Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

St Peter's Hospital

Iris Care group

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

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales
Website: www.hiw.org.uk

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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 Peter's Hospital, on the evening of 26 February and following days of 27 and 28 February 2024.

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.

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 4 questionnaires were completed by patients or their carers and none were completed by staff. Feedback and some of the comments we received appear throughout the report, however, the low number of completed questionnaires should be bourne in mind when considering the comments in 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.

This (full) report 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.

2. Summary of inspection

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.

Patients had access to a variety of activities, and during the inspection it was positive to see staff encouraging and supporting the patients to participate in activities.

The registered provider should reconsider the location of the complaints poster to improve patient accessibility and ensure that feedback forms are available for patients and visitors.

This is what we recommend the service can improve:

- Availability of feedback forms
- Location of posters for complaints process.

This is what the service did well:

- Easy read documentation
- Variety of patient activities.

Delivery of Safe and Effective Care

Overall summary:
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.

Excellent standard of care planning which reflected the domains of the Welsh Measure. Care plans were well detailed, individualised, and reflected a wide range of MDT involvement and there was clear and documented evidence of patient involvement.

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

More robust governance process on key security needs to be implemented, along with some improvements around fire safety signage.

This is what we recommend the service can improve:

- Key security
- Fire safety signage.

This is what the service did well:

- Comprehensive and detailed care planning
- Easy read documentation developed for Mental Health Act.

Quality of Management and Leadership

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

Improvements had been made since our last inspection in 2021. These improvements related to minimising the use of agency staff, recruitment and retention of staff, and there were clear systems in place to ensure that clinical records, and observation records were accurately being completed and audited.

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 and clinical lead. However, some improvements are required in updating policies and compliance with mandatory training.

This is what we recommend the service can improve:

- Mandatory training compliance
- Review and update policies.

This is what the service did well:

- Recruitment and retention of staff
- Strong leadership provided to staff by the hospital director, clinical lead and multi-disciplinary team.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Some of the comments provided by patients on the questionnaires included:

" Very clean"
"Wonderful staff"

Health promotion, protection and improvement
St Peter's had a range of facilities to support the provision of therapies and activities. We observed patients at the hospital being involved in a range of activities throughout the inspection. These activities included arts and crafts, board games, reading books, and music therapy. Patients had access to large outdoor spaces, and during the inspection we observed patients accessing and frequently using this space and participating in musical activities.

Patients were able to access GP, dental services and other physical health professionals as required. Patient records evidenced detailed and appropriate physical assessments and monitoring.

Patients at St Peter's had hospital passports; these documents contained comprehensive information that assisted patients with complex needs to provide staff in general hospitals with important information about the person and their physical health when they are admitted.

Dignity and respect
We noted that all employees; unit staff, senior management, and administration staff, interacted and engaged with patients appropriately and treated patients with dignity and respect.

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

Some patients had access to en-suite rooms that provided a good standard of privacy and dignity. Patients could lock their rooms, but staff could override the locks if needed. We saw staff respecting the privacy of patients by knocking on bedroom and bathroom doors before entering.

Each bedroom door had a vision panel which enabled staff to undertake observations from the corridor without opening the door to minimise any potential

disruption to patients sleeping. During our tour of the hospital, we positively noted that the vision panels were closed by default to protect the privacy of patients as people passed the rooms.

Patients were able to personalise their rooms and store their own possessions. Personal items were risk assessed on an individual basis for the safety of each patient.

A telephone was available at the hospital for patients to use to contact family and friends if needed.

Plans were in place for a multi faith room to be developed, for both staff and patients to use.

Patient information and consent
Written information was displayed on the units for patients and their families. We saw that posters displayed information about advocacy services and how patients could provide feedback on the care they received on the units.

Information on visiting times was also displayed. We saw that there was clear signage within the units in both Welsh and English.

The registered provider's statement of purpose also described the aims and objectives of the service. This document was up to date and contained all the relevant information required by the regulations. Registration certificates from Healthcare Inspectorate Wales and information on how to raise a complaint were on display.

Communicating effectively
During the inspection we observed staff engaging with patients in a sensitive way and took time to help them understand their care using appropriate language.

