Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Pinetree Court Hospital

Inspection date: 21, 22 and 23 October 2024

Publication date: 23 January 2025

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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

Digital ISBN 978-1-83715-225-4

© Crown copyright 2025

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 5

2. Summary of inspection 6

3. What we found 9

- Quality of Patient Experience 9
- Delivery of Safe and Effective Care 14
- Quality of Management and Leadership 21

4. Next steps 25

Appendix A - Summary of concerns resolved during the inspection 26

Appendix B - Immediate improvement plan 27

Appendix C -improvement plan 28

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 Pinetree Court Hospital, on 21, 22 and 23 October 2024.

The following hospital units were reviewed during this inspection:

- Juniper - 12 bed single gender female unit
- Larch – 14 bed single gender male unit
- Cedar – 3 bed mixed gender unit.

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 reviewers).

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. No questionnaires were completed by patient or carers. Eleven questionnaires 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:
All patients we spoke with said they felt safe and were able to speak with staff when needed, and that they were happy at the hospital, and that staff were kind and helpful. Other data received through hospital internal feedback etc was also generally positive.

There was a range of activities in place providing therapies to patients, to support and stimulate them as part of their recovery. It was positive to see staff supporting patients to engage in activities.

Overall, we found that patients are provided with timely care. We found their needs were promptly assessed upon admission, and staff appropriately provided care and assisted patients when required. Staff were knowledgeable of each patient and strove to provide individualised care. We observed kindness, warmth and respect between staff and patients. Most patients we spoke with were very complimentary of staff and told us that they were treated well and felt safe.

However, some patients told us that they would like staff to improve their communication with other staff when on observations.

This is what we recommend the service can improve:

- Staff engagement with each other whilst on observations
- Health promotion information.

This is what the service did well:

- Good team working and motivated staff
- Patients and carers spoke highly of staff and told us they were treated well.

Delivery of Safe and Effective Care

Overall summary:

Overall, we found appropriate systems and governance arrangements in place, which helped ensure the provision of safe and effective care for patients. A range of up-to-date health and safety policies were in place and various risk assessments had been completed, such as ligature point risk assessments and fire risk assessments. We also found evidence of effective clinical audit taking place, which was monitored by the clinical leads.

Appropriate processes were in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies when required.

A medication dispensing cabinet system was in place which aids the safe storage of medication. Stock is adequately checked daily by registered staff, and effective weekly audits are undertaken by the clinical leads and pharmacy staff. However, improvement is required to the environment to ensure that medication in the clinical area is safe and secure when being administered to patients. In addition, improvements are required to medication stock checks to ensure availability of medications for the patient group.

We reviewed the hospitals use of restrictive practices and found there was evidence of ongoing reduction in usage, along with effective systems for reviewing and monitoring.

We saw a good standard of care planning which reflected the domains of the Welsh Measure. Care plans were well detailed, individualised, and reflected a wide range of Multi-disciplinary Team (MDT) involvement, and there was clear and documented evidence of patient involvement.

This is what we recommend the service can improve:

- Meal choices and portion sizes
- Medication stock checks
- Safe environment for administration of medications.

This is what the service did well:

- Staff interacted and engaged with patients respectfully
- Good standard of care planning
- Range of effective audits undertaken by clinical leads.

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. We found a friendly, professional and kind staff team who demonstrated a commitment to providing high quality care to patients. There was dedicated and passionate leadership displayed by staff, the ward managers and senior leadership team.

There was a well-defined organisational structure in place, which provided clear lines of management and accountability. Effective systems provided access to management support during the day, with an on-call system in place for the night. Staff felt the culture on the ward was positive and said they would feel confident in raising a concern and knew the process of how to do so, and we saw evidence to confirm this.

Most staff spoke favourably about the support from colleagues working within the hospital and reported a good team-working ethos. However, staff indicated that staffing levels should increase to enable staff to meet general requests from the patient group and to further facilitate patient activities.

Results from our questionnaire also indicated that staff would like more communication from senior management and the multi-disciplinary team around decision making. Some staff commented that communication from the senior management team and MDT is not always communicated clearly and effectively throughout the wider organisation in terms of decision making or why specific decisions have been made.

This is what we recommend the service can improve:

- Availability of staff to support patients
- Communication on decision making from management and Multi-Disciplinary Team.

This is what the service did well:

- Mandatory training compliance figures were good.

