Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

St Peter's Hospital
Inspection date: 17, 18, and 19 October 2022
Publication date: 20 January 2023

This summary document provides an overview of the outcome of the inspection

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We found staff were dedicated to providing a high standard of care.

Suitable protocols were in place to manage risk, health and safety and infection control.

We did identify areas for improvement, but no areas of non-compliance with the regulations were identified.

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

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 Peter's Hospital, on the evening of 17 October 2022 and following days of 18 and 19 October.

The following hospital units were reviewed during this inspection:

- Brecon Unit
- Caldicot Unit
- Raglan Unit

Our team, for the inspection comprised of two HIW Inspectors, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer). The inspection was led by a HIW Senior Healthcare Inspector.

This summary version of the report is designed for members of the public.

A (full) report which is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients can be found on our website.

Quality of Patient Experience

Overall Summary

We found a dedicated staff team that were committed to providing a high standard of care to patients. We saw staff interacting with patients respectfully throughout the inspection. Staff demonstrated a caring, compassionate, and understanding attitude to patients.

What we found this service did well

- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff
- Care for patients' physical health needs and individual risks.

Where the service could improve

- Re-commence patient community meetings
- On site Advocacy support.

Delivery of Safe and Effective Care

Overall Summary

We found that staff were completing clinical processes and documentation as required. There were established processes and audits in place to manage risk, health and safety and infection control. This enables staff to continue to provide safe and clinically effective care. Legal documentation to detain patients under the Mental Health Act was compliant with the requirements of the legislation.

What we found this service did well

- Medication records and patient records were comprehensive and complete, and we saw evidence of regular audits taking place
- Individual restrictive practice reviews supported learning from incidents and informed updated positive behavioural support plans.

Where the service could improve

- Increase number of personal alarms available for staff and visitors
- For staff to consistently wear red tabards when delivering and administrating medication.

Patients told us:

Patients provided us with the following comments:

Patients told us they would like advocacy to visit.

Quality of Management and Leadership

Overall Summary

We observed a committed staff team who had a good understanding of the needs of the patients at the hospital. There was dedicated and passionate leadership displayed by the hospital director who is supported by a committed multidisciplinary team. Mandatory training, supervision and annual appraisal completion rates were generally high. However, improvements were needed in training compliance for basic life support and safer people handling.

What we found this service did well

- We found an effective governance structure in place in terms of regular audit activities and meetings to discuss incidents, findings and issues related to patient care.

Where the service could improve

- Completion rates of certain mandatory training courses
- Review current registered nursing requirements covering Raglan and Caldicot unit.

Staff told us:

Staff provided us with the following comments:

Some staff told us that management were visible and approachable whilst other staff mentioned that they would like to see more of senior management on the wards.

Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the appendices of the full inspection report.

When we identify concerns that pose an immediate risk to patient safety we ask the health board to undertake urgent action. These concerns are outlined in the appendices and outline the action taken by the health board to protect patient safety and approved by us. We also provide a detailed table of improvements identified during the inspection where we require the service to tell us about the actions they are taking to address these areas and improve the quality and safety of healthcare services. In addition we outline concerns raised and acknowledge those resolved during the inspection.

At the appropriate time HIW asks the health board to confirm action has been taken in line with management responses documented in the improvement plan. We also ask health boards to provide documented evidence of action taken and/or progress made.