patient relationships were observed to be respectful and supportive, contributing to a therapeutic environment. Staff demonstrated knowledge of individual patient needs and engaged in monthly reflective practice and psychology-led training. Safety intervention training compliance was above 80% and all incidents of violence and aggression were investigated and discussed in clinical governance forums.

Quality of Management and Leadership

Staff Feedback

HIW issued a questionnaire to obtain staff views on the care at the ward for the inspection. In total, we received five responses from staff at this setting. Due to the low number of replies, we were unable to draw any definitive conclusions. However, all said that their current working pattern and off duty allowed for a good work-life balance and patients' privacy and dignity was maintained. Whereas four out of five said that there were enough staff for them to do their job properly.

Staff comments included:

> ***"Fantastic supportive team during difficult times."***
>
> ***"Staff genuinely care about the patients in our care.***
> ***Care is at the centre of everything we do.***
> ***It is lovely to see patients make recovery."***
>
> ***"At St Teilo we have a great team that cares deeply for all our patients, we have a dedicated home manager and with my RFM I am well supported to do my job and always feel appreciated."***
>
> ***"Done well is patient care and great teamwork. Staff are passionate and empathetic."***

Governance and accountability framework

There was strong governance and leadership evident at the hospital, with systems in place to monitor performance, respond to risks and promote continuous improvement in line with regulatory standards.

The service complied with HIW registration conditions, with regular updates to its statement of purpose and patient guide, which were shared with HIW when revised. Unannounced visits by the responsible individual (RI) occurred every six months in line with regulation 28 of the Independent Health Care (Wales) Regulations 2011.

Governance structures were well-established, with monthly local governance meetings and quarterly regional governance forums. These meetings followed a set agenda covering patient safety, staff training, clinical effectiveness and lessons

learned. Patient representatives were invited to attend, although recent engagement had been inconsistent.

Quality assurance was supported by a structured audit schedule, with thematic reviews and inspections aligned to HIW standards. Clinical governance meetings reviewed audit outcomes to drive improvements. August's governance minutes showed 22 minor incidents, with themes including self-harm and aggression.

Risks, incidents and complaints were reported via Datix and escalated appropriately. Lessons learned were shared through emails, handovers, reflective practice and monthly bulletins displayed in staff areas. Safety information was distributed to clinical managers and business managers via email. Policies and procedures were reviewed centrally and changes communicated to staff through emails, bulletins and posters.

A corporate and local structure outlined reporting lines and responsibilities, ensuring accountability across the service.

It was positive to note the staff interaction with the inspection team including willingness to address any improvements as necessary. Staff were confident and clear in their roles, supported by management. Staff described senior management as approachable and could reach out if there were any problems and were confident that they would deal with any concerns raised. One member of staff commented:

> ***"Honestly working here was lovely"***

Dealing with concerns and managing incidents
Clear and structured processes were in place for managing complaints, concerns and incidents, ensuring transparency, accountability and continuous improvement. Patients, families and carers could raise complaints through various channels, including leaflets available in the visitor areas, direct emails to the manager and an anonymous suggestion box. The complaints policy was up to date and outlined a staged process, acknowledgement within three days, investigation within 20 days and formal resolution. Informal complaints were resolved through direct contact,

All complaints, formal and informal, were logged on the complaints system, detailing dates, categories and resolutions. There had been five complaints in the previous year. Compliments were also tracked, with 50 received via email, highlighting positive feedback from patients and families.

Themes and trends from complaints were reviewed regularly, lessons learned were shared through monthly bulletins, posters in staff areas and daily morning safety

meetings. These bulletins included summaries of incidents, good practice and key learning points. Staff were supported during complaint investigations through designated contacts and the Freedom to Speak Up ambassador, with whistleblowing policies accessible via the intranet and displayed in staff areas. The policy on Raising Concerns: Freedom to Speak Up (Whistleblowing) Policy aimed to support staff to feel empowered and safe to raise concerns in the workplace.