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

Patient feedback
No patient or carer responses to our questionnaires were completed. We therefore considered the hospitals internal patient feedback, any complaints, and patient discussion data, to help us gain a better understanding of the overall patient experience. Feedback was generally positive. All patients we spoke with said they felt safe and were able to speak with staff when needed, and that they were happy at the hospital, and that staff were kind and helpful.

Health promotion, protection and improvement
Pinetree Court Hospital had a range of facilities to support the provision of therapies and activities for patients. In addition, patients have regular access to community services for those who are authorised to leave the hospital.

We observed patients at the hospital being involved in a range of activities throughout the inspection. We saw a weekly activity timetable and activities included art and crafts, walking football, sit down volleyball and cooking activities. We saw that the OT department, along with the activities co-ordinator were providing a range of activities and beneficial therapeutic activities for the patient group.

Patients had good access to outdoor spaces and staff and the activity co-ordinators regularly take patients off site to use community facilities.

Services are also provided by other professionals, such as physiotherapy, dietetics, in line with individual patient needs. Patients can also access a GP service, dental service and other physical health professionals where required. We found that patient records evidenced the appropriate physical assessments and ongoing monitoring.

The weekly GP visits allow for excellent MDT working and building positive relationships with patients.

Dignity and respect
We found that staff engaged with patients appropriately and treated them with dignity and respect, which included ward staff, senior management, and administration staff.

The staff we spoke with were enthusiastic about their roles and how they support and care for the patients. We saw most staff taking time to speak with patients and address any needs or concerns they had. This suggested that staff had responsive and caring attitudes towards patients.

Not all patient rooms were ensuite. Communal bathrooms were available, and we saw staff respecting the privacy of patients by knocking on bedroom and bathroom doors before entering. Whilst we acknowledge the cost involved with renovating a ward environment and the disruption this may have to bed availability during renovation, it would be beneficial to patients if the bedrooms were adapted to allow all patients to have ensuite provisions.

All patient rooms have observation panels that can be open or closed from the outside, to enable staff to monitor a person when necessary. Patients can lock their bedroom doors; however, staff could override this when necessary.

There were nurse call points around the hospital and within patient bedrooms and bathrooms so that patients could call for help if needed.

Patients were able to personalise their rooms and store their own possessions. Personal items are risk assessed on an individualised basis, to help maintain the safety of each patient. This included the use of personal mobile phones and other electronic devices. A telephone was also available for patients to use to contact friends or family if needed, and there were electronic devices available on the units for patients to use.

There was also a well-equipped laundry room in place for use by patients, under supervision and patients are encouraged to manage their own laundry to promote independence.

Patient information and consent

Patient boards displayed in the hospital contained relevant information to help patients and their families understand their care. This included information such as the weekly activity timetable and advocacy services.

Registration certificates from Healthcare Inspectorate Wales and information on how to raise a complaint were on display in the reception. This information was also available in Welsh.

We saw limited information on health promotion and how to make a complaint or raise a concern on the units, however the patients we spoke to during the inspection were aware of the complaints and concerns procedure.

The registered provider must ensure that there is health promotion information available to patients.

Communicating effectively

All patients we spoke with said they felt safe and were able to speak with staff when needed. They also said they were happy at the hospital, and that staff were kind and helpful. There seemed to be mutual respect and strong relational security between staff, patients and family carers.

Throughout the inspection, we observed staff engaging and communicating in a positive and sensitive way with patients, taking time to help them understand their care, and using appropriate language or communication styles.

We did not observe any bilingual posters and patients and staff we spoke to were unaware if information was available bilingually.

The registered provider must ensure that patients are aware of the active offer of speaking Welsh to patients and staff area aware of how to access bilingual information.

For specific meetings, and where applicable, patients can receive support from external bodies to provide support and guidance, such as solicitors or patient advocacy. With patients' agreement, and wherever possible, their families or carers were included in these meetings.

In addition, each unit has a patient representative who attends part of the clinical governance meetings where the patient representative discusses any issues, improvements or changes that the patient group would like to make.

Some patients told us that when they are on observations some staff will speak to each other in their native language and this often causes the patients to become unsettled and 'paranoid'. This issue needs to be addressed with the staffing group so that patients can feel safe and settled.

The registered provider must ensure that during observations staff engage with patients and respond appropriately to minimize stress amongst the patient group.