There were a number of easy read documentation posters available to help staff understand and provide individualised care for the patient, posters such as 'How I take my medication' were highlighted as an area of noteworthy practice.

Patient meetings were taking place monthly, this was another area of improvement since the last inspection.

There was a complaints policy and procedure in place. The policy provided a structure for dealing with all complaints at the hospital.

A sample of informal and formal complaints we reviewed showed that an independent person was assigned to investigate the complaint and actions were

taken in line with the organisation's complaints policy to ensure that complaints were dealt with appropriately at the hospital.

Care planning and provision

Patients had their own individual weekly activity planner including individual and group sessions based within the hospital and the community (when the required authorisation was in place). During the inspection we observed staff and patients engaging in activities in the hospital and in the community.

We observed staff respecting patient privacy. For example, by understanding when patients preferred their own space and facilitating this whilst maintaining appropriate levels of observation.

Patients were fully involved in monthly multidisciplinary reviews. We saw evidence that care plans were person centred with support provided in a structured way to enable patients to achieve individual goals. Care plans were very detailed and personalised, this helped support the hospital in being able to deliver comprehensive care to the patients.

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

Equality, diversity and human rights

We found that arrangements were in place to promote and protect patient rights.

Legal documentation we saw to detain patients under the Mental Health Act was compliant with the legislation. All patients had access to advocacy services, and we were told that advocates visit the hospital.

Staff told us that patients are invited to be part of their MDT meetings and that the involvement of family members or advocates was encouraged where possible.

Citizen engagement and feedback

Information was also available to inform relatives and carers on how to provide feedback. A suggestion box was available in the reception area, however no forms were available to complete.

The registered provider must ensure that forms are available for completion in the suggestion box.

There was a complaints policy and procedure in place. The policy provided a structure for dealing with all complaints at the hospital.

Posters on how to make a complaint were displayed in the reception area, however, this may not be the most appropriate place for the patient group to access this information.

The registered provider should consider displaying complaints posters in an area where patients would have greater access to the information.

A sample of informal and formal complaints we reviewed showed that an independent person was assigned to investigate the complaint and actions were taken in line with the organisation's complaints policy to ensure that complaints were dealt with appropriately at the hospital. There were currently no ongoing complaints subject of investigation.

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety
Access to the hospital site was secured by the main hospital gate, with entry gained via an intercom to reception. Entry on and off each unit was secured by electronic locks that needed a swipe card and keys were provided to staff to access areas of the hospital.

A review of governance documentation highlighted that some keys had gone missing from the hospital, it is acknowledged that access to the hospital could not have been achieved with the sets of missing keys, however, this demonstrated that a more robust governance process needs to be put in place to manage key security to ensure that the security of the hospital is maintained.

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

We saw evidence of various risk assessments that had been conducted including, ligature point risk assessments and fire risk assessments. We were told of the environmental checks that are completed and saw evidence of the weekly manager checks across the units.

There were weekly audits of resuscitation equipment; staff had documented when these had occurred to ensure that the equipment was present and in date.

The hospital had a business continuity plan in place, there was no evidence that the business continuity policy had been reviewed or updated since 2021.

The registered provider must ensure that the business continuity plan is reviewed and updated.

Overall, the environment of care was clutter free and there was a relaxed, calming atmosphere on the units. Patients had access to pleasant outdoor areas, however some paving stones in the courtyard had come loose and was a potential safety hazard for patients and staff.

The registered provider must ensure that the paving stones in the courtyard are fixed or replaced.

Staff informed us that due to the lack of ventilation on Brecon Unit unpleasant smells can sometime linger in this area, making it unpleasant for the staffing and patient group.

The registered provider must ensure that adequate ventilation is provided on Brecon Unit.

Fire safety policies were all up to date and fire risk assessments had all been completed, however the fire exit signage direction indicators could become confusing in terms of what direction they were pointing. This was highlighted to the hospital director, who was going to undertake a review and replacement of the signage to make exit points clearer.

The registered provider must ensure that fire exit signs are reviewed.

Infection prevention and control (IPC) and decontamination

A system of regular audit of infection control arrangements was described. This was completed with the aim of identifying areas for improvement so that appropriate action could be taken where necessary.