Annual surveys and weekly community meetings provided additional feedback from patients and carers. There was a commitment to learning from complaints and incidents, with systems in place to ensure concerns were addressed and improvements implemented.

whilst
The service had a structured workforce plan and coordinated system for staff training and development, ensuring staff were competent, motivated and equipped to deliver high-quality care. Pre-employment checks, including references, disclosure barring service (DBS) and professional registration, were managed centrally via the onboarding system, with employment records stored securely on the human resources platform. The administration manager ensured that renewals of professional registrations and DBS were completed in a timely manner.

There was a Recruitment, Selection and Appointment of Staff Policy. It was applicable to all people employed or engaged to work at the group.

Supervision and appraisals were regularly conducted, with full compliance amongst staff. We were told that staff meetings were held across departments, with minutes circulated for those unable to attend. However, there had not been recent meetings for the following groups that needed to occur more often:

- Nurses, last meeting - January 2025
- Healthcare support workers last meeting – February 2025
- Activities co-ordinators last meeting – October 2024.

The registered manager must ensure that regular monthly staff meetings are held.

There were a range of plans for dealing with incidents or emergencies. There was an in-date business continuity plan that included examples of loss of premises and water damage. There was evidence of training to deal with emergency situations such as fire and resuscitation. Staff were aware of the arrangements for escalating issues to senior managers during the day and out of hours.

Workforce planning, training and organisational development
All staff spoken with said they enjoyed their work, felt confident and clear in their roles and spoke of strong and supportive managerial and clinical leadership, collaborative teamwork and feeling a valued member of the team. They also spoke of their supervision and appraisals being carried out regularly, identifying personal and professional development and were supported with further training and development. Staff also said they developed excellent relationships with families. Staff commented on additional training they would find useful:

> ***"Open to take on any training available to me."***

> ***"Face to face autism training."***

Staffing levels and skill mix were managed by the clinical manager, business manager and senior nurses. Unplanned absences and high observation needs were addressed through bank staff and occasionally agency staff. Acuity and patient needs were considered in staffing decisions, ensuring safe coverage.

Staffing levels were planned for two qualified nurses at least, at all times, and the rota for the last three months confirmed that this was the case. Whilst on the first night of the inspection, due to a sickness in the day there was only one registered nurse on duty from midnight to 8am. We were told that the registered manager was available on call if necessary.

Mandatory training compliance was over 80% and in most instances over 90%. Training was embedded in staff induction and ongoing development, with policies and procedures accessible via the intranet. The service demonstrated a proactive approach to workforce management, supporting staff competence and continuity of care. There was evidence of 100% compliance with staff appraisals.

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

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

Appendix B - Immediate improvement plan

Service: Cygnet St Teilo House

Date of inspection: 18 - 20 August 2025

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

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	There were NO immediate non-compliance issues.					

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan was actioned.

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Cygnet St Teilo House

Date of inspection: 18 - 20 August 2025

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 were taking to address these areas.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	There was limited information for support services which patients could self-refer to such as alcohol or drug abuse groups.	The registered manager must ensure that more information on support services is available to patients.	National Minimum Standard - Health promotion, protection and improvement	Registered Provider with link in with local services to provide information for patients.	Anna Cherrett	30 November 2025
2.	The annual patient and carer surveys ending January 2025 only had three patients involved. Increasing the frequency of these surveys could enhance responsiveness and provide more timely insights.	The registered manager must ensure that there are more regular family and patient surveys to provide more timely insights.	Independent Health Care (Wales) Regulations 2011 - regulation 19 (2) (e)	Registered Provider will review this recommendation with Operations Directorate of Cygnet Health as Audits are Corporate led.	Byron Mtandabari	3 months

