Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

St Peter's Hospital

Iris Care Group

Inspection date: 18,19 and 20 November 2024
Publication date: 20 February 2025

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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.

St Peter's hospital provides a service for patients with a diagnosis of Organic Brain Disorder, Dementia or Acquired Brain Injury who may be liable to be detained under the Mental Health Act 1983.

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 and 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. No questionnaires were completed by patients, carers or staff.

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:
We found a dedicated staff team that were committed to providing a high standard of care to patients.

Overall, we found that patients are provided with timely, safe and effective 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 spoke highly of staff and told us they were treated well by staff and felt safe.

This is what we recommend the service can improve:

- Improvements to outdoor environment to improve patient experience.

This is what the service did well:

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

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.

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 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 family involvement.

We viewed a sample of Medication Administration Records (MAR charts) and found they were being maintained to a good standard. The statutory detention documentation we saw was compliant with the Mental Health Act and Code of Practice.

This is what we recommend the service can improve:

- Key security.

This is what the service did well:

- Staff interacted and engaged with patients respectfully
- Good standard of care planning
- Safe and effective medication management.

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 unit managers and senior leadership team.

We found an effective governance structure in place in terms of meetings to discuss incidents, complaints and issues related to patient care.

This is what we recommend the service can improve:

- Role of night shift co-ordinator.

This is what the service did well:

- Completion rates of mandatory training across all units
- Motivated and patient focussed staffing group
- Recruitment and retention of staff.

3. What we found

Quality of Patient Experience

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, books, and music therapy. Patients had access to large outdoor spaces, and during the inspection we observed patients accessing and frequently using this space.

Records we reviewed confirmed that patients were able to access GP, dental services and other physical health professionals as required.

Services are also provided by other professionals, such as physiotherapy, dietetics and speech and language therapy, in line with individual patient needs. Our review of patient records confirmed detailed and appropriate physical health assessments and monitoring. We saw that patients at St Peter's had hospital passports.

We observed health promotion leaflets and details of support organisations available in the hospital for patients.

Dignity and respect
We found that all employees engaged with patients appropriately and treated them with dignity and respect. This included unit staff, senior management, and administration staff.

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

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

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

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, healthy eating, advocacy services and how to make a complaint or raise a concern. Easy read patient information guides were also available for patients on each unit.

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. This information was also available in Welsh.

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 was a clear mutual respect and strong relational security between staff and patients. 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.

There were several easy read documentation posters available to help staff understand and provide individualised care for the patient.

For specific meetings, and where applicable, patients can receive support from external bodies to provide support and guidance, such as solicitors or patient

advocacy services. With patient agreement and wherever possible, their family members or carers were included in these meetings.

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 the occupational therapists 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 we reviewed 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 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.

Patient meetings were taking place, and these were minuted. One issued raised in the meeting minutes we reviewed were the lack of outdoor shelters available in the garden area. During our inspection we confirmed that there were no sheltered areas to protect and allow the patients to continue using the garden areas during any adverse weather conditions.

The registered provider should consider installing shelters to enable the patients to use the garden area during all weathers.

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
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.

We noted a set of keys had gone missing, but were assured that access could not be achieved if they were found by the public, and that a new security system is being implemented shortly after the inspection which would be more robust.

The inspection team considered the hospital environment and noted some improvements required:

- Ripped armchair in the lounge area of Lower Caldicot requires fixing or replacing
- Glass server in Caldicot was cracked and needs replacing
- Table in TV lounge in Raglan was chipped, worn and damaged
- Extractor fan in the communal bathroom on Raglan Unit was very loud and could disturb patients who are asleep.

The registered provider must address the environmental issues and resolve them in a prompt and timely manner.

Managing risk and health and safety
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. 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 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 fully complete at the time of the inspection.

Infection prevention and control (IPC) and decontamination

We found suitable IPC arrangements in place at the hospital. A range of up-to-date policies were in place to support staff with infection prevention and control procedures, to maintain patient and staff safety. Regular audits had been completed to check the cleanliness of the environment and check compliance with hospital procedures.

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

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

Staff compliance with mandatory IPC training was 100 percent and was being continually monitored to ensure staff remained in compliance.

Nutrition

Patients were supported to meet their dietary needs, and we noted 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). 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

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

There was a controlled drugs cabinet which met the required standard. A controlled drugs book and Drugs Liable for misuse book were also available on the units.

There was regular pharmacy input and audit undertaken on a weekly basis that helped the management, prescribing and administration of medication on all units.

We observed several medication rounds, and saw staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately.

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 managers 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
Newsletters and quarterly themes and feedback from other hospitals within the IRIS group are disseminated to staff, which contain good new stories and key learning topics.

A new records management and audit system was in place and staff feedback on the system was positive.

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 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 and paper records were stored securely. The records we viewed were well organised, easy to navigate and contained detailed and relevant information.

In records we reviewed we identified that capacity assessments were being completed but were very brief and didn't inform the decision-making process.

The registered provider must ensure that the decision-making process is documented within capacity assessments.

There was evidence that patients could access advocacy and where appropriate staff referrals to advocacy were made on behalf of the patient. Advocacy visit at least twice monthly and more frequently as required by individuals.

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.

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 GPs attending the hospital and contributing to patients health needs.

Management of patient behaviours were reflected in their care plans and risk management profile, along with staff training, to use skills to manage and defuse difficult situations.

It was positive to see that the clinical records clearly showed patient and family involvement in care discussions, which were patient focussed. Records also included evidence of the patients' voice to reflect their views.