Staff confirmed that cleaning schedules were in place to promote regular and effective cleaning of the hospital. Staff were aware of their responsibilities around infection prevention and control and staff were observed undertaking cleaning duties effectively.

The hospital was very clean, tidy, and organised. Cleaning equipment was stored and organised appropriately.

Throughout the inspection, the inspection team noted a high level of cleanliness at the hospital, which contributed to the patients having a better experience whilst staying at the hospital.

Nutrition

Patients were supported to meet their dietary needs, a dietician worked at the hospital to support staff and patients with nutritional requirements.

The hospital provided patients with meals on the units, making their choices from the hospital menu. We were told that specific dietary requirements were accommodated. Staff said patients make their food choices in advance and stated if a patient changes their mind they can usually be accommodated with another option.

The dining areas were clean and tidy and provided a suitable environment for patients to eat their meals.

Some patients at the hospital were receiving the nutrients and fluids they required through a percutaneous endoscopic gastrostomy feeding tube (PEG). It was positive to see that improvements had been made and staff we spoke with stated that they had received additional training in this area to further develop their competencies and refresh their knowledge and skills.

Medicines management
Medicines management was safe and effective. Medication was stored securely with cupboards and medication fridges locked. There was evidence of regular temperature checks of the medication fridge to monitor that medication was stored at the manufacturer's advised temperature.

During the night visit the medication trolley on lower Caldicott was not secured to the wall, this was immediately rectified by staff.

There was regular pharmacy input and audit undertaken on a weekly basis that helped the management, prescribing and administration of medication on the units. However, some out of date medication and clinical waste had not been disposed of correctly. This was brought to the attention of the hospital director and was immediately resolved.

The registered provider must ensure that out of date medications and clinical waste is disposed of correctly.

There were arrangements in place on the units for the storage and use of Controlled Drugs and Drugs Liable to Misuse. Records we viewed evidenced that twice-daily checks were conducted with nursing signatures confirming that the checks had been conducted.

Discussions with the consultant psychiatrist confirmed that no patients were on levels of medication above the British National Formula medicines guidance (BNF) and the hospital was working towards deprescribing as a clinical improvement focus.

The Medication Administration Records reviewed were fully completed by staff. We saw several medication rounds, and saw that staff undertook these appropriately and professionally, interacting with patients respectfully and considerately.

A range of easy read medication information leaflets were available for patients to access.

We noted that the medication policy displayed on the wall in the clinical room was out of date.

The registered provider must ensure that policies in clinical room are up to date.

The clinical rooms were well organised, however the clinical room in Caldicott was very small and items were stored on the work surface. This room would benefit

from more storage space such as shelves to store items that are currently stored on work surfaces.

The registered provider must ensure that more storage space is provided in clinical room on Caldicott Unit.

Safeguarding children and safeguarding vulnerable adults
There were established hospital policies and processes in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

Hospital staff had access to safeguarding procedures via its intranet. Senior staff confirmed they were confident that staff were aware of the correct procedure to follow should they have a safeguarding concern. During discussions with staff, they were able to show knowledge of the process of making a safeguarding referral.

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.

Through conversations with staff, it was evident that the hospital had built up a close working relationship with the local authority. This collaborative approach is key to effective safeguarding processes and demonstrated that the hospital placed a strong emphasis on safeguarding their patients.

Medical devices, equipment and diagnostic systems
We saw evidence of regular auditing of resuscitation equipment. Staff had documented when these had occurred to ensure that the equipment was present and in date.

During staff discussions, it was evident that staff were aware of the locations of ligature cutters in case of an emergency. There were up-to-date safety audits in place, including ligature point risk assessments.

Safe and clinically effective care
Overall, we found that systems and governance arrangements were in place, which helped ensure that staff provided safe and clinically effective care for patients.

There was an established electronic system in place for recording, reviewing, and monitoring patient safety incidents. All data regarding incidents is collated and a detailed incident analysis is prepared by psychology assistants. This is discussed in the monthly MDT and any care plans that require changing are updated. A more detailed analysis is presented in CTP reviews and again this triggers care plan reviews.