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. Patients told us that they enjoyed the sessions that OT and the activities co-ordinator arranged for them.

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 good arrangements in place to promote and protect patient rights.

There were facilities for patients to see their families in private. Rooms were also available for patients to spend time away from other patients according to their needs and wishes.

Legal documentation relating to detained 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.

During our discussions with staff, they demonstrated suitable regard for upholding patient rights and individual patient preferences. The Care and Treatment Plans (CTPs) we reviewed evidenced that the social, cultural, and spiritual needs of

patients had been considered. We saw that the hospital had an appropriate Equality, Diversity, and Inclusion policy available to help ensure that patients' equality and diversity were respected.

Citizen engagement and feedback

There were regular patient meetings and surveys to allow patients to provide feedback on the provision of care at the hospital. Information was also available to inform relatives and carers on how to provide feedback.

There was a complaints policy and procedure in place. The policy provided a structure for dealing with all complaints within the hospital. It was evident that an independent person is assigned to investigate complaints and actions were taken in line with the registered provider's complaints policy to ensure that complaints are dealt with appropriately. We reviewed a sample of formal and informal complaints and confirmed that they had been actioned in line with the organisational complaints policy.

Delivery of Safe and Effective Care

Safe Care

Environment
The hospital car park was appropriately secured via a locked gate and access is gained via the intercom for visitors or an electronic key fob for staff.

Reception staff are responsible for booking visitors appointment and ensuring safety of the hospital keys.

We saw evidence of various risk assessments that had been conducted including ligature point risk assessments. The ligature audits require some additional areas to be added, and the areas concerned were brought to the attention of the setting. We were told of the environmental checks that are completed and saw evidence of the weekly manager checks across the units.

We saw 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 to follow in the event of a major incident occurring at the hospital. These included events such as fire, loss of water and electricity supply and severe weather conditions. Fire safety policies were all up to date and fire risk assessments had all been completed.

Evidence of audits were recorded electronically, and all were up to date and complete at the time of the inspection.

Patients told us that when damage is caused to doors, the damaged areas are not replaced in a timely fashion. It is important that any damaged fixtures and fittings are fixed or replaced and made safe for the patient group.

The registered provider must ensure that any damaged fixtures or fittings are replaced or repaired immediately to make the environment safe for the patient group.

Managing risk and health and safety
There was an electronic system in place for recording, reviewing, and monitoring patient safety incidents. Staff confirmed that de-briefs take place following incidents. The meetings we attended, and the evidence obtained during the

inspection suggested that incidents and the use of physical restraint interventions are monitored and supervised robustly.

Quarterly reports are produced detailing all physical interventions used for patients. The data reviewed demonstrated a progressive decrease in overall restraint use and there was a positive and effective approach to reviewing and monitoring.

The physical intervention used are selected to best meet the needs of an individual patient and a process of risk assessment will inform this, considering risks due to age, frailty, health problems, trauma history and religious and cultural needs.

After each physical intervention incident, both patients and staff are invited to engage in a debrief focused on their psychological and physical health and wellbeing.

A range of up-to-date health and safety policies were in place.

Infection prevention and control (IPC) and decontamination

We found suitable infection prevention and control (IPC) arrangements in place which were supported by a range of up-to-date policies to maintain patient and staff safety. Regular ward audits had been completed to review the cleanliness of the environment and check compliance with hospital procedures. All were appropriate and compliance was checked by senior ward staff.

We saw evidence to confirm that staff had conducted the necessary risk assessments and relevant policies and procedures were updated accordingly. Staff also explained their responsibilities in line with infection prevention and control.

We found that staff had access to and were appropriately using personal protective equipment (PPE). Staff told us that PPE was always readily available, and we saw that sufficient hand washing and drying, and sanitisation facilities were available.

Cleaning equipment was stored safely and organised appropriately and there were suitable arrangements in place for the disposal of domestic and clinical waste.

Staff compliance with mandatory IPC training was currently at 93% and was being continually monitored to ensure staff remained in compliance.

Nutrition

The hospital provided patients with regular meals on the units, making their choices from the three weekly rotational menus.

Patients were supported to meet their dietary needs, and we were told that specific dietary requirements were accommodated, as appropriate.

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

Most patients told us that they don't feel involved in menu planning and the quality and portion sizes of food required improvements. In addition, patients told us that fruit choices were limited.