There was evidence that care plans are reviewed regularly by staff and updated to reflect current needs and risks. Risk management plans were good with detailed risk assessments and risk management strategy plans.

Mental Capacity Act and Deprivation of Liberty Safeguards
Mental capacity assessments were being undertaken as required, when Depravation of Liberty Safeguards (DoLS) referrals were made.

We reviewed one DoLS Record, and this evidenced that the correct procedures had been followed relating to DoLS applications. It was evident that the processes were being applied appropriately, however, we identified that there was a backlog of patients waiting to be assessed by the local authority. It was positive to see that the situation is closely monitored by the hospital director on a 'live data' system.

The hospital must liaise with the local authority to ensure that the local authority is completing assessment requests in accordance with the statutory timescales set out in the Mental Capacity Act.

Quality of Management and Leadership

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.

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 hospital staff. Staff showed us documentary evidence and talked us through the systems of induction in place.

We were provided with a range of policies, all of which were up to date.

Workforce planning, training and organisational development
The inspection team considered staff training compliance and we were provided with a list of staff mandatory training compliance. Training figures provided to us on the inspection indicated that overall compliance figures for Brecon Unit were 93.96%
Raglan Unit were 94.41% and Caldicott were 92.13%. This was an area of improvement since the last inspection.

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 units at the time of our inspection. We were told that agency staff are used, however this is rare but 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.

The hospital currently had no staffing vacancies. A new clinical lead was due to be appointed but was not in role at the time of the inspection. Staff sickness rates were also low.

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, and we saw evidence during the inspection of whistleblowing concerns and how the hospital had responded and addressed these. Reflective practice sessions and additional training sessions had been put in place after some recent whistleblowing concerns and staff surveys had been provided to staff, a report was due to be completed but had not been published at the time of the inspection.

An additional nurse position had been introduced onto night shifts as a 'floater' to work across all units at night to ensure that there was adequate cover for breaks. This was a relatively new role and on the first night of our arrival there was some confusion over who was responsible for providing information to the inspection team regarding the hospital staffing and patient group.

The registered provider must ensure that the dedicated additional night nurse has relevant information and knowledge on the staffing and patient group to provide to an external visitor.

It was positive to see that senior management undertake unannounced night shift audits. These visits ensure that staff are complying with observations, policies and procedures and provide regular night shift workers with the opportunities to engage with senior management.

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.			

Appendix B – Immediate improvement plan

Service: St Peter's Hospital

Date of inspection: 18 – 21 November 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.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate assurances.					
2.						
3.						
4.						

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: 18 – 20 November 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.	There were no sheltered areas to protect and allow the patients to continue using the garden areas during any adverse weather conditions.	The registered provider should consider installing shelters to enable the patients to use the garden area during all weathers.		We have rearranged the main Brecon and Caldicot garden area to allow for seating to be placed under the shelter to make it a more useable space. We are currently in the process of purchasing a	Hospital Director / General Manager	3-months

				new shelter for Raglan.		
2.	Ripped armchair in Caldicott lounge.	The registered provider must ensure that the ripped armchair is fixed or replaced.		The chair was removed immediately and is being re-covered. Unit Managers environmental audit has been re worded to ensure damaged furniture is removed immediately and placed on maintenance request system for re upholstering.	Hospital Director / General Manager	Completed (awaiting the chair to be delivered when completed)
3.	Glass server in Caldicott was damaged and cracked.	The registered provider must ensure that the glass server is fixed or repaired.		The server is not glass it is Perspex and has cracked. We are currently trying to source a replacement. In the interim there is no safety or risk presented to the patients.	General Manager	3 months

4.	Table in the tv lounge area of Caldicott was worn and damaged.	The registered provider must ensure that the table is fixed or replaced.		The table has been removed and replaced. Managers environmental audit has been re worded to ensure damaged furniture is removed immediately and placed on maintenance request system for replacement.	General Manager	Completed
5.	The extractor fan in the communal bathroom on Raglan Unit was loud and needs to be reviewed.	The registered provider must ensure that the noise level from the extractor fan is reduced.		This has been raised with maintenance and replacement is currently being sourced.	General Manager	3 months
6.	Capacity assessments were being completed but were very briefed and didn't inform the decision-making process	The registered provider must ensure that the decision-making process is documented within capacity assessments.		The MCA and DOLs Policy & Procedure has been re circulated to the SMT and our Ethics and Safeguarding Lead will be facilitating training during our SMT meeting to ensure MCA documentation is completed accurately.	Hospital Director	2 months

7.	There was a backlog of patients waiting to be assessed by the local authority.	The hospital must liaise with the local authority to ensure that the local authority is completing assessment requests in accordance with the statutory timescales set out in the Mental Capacity Act.		The Hospital Director has sent communication to the local authorities in relation to outstanding DOLS assessments. Since Your visit we have had a number of patients assessed and we are waiting to hear back. We have chased the DOLS team again in regards to the current outstanding assessments. We have also introduced a monthly audit in relation to outstanding DOLS assessments which will be chased monthly by the HD moving forward.	Hospital Director	1 month
8.	On the first night of the inspection there was some confusion	The registered provider must ensure that the dedicated additional night		The role of the Senior Nurse on Site (SNOS) will be reinforced with	Hospital Director	1 month

	over who was responsible for providing information to the inspection team regarding the hospital staffing and patient group.	nurse has relevant information and knowledge on the staffing and patient group to provide to an external visitor.		all nursing staff to ensure they are aware of their responsibilities, but also how to access the correct information and support if required.		

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: **02/01/25**