Evidence obtained during the inspection confirmed that incidents and use of physical interventions are rare. This demonstrated that the use of least restrictive model of care was being used effectively at the hospital focusing on therapeutic engagement between staff and patients which created a relaxed atmosphere on the units. When a restraint does take place, all completed paperwork is checked and robustly supervised and any lessons learnt are disseminated to staff. Staff confirmed that de-briefs take place following incidents.

Observation charts were completed in line with guidance and there was evidence of these being regularly audited to ensure compliance. During the morning meetings we attended it was positive to hear staff discussing and reviewing the reasons for observations. The hospital director informed the inspection team that there was a focus on training staff to become more goal focussed with an empahsis around reduction of observations with staff having to evidence why observations were required. Staff were being encouraged to constantly review decision making around observations.

Records management

Patient records were a combination of electronic and paper records. Electronic records were password protected and paper documentation were stored securely within locked offices to prevent unauthorised access and breaches in confidentiality. We observed staff storing the records appropriately during our inspection.

We used the electronic record system throughout the inspection and found patient records to be comprehensive and well organised.

Mental Health Act Monitoring

We reviewed the statutory detention documents of five patients all found to be fully compliant with the Mental Health Act (MHA) and Code of Practice for Wales,1983 (revised 2016).

Mental Health Act records were appropriately stored, well organised, and maintained and very easy to navigate.

The Mental Health Act administrator ran an efficient and effective system to support the implementation monitoring and review of the legal requirements of the Mental Health Act.

The easy read documents developed for patients with limited cognitive abilities was identified as an area of noteworthy practice. This document described in simplified terms what section of the MHA a person is detained under, how it affects them, what their rights are and how to appeal.

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

We reviewed the care plans of four patients and found that they were kept to a good standard.

Entries were comprehensive and recognised assessment tools were used to monitor mental and physical health.

Physical health monitoring is consistently recorded in patient records and are embedded throughout patient files. There was a wide range of evidence based physical health assessments completed. It was also positive to see evidence of local GP's attending the hospital and contributing to patients health needs.

We saw evidence that care plans were detailed, comprehensive and person centred with support provided in a structured way to enable patients to achieve individual goals. Our findings showed clear evidence of multidisciplinary involvement in the care plans; this helped support the hospital in being able to deliver comprehensive care to the patients.

Management of patients' behaviours were reflected in their care plans and risk management profile, along with staff training to use skills to manage and defuse difficult situations. Individuals have comprehensive plans entitled person-centred care plan (PCCP) these plans define each stage of the behavioural issue and includes post incident plans for both the patient and staff.

The plans also include what works to prevent incidents in the future. A review of the PCCP demonstrated that the assessors have a good understanding of what works with an individual and what doesn't and details steps to prevent escalation of patient behaviours. These plans are regularly reviewed, discussed and if required, amended in MDT.

Within some records we identified that there was not always evidence of the patients voice and standardised generic medical terms were used rather than words the patient would use.

The registered provider must ensure that the words used by patients are recorded in plans to reflect their views.

There were examples of easy read documents in patients files and all of these were very individualised. Documents such as "My best day", "My communication passport" and "My hospital passport" all helped staff to care for the patients in a dignified and caring way.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental capacity assessments were being undertaken as required, when DoLS referrals were made.

All records evidenced that the correct procedures had been followed relating to DoLS applications. It was evident that the processes were being applied appropriately. Part A of the process relating to authorisation and replacement was conducted in a timely manner by St Peter's staff and the 'placing' local authorities carry out assessment visits within the relevant timescales. However, there were delays of several months in some cases in the hospital receiving Part B forms to conclude the process. It was positive to see that the situation is closely monitored by the hospital director and clinical lead on a 'live data' system.

It was positive to see that advocacy visited and engaged with the patients on a regular basis, which is an improvement since our last inspection. We met the Independent Mental Health Advocacy (IMHA) from Advocacy Support Cymru. They spoke very positively about the hospital and the quality of care and support. Advocacy visit at least twice monthly and more frequently as required by individuals.

Quality of Management and Leadership

Governance and accountability framework

We found that there had been improvements made since our last inspection in 2021. There were well-defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. They defined these arrangements during the day, with senior management and on-call systems in place for the night shift. Ongoing improvements need to focus on staff compliance with mandatory training.