The registered provider must ensure that menu choices and portion sizes improve and ensure that a variety of fresh fruit is available to patients daily.

Medicines management

We found suitable arrangements in place for the management of medicines and safe and secure storage. We also saw evidence of regular temperature checks of medication fridges to maintain safe storage.

The hospital had an automated medication dispensing cabinet system in place, which aids the safe storage of medication. Stock is checked daily by registered staff, and weekly audits are undertaken by the clinical leads and pharmacy staff. However, we found that some patients had missed medication due to lack of stock.

The registered provider must ensure that robust checks are undertaken on medication to ensure that all patient medication is available.

We observed several medication rounds, and saw staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately. However, patients wait by the main clinical room door for medication, which is not locked during the medication round and there is no hatch available to dispense to patients. This could potentially pose a risk when administering medication if patients are not observed or supervised when the door to the clinic containing medication is unlocked.

The registered provider should undertake a risk assessment on current process of administering medication and determine if a more robust system could be implemented.

We saw the controlled drugs cabinet and it met the required standard. A controlled drugs book and Drugs Liable for misuse book were also completed on the units.

Minimal and least restrictive prescribing of medications was observed. The medication policy was up to date and kept in the clinical rooms.

Medication Administration Records (MAR Charts) reviewed were fully completed by staff. This included completing all patient details on the front and subsequent pages and their Mental Health Act legal status.

Safeguarding children and safeguarding vulnerable adults

Appropriate processes were in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies when required.

Unit staff had access to safeguarding procedures, which were supported by the Wales Safeguarding procedures, accessible via the intranet.

Senior unit 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.

Medical devices, equipment and diagnostic systems

There were regular clinical audits undertaken at the hospital and we saw evidence of regular auditing of resuscitation equipment. Staff had documented when this had occurred to ensure that the equipment was ready for use and in date. During staff discussions, it was evident that staff were aware of the locations of ligature cutters in case of an emergency.

Storage of oxygen complied with regulations and guidance; risk assessments are completed for the clinical areas including the storage of oxygen.

Safe and clinically effective care

Overall, we found appropriate governance arrangements in place which helped ensure that staff provide safe and clinically effective care for patients.

Staff confirmed that de-briefs take place following incidents. Meetings we attended and evidence obtained during the inspection demonstrated that incidents and use of physical interventions are monitored and reviewed.

The inspection team witnessed positive redirection and de-escalation of behaviours of concern during the inspection, all of which were done respectfully and in a supportive manner.

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

Participating in quality improvement activities
During our discussions with staff and senior managers, we were provided with numerous examples where they were reviewing the service provision and looking to develop some aspects of the hospital.

At the time of our inspection there were several ongoing improvements being made across the hospital site, such as a new annexe and improvements to the lay out and use of the Cedar lodge.

Improvements had been made across the hospital environment since our previous inspections. A new records management and audit system was in place and staff feedback on the system was positive.

We were told of initiatives where patients had been trained in fire safety and first aid training.

Monthly themes to raise staff knowledge, awareness and understanding are provided to the staffing group. The theme at the time of the inspection was around safeguarding.

Information management and communications technology
The computerised patient record systems were well developed and provided high quality information on individual patient care. The system was comprehensive, and easy to navigate.

There were good electronic systems in place for incident recording, clinical and governance audits, human resources, and other hospital systems, which assisted the management and running of the hospital. Staff indicated that the electronic system was working well.

Records management
Patient records were kept electronically. The electronic system was password protected to prevent unauthorised access and any breaches in confidentiality.

Overall, we found robust systems in place to ensure that personal information relating to patients and staff were kept securely. There was a formal information governance framework in place and staff were aware of their responsibilities in respect of accurate record keeping and maintenance of confidentiality.

Mental Health Act monitoring

The Mental Health Act (MHA) administrator runs an efficient and effective system to support the implementation monitoring and review of the legal requirements of the mental health act.

We reviewed the statutory detention documents of three patients, all found to be fully compliant with the MHA and Code of Practice for Wales,1983 (revised 2016) Electronic documents on the units were stored securely. The records we viewed were well organised, easy to navigate and contained detailed and relevant information and fully compliant with the legal requirements of the MHA.

Section 17 leave forms have been updated since the last inspection to include patient agreement or involvement to leave. During the inspection we noted that some staff were not completing the most up to date versions of these forms. It is important that all staff complete the most up to date form which contains the patient's signature.