3.	Some patients noted that feedback following complaints was not consistently communicated.	The registered manager must ensure that responses to complaints are timely and consistent.	Independent Health Care (Wales) Regulations 2011 – regulation 19 (2) (e)	Cygnet Complaints policy has been amended in the past year – previously patients received acknowledgement and outcome letters following complaints. New process states that complaints that can be managed at ward level do not require written outcomes. All complaints are now uploaded to clinical notes along with outcome discussion with patient within 24 hours of manager receiving the complaint.		Completed
4.	Patients had access to outdoor spaces, although	The registered manager must consider the view	Independent Health Care	Registered Provider submitted Capex	Registered Provider	Completed

	access to one garden area was restricted due to a low wall and associated absconding risks. Patients could only use this space following a risk assessment and with staff supervision or when section 17 leave had been authorised, which limited their independence. Patients we spoke with said that if the walls were higher, they felt they would be able to access the garden more and spend more time out there. It is recommended that the hospital reviewed this area to improve access whilst maintaining safety.	of the patients regarding access to the second garden and the height of the walls in this area and inform the patients of any actions they would take to address this.	(Wales) Regulations 2011 - regulation 26 (2) (a)	request on 12/8/2025. Registered Provider with include this in CAPEX request for 2026		August 2026
5.	Some areas required attention such as the chairs in the nursing station and boardroom were found to be damaged, which could pose infection prevention and	The registered manager must ensure that the chairs in the nurses' station and the board room are replaced to reduce the IPC risk	Independent Health Care (Wales) Regulations 2011 - regulation 26 (2) (c)	New chairs arrived and installed 2nd September		Completed

	control (IPC) concerns and in need of replacement. We were told these were on order.	presented by these chairs.				
6.	We saw evidence that patients would comment on food and make suggestions for the menu at weekly community meetings. Despite this, the menu offered variety and included healthy options such as fruits and balanced meals.	The registered manager must ensure that the patient menu options are changed on a more frequent basis.	Independent Health Care (Wales) Regulations 2011 – regulation 15 (9) (b)	Full menu changes are completed quarterly with co-production of patients and staff. Monthly People's Council meetings allow for any changes/amendments to be agreed outside of quarterly menu change.	Diane Jones and Byron Mtandabari	Completed and Ongoing
7.	Food storage practices in the patient kitchen could be improved. General use opened items were not labelled or dated, indicating poor monitoring. Management acknowledged this issue and committed to improving food	The registered manager must ensure that patients are educated on proper waste segregation of food waste and general waste.	Independent Health Care (Wales) Regulations 2011 – regulation 15 (9) (b)	OT department to complete education with patient group around food waste.	Louise Chinnock and Diane Jones	3 months

	labelling and storage protocols.					
8.	It was noted that food and general waste were disposed of in the same bin by patients. Although kitchen staff confirmed separate waste disposal systems existed, it was recommended that patients be educated on proper waste segregation to support independent living skills.	The registered manager must ensure that open food and beverage items are clearly labelled with dates when opened, using the form of education for the patients suggested by OT, without being too restrictive.	Independent Health Care (Wales) Regulations 2011 – regulation 15 (9) (b)	OT department to complete education with patient group around food waste.	Louise Chinnock and Diane Jones	3 months
9.	Records were maintained across both paper and electronic systems, including 'MyPath', shared drives, physical health files and paper-based patient records. The use of multiple formats and storage locations made navigation and information retrieval challenging. Staff	The registered manager must ensure that information is captured in a more streamlined way to help keep patient data accurate, up-to-date, complete and contemporaneous	Independent Health Care (Wales) Regulations 2011 – regulation 23	Registered Manager has commenced processes for records to be uploaded to patient clinical notes on completion to allow for easier access to documents for internal staff and external agencies	Byron Mtandabari and Anna Cherrett	6 months

	could access the necessary information with support, but triangulating data across sources required effort. 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. This was also reported in the 2022 report where we were told that the hospital was taking steps to collate patient information into a single file.					
10.	We were told that staff meetings were held across departments, with minutes circulated for those unable to attend. However, there had not been recent meetings for	The registered manager must ensure that regular monthly staff meetings are held.	National Minimum Standards, standard 26 - Workforce recruitment and	Group staff meetings held at 3 monthly intervals, monthly meetings would not be sustainable however clinical supervisions		Completed

	the following groups that needed to occur more often, nurses, healthcare support workers activities co-ordinators.		employment practices	are completed monthly and managerial supervision also 3 monthly. Also group reflective practice sessions twice a month.		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan was actioned.

Service representative

Name (print): **Byron Mtandabari**

Job role: **Hospital Manager**

Date: **21/10/2025**