During the inspection senior management were able to assure us that internal audits were undertaken and provided the team with evidence of a range of audits and improvements that have taken place, these documents were provided promptly to the team demonstrating that the correct systems and structures are in place.

There was dedicated and passionate leadership from the hospital director and clinical lead, who are supported by committed multidisciplinary teams and staffing group. We found a friendly, professional staff team who showed a commitment to providing high quality care to patients. Staff were able to describe their roles and appeared knowledgeable about the care needs of most patients they were responsible for.

During our time at the hospital, we observed a positive culture with good relationships between staff who we observed working well together as a team. It was evident that staff were striving to provide high levels of care to the patient groups.

During meetings we attended it was positive to see discussion and debates taking place amongst the staff. During the meetings we attended staff demonstrated that they cared for the patients and during meetings staff views and opinions were welcomed and valued on how to make improvements.

It was clear to see that the hospital director, clinical lead, and unit managers had a very supportive and approachable leadership style, this was also confirmed during staff interviews and documentation we reviewed during the inspection.

Dealing with concerns and managing incidents

As detailed earlier, there were established processes in place for dealing with concerns and managing incidents at the hospital.

Arrangements were in place to disseminate information and lessons learned to staff from complaints and incidents at the hospital and the wider organisation.

This helps to promote patient safety and continuous improvement of the service provided.

Workforce planning, training and organisational development
Staff showed strong team working and appeared motivated to provide dedicated care for patients. Staff we spoke with were positive about the support they received from colleagues, and leadership by their managers. There were some mixed responses from staff regarding the visibility of the senior management team on the units, most staff stated that some were visible, whilst others indicated that management are not often seen on the units.

Staff annual appraisals completion rates on all three units were under 30 percent and require improvements. Efforts were being made to increase the completion rates of appraisals and on the first night of the inspection some unit managers were on site undertaking appraisals with the night shift staff. Staff supervision percentages were over 90 percent on all three units.

The registered provider must ensure that appraisal completion rates are improved.

The inspection team considered staff training compliance and provided us with a list of staff mandatory training compliance. Overall, training figures were high however, improvements are required for physical intervention training with overall compliance currently at 85 percent and immediate life support was currently 70 percent.

The registered provider must ensure that physical intervention and immediate life support training compliance figures are improved.

We were told that staff whose training had expired for physical intervention did not become involved in restraints and would be re-deployed until they have successfully completed their training.

Staff who were out of compliance for immediate life support had received additional training which had been delivered to bridge the gap between their annual ILS training. This training included use of Automated External Defibrillator (AED), Cardio Pulmonary Resuscitation (CPR) and Airways Management which included administration of oxygen.

In addition to mandatory training, bespoke training for the needs of the patients group had been delivered around Huntington's disease, catheter, peg training, choke training and trolley dash training. The hospital was also due to run training scenarios for choking, falls and trolley dashes, to provide staff with the ability to practice what they have learnt from training courses.

We were provided with a range of policies, however, upon review some of the versions we received had passed their review date. The following policies were found to be out of date:

- Medication management policy review date 2022
- Rapid tranquilisation policy review date 2019

The registered provider must make sure that all policies are updated and reviewed.

It was pleasing to see the amount of ongoing research projects and quality improvements taking place in the hospital. Calendar awareness events are held monthly which focusses on events that are important to the staff and patient group. In addition, monthly raising awareness workshops are provided to staff, facilitated by the MDT team.

News updates and information for both staff, patients and visitors were displayed on a tv monitor in the reception area of the hospital.

The hospital had also set up an internal social media platform viva engage; this platform is used to post positive stories from the patient group. There was also an internal app called recognise me, where any staff member could record a positive comment to recognise and reward staffing achievements.

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 Service (DBS) checks were undertaken and professional qualifications checked. Therefore, we were assured that recruitment was undertaken in an open and fair process.

Significant improvements had been made in reducing the use of agency staff at the hospital since the last inspection and there were currently no nursing or health care support vacancies at the hospital which reflected the success of the recruitment and retention of staff.

There were good systems in place to support staff welfare.