The registered provider must ensure that the most up to date Section 17 leave form is completed.

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

We reviewed the Care and Treatment Plans (CTPs) of four patients. The records evidenced a fully completed and current overall physical health assessment and standardised monitoring documentation, such as NEWS and MUST. In addition, there were standardised assessments based on the individual patient needs.

Strategies for prevention and management of behaviours of concern were contained in patient care plans and risk management profile. Staff were provided with skills to manage and defuse difficult situations through training.

Comprehensive Positive Behavioural Support plans are written by the Psychology team. There is dedicated high quality focus on the importance of engaging in activities both on and off the unit supported by a dedicated team including several Occupational Therapists.

It was positive to see that care files clearly showed patient involvement in care discussions, which were patient focussed and signed by the patient. Records also included evidence of the patient voice to reflect their views.

There was evidence that care plans are reviewed regularly by staff and updated to reflect current needs and risks. Physical health monitoring is consistently recorded in patient records. Risk management plans were good with detailed risk assessments and risk management strategy plans, these plans also evidenced physical health considerations for staff to consider when physical interventions were required.

In addition, there was evidence of active planning and discharge planning for long term placements.

Quality of Management and Leadership

Staff Feedback
We invited staff to complete HIW questionnaires following the inspection to obtain their views on the service provided at the hospital. In total, we received 18 responses from staff at the setting. Some questions were skipped by some respondents, meaning not all questions had 18 responses. We also spoke to staff during the inspection.

Staff told us that the culture on the ward was positive, and that they would feel confident in raising a concern and knew the process of how to do so, and we saw evidence to confirm this. Staff also said they enjoyed working on the ward and they were a supportive team.

Staff comments included:

> *"There's a pride within the team about how we look after patients"*
>
> *"Staff care about the wellbeing of each other as well as patients and work as a team to support one another during stressful or challenging periods at work"*

Governance and accountability framework
There was a clear organisational structure in place which provided clear lines of management and accountability. They defined these arrangements during the day, with senior management and on-call systems in place for the night shift.

It was positive to see that senior staff attended when notified of the inspection team's arrival and were on hand to provide additional support.

The day-to-day management of the hospital was the responsibility of the unit managers, assisted by the deputy managers.

There was clear, dedicated and passionate leadership from unit staff, who are supported by committed multidisciplinary teams and senior hospital managers. 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. Most staff spoke positively about the leadership at the hospital. Most staff also

spoke favourably about the support from colleagues working within the hospital and reported a good team-working ethos at the hospital.

Arrangements were in place to quickly share information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helped to maintain patient safety and continuous improvement of the service provided.

Although not noted during the inspection, some staff in the questionnaire suggested that the senior management team and MDT did not always communicate clearly and effectively throughout the wider organisation in terms of decision making or why specific decisions have been made.

The registered provider should reflect on this feedback and improve methods of communication and explanations on decision making to the wider organisation.

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

We reviewed a sample of informal and formal complaints and saw 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.

Arrangements were in place to quickly share information and lessons learnt 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 recruitment and employment practices
Staff we interviewed spoke passionately about their roles, and throughout the inspection we observed a strong cohesive team working together. Staff were able to access most documentation requested by the inspection team in a prompt and timely manner, demonstrating that there are good governance systems in place.

There were systems in place to ensure that recruitment followed an open and fair process. We were told staff references were checked prior to employment. Disclosure and Barring Service (DBS) checks were undertaken, and professional qualifications were checked. Therefore, we were assured that recruitment was undertaken in an open and fair process.

Newly appointed staff undertook a period of induction under the supervision of the experienced ward staff. Staff showed us documentary evidence and talked us through the systems of induction in place.

We were provided with a range of policies, the majority of which were up to date, however, the rapid tranquilisation policy was due for renewal in December 2022.

The registered provider must ensure that the rapid tranquilisation policy is reviewed and updated.

Workforce planning, training and organisational development
The inspection team considered staff training compliance and provided with a list of staff mandatory training compliance. Training figures provided to us on the inspection indicated that overall compliance figures were 95% for Juniper and 99% for Larch.

We saw evidence of staff annual appraisals and supervision in staff files and staff told us that supervision takes place on a regular basis.

Staffing levels were appropriate to maintain patient safety within the hospital at the time of our inspection. We were told that agency staff are used, however when there are shortfalls the hospital will try and use regular agency staff who were familiar with working at the hospital and the patient group.