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

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

Appendix B - Immediate improvement plan

Service: St Peter's Hospital

Date of inspection: 26 - 28 February 2024

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

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate assurances were identified				

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):

Job role:

Date:

Appendix C - Improvement plan

Service: St Peter's Hospital

Date of inspection: 26 - 28 February 2024

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

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The registered provider must ensure that feedback forms are available for the suggestion box	Patient Information	This action has been completed. A suggestion box has been added to the reception area for all staff, patients, and visitors. We have already had over 10 suggestions added to the box.	Amy Dymond	Completed
The registered provider must ensure that complaints posters are displayed in areas where patients can access the information.	Patient Information	All complaints posters are clearly visible on the units for all patients, staff and visitors to see. These were present during the inspection, and this was discussed at the time.	Amy Dymond	Completed

The registered provider must ensure that the business continuity plan is reviewed and updated.	Patient Information	Hospital director has worked with Health and Safety and the Operations Director to review the business continuity plan for Saint Peters Hospital. This is currently ongoing.	Rachael Hussey (Health and Safety)	1 month- To be completed by the end of May
The registered provider must ensure that the paving stones in the courtyard are fixed or replaced.	Managing risk and health and safety	Hospital director has contacted the maintenance team and contractors have been out to review the paving in the courtyard.	Amy Dymond and Maintenance team and external contractors.	3 months- To be completed by the end of July
The registered provider must ensure that adequate ventilation is provided on Brecon Unit.	Managing risk and health and safety	Maintenance visited site and have reviewed how we can utilise the air conditioning unit for ventilation. We have contacted the external contractor to review.	Amy Dymond, James Ford (General Manager)	3 months- To be completed by the end of July
The registered provider must ensure that fire exit signs are reviewed.	Managing risk and health and safety	This has been resolved. Fire exit signs arrows have been reviewed by maintenance and health and safety and any incorrect arrows have been changed. New signs have also	Patryk Galczyk (Maintenance) and Rachael Hussey (Health and Safety)	Completed

		been added where required, also 2 emergency direction lights (green man) have been updated to LED lights. Health and Safety team to complete a final walk around with maintenance to ensure all signs are reviewed to ensure none have been missed.	Patryk Galczyk (Maintenance) and Rachael Hussey (Health and Safety)	1 month- to be completed by the end of May
The registered provider must ensure that out of date medications and clinical waste is disposed of correctly.	Safe and clinically effective care	Hospital director has linked in with General manger to arrange storage for the sealed medication waste while we are awaiting collection, this will be a holding point for the waste. We have our waste contract through Boot's but we are also able to arrange one off collections. Waste will be monitored by the clinical lead. Medication room policies to be reviewed by clinical lead and	Amy Dymond, James Ford (General Manager) and Carla Rawlinson (Clinical Lead). Amy Dymond and Carla Rawlinson (Clinical Lead).	One month- to be completed by the end of May

The registered provider must ensure that policies in clinical room are up to date.	Workforce planning, training, and organisational development	replaced. Medication policy was replaced during the inspection however this policy has not been ratified. Once this has been ratified this will also be updated.		One month- to be completed by the end of May
The registered provider must ensure that more storage space is provided in clinical room on Caldicott Unit.	Safe and clinically effective care	We are reviewing the storage in the clinic rooms and reviewing what can be moved from there to free up more space while adding shelving where possible.	Amy Dymond and Patryk Galczyk (Maintenance)	2 months (to be completed by the end of June)
The registered provider must ensure that physical intervention and immediate life support training compliance figures are improved	Workforce planning, training, and organisational development	All nurses have now been trained to the ILS level and will be receiving this training annually moving forward. Physical Intervention is currently at 77%, but below is the breakdown of all outstanding	Amy Dymond, Carla Rawlinson (clinical lead) and Learning and development.	Ongoing. All training for staff out of date is booked in between April and July. 2 months- This will be completed by the end of June.

		staff and when they are booked to attend the training. Nurse ILS training- All nurses undertook ILS training March – April 2023 we are currently in the process of re training expired nurses.		
The registered provider must make sure that all policies are updated and reviewed.	Workforce planning, training, and organisational development	There is an integrated working policy committee that is reviewing all policies post integration on a RAG rated scale all existing LSH policies remain in situ until the integrated version has been ratified.	Operations Director	6 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): Amy Dymond

Job role: Hospital Director

Date: 24/04/24