Some patients told us that there are insufficient staff available on general observations to support patient requests. Patients told us that they are frustrated because there are no other staff available other than those on enhanced observations. Patients explained to us that when the staff providing general observations go on breaks, there are often no staff are available to accommodate patient requests.

Rotas and scheduling of staff breaks should be reviewed to improve this aspect for patients. This was also supported in the staff questionnaire feedback where staff reported that due to staff shortages, they often do not have time to facilitate patient requests for drinks, breaks outside or patient activities.

The registered provider must ensure that scheduled breaks for staff on general observations are reviewed and that enough staff are available to meet the requests from the patient group.

We noted there were staff nurse vacancies, and we were told about recruitment initiatives being undertaken to attract new staff.

Staff also told us that they would feel secure raising concerns about patient care or other issues at the hospital and felt confident that the hospital manager would address their concerns. A whistleblowing policy was in place to provide guidance on how staff can raise concerns.

Results from the questionnaire also confirmed that all 18 respondents knew how to report unsafe practice and would be confident in reporting. However, some respondents indicated that their workplace was not supportive of equality and diversity matters in relation to staff.

The registered provider must undertake further work to ensure that all staff feel supported on equality and diversity matters in the workplace.

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 identified on this inspection			

Appendix B - Immediate improvement plan

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.

Service: Pinetree Court Hospital

Date of inspection: 21 – 23 October 2024

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No Immediate Assurances identified on inspection					

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: Pinetree Court Hospital

Date of inspection: 21 - 23 October 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.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	We did not observe any bilingual posters and patients and staff we spoke to were unaware if information was available bilingually.	The registered provider must ensure that patients are aware of the active offer of speaking Welsh to patients and staff area aware of how to access bilingual information.	Communicating Effectively	We are printing bilingual posters and information to display at the hospital, we have a commitment to deliver and offer an "Active offer" and have a designated staff member who can speak Welsh. We have also displayed a series of bilingual greetings on both of the wards	Julie Nolloth Hospital Direction	1 week

2.	Patients told us that when they are on observations some staff will speak to each other in their native language and this often causes the patients to become unsettled.	The registered provider must ensure that during observations staff engage with patients and take appropriate measures to minimize stress amongst the patient group.	Communicating Effectively	We have communicated the findings and recommendations of the inspection report to staff and reminded all staff to be mindful of using native languages when interacting with each other - we have provided education and advised the staff team that patients at Pinetree have a learning disability and communication is often a struggle - patients can often become anxious and display paranoia if they cannot understand the speech of others. This can make them feel disrespected, and angry, this message will be reiterated and	Julie Nolloth Hospital Director	1 week - ongoing education

				communicated on handovers and spot checks will occur by management.		
3.	Patients told us that when damage is caused to their doors, the damaged areas aren't replaced	The registered provider must ensure that any damaged fixtures or fittings are replaced or repaired immediately to make the environment safe for the patient group.	Citizen engagement and feedback	We have an electronic maintenance system in place (Infraspeak) all damages are reported via this system and addressed with our hospital maintenance. As soon as an incident is reported it is logged on the system. We have an emergency maintenance on call who will repair and make the area safe until a full assessment of the area can be conducted. On occasions, we may have to wait for parts / all doors must be to fire regulation standards. However, moving forward it has been agreed for a	Julie Nolloth Hospital Director Maintenance team	Within 24 hours if possible

				stock of doors to be held by the maintenance team to allow us to respond timely.		
4.	Most patients told us that they don't feel involved in menu planning and the quality and portion sizes of food requires improvements.	The registered provider must ensure that menu choices and portion sizes improve, and opportunities should be provided for patients to be involved in menu planning.	Citizen engagement and feedback	We have met with the kitchen manager and the head cook to agree an improvement plan. We have agreed that the head cook will attend patient meetings once a month. The head cook has agreed that patients can ring the kitchen and speak directly to her if they are unhappy about any aspect of their meal. This has been communicated to the patient group. The potion sizes are governed by the dietitian and the eat well plate guidance - however we recognise	Julie Nolloth Hospital director Dean Laud kitchen manager	1 month - on going quality checks

				that people have different ideas of portion sizes and if there are individual concerns moving forward, then we link in with the dietitian to offer a solution. Patients were involved in planning a menu and the head cook is planning on doing some taster sessions with the patients in the New Year. There is always a healthy option and a vegetarian option on offer.		
5.	Patients told us that fruit choices were limited.	The registered provider must that a variety of fresh fruit is available to patients daily.	Citizen engagement and feedback	We have spoken to the kitchen to increase the amount of fruit available and will provide more choice and healthy snack options.	Julie Nolloth Hospital Director Head chef Pinetree	1 week – on going

6.	We identified that some patients had missed medication due to lack of stock.	The registered provider must ensure that robust checks are undertaken on medication to ensure that all patient medication is available.	Medication management	The clinical lead checks the electronic dashboard daily and this is nominated to one of the nurses if she is away. Boots Pharmacy audit occurs weekly. Nurses by night also check stock on both units and cross check this against the dashboard to ensure there is no missed stock. Any medication which is due to expire is discussed within the GP clinics held on site in PTH. Any individual cases where there is out of stock medication will be investigated by the Clinical Lead for future learning.	Hannah McGrath Clinical lead	24 hours
7.	Current process of administering medication from	The registered provider should undertake a risk assessment on current process of administering	Medication management	Both medication rooms are locked and are accessible only by the nurse's fob. This	Hannah McGrath Clinical lead	1 week

	unlocked medication room requires review.	medication and determine if a more robust system could be implemented.		followed the recommendation from the HIW inspection in 2021. In Larch the medication room is accessed through a main office door through another door to the clinic where the medication trolley is stored. The main office door should not have been open - communication has been sent to all nurses to make them aware of this - The clinic room door should be shut at all times. Communication has been sent and addressed with all Nurses in supervision - and all agency nurses have been made aware.		

8.	Some staff were not completing the most up to date versions of Section 17 leave forms.	The registered provider must ensure that the most up to date Section 17 leave form is completed.	Mental health act monitoring	All old section 17 forms have been removed from the electronic system and paper copies on reception – only the updated ones are now in circulation and communication has been circulated to the staff team advising them to only use the new form.	Julie Nolloth Hospital director	Immediately addressed
9.	Some staff commented that communication from the senior management team and MDT is not always communicated clearly and effectively throughout the wider organisation in terms of decision making or why specific decisions have been made.	The registered provider should reflect on this feedback and improve methods of communication and explanations on decision making to the wider organisation.	Communicating Effectively	In order to increase communication from the MDT and senior management team to the wards all morning meeting discussions and decisions are now recorded by the hospital manager or clinical lead on Nourish, which is immediately available to the staff team. The clinical lead has produced a feedback		

				sheet for the MDT to complete with the patient following the MDT meeting, so staff are immediately aware of any actions implemented following MDT.		
10.	Rapid tranquilisation policy was due for renewal in December 2022.	The registered provider must ensure that the rapid tranquilisation policy is reviewed and updated.	Medication management	This has now been updated and is incorporated into the medicine management policy.	Julie Nolloth Hospital director Policy working group	Completed
11.	Patients stated that insufficient staff are available to accommodate their requests such as breaks and access to personal items.	The registered provider must ensure that scheduled breaks for staff on general observations are reviewed and that enough staff are available to meet the requests from the patient group.	Workplace planning training and organisational development	The unit managers and the management team are in regular consultation with the wards re planning of the shifts and facilitation of breaks, with extra staff allocated to cover staffing breaks. By day there is 1 staff allocated to 2 general patients and by night there is 1 staff	Julie Nolloth Hospital Director Operations Director Sarah House	24 hours

				allocated to 3 general patients. There are also ‘additional’ staff allocated to each ward to support with activities, staff breaks and Section 17 leave. Unit Managers also attend a weekly meeting with the Board of Directors and if any concerns are raised by staff or patients staffing numbers are reviewed and amended accordingly.		
12.	Some respondents to the questionnaire indicated that their workplace was not supportive of equality and diversity.	The registered provider must undertake further work to ensure that all staff feel supported on equality and diversity matters in the workplace.	Workplace planning training and organisational development	We are engaging with the staff team in relation to this point and other areas of the inspection report for feedback on how to improve the service and ensure all members of the team feel valued and appreciated. Any actions will be added	Julie Nolloth Hospital Director Wellbeing officer	1 month

				to the Governance agenda for discussion and implementation.		

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: **Julie Nolloth**

Name (print): **Julie Nolloth**

Job role: **Hospital Director**

Date: **16th December 2024**