Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection (Unannounced)

St Peter's Hospital/Wards:

Brecon, Raglan and Upper Raglan/ Ludlow Street Healthcare

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Contents

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

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection of St Peter's hospital on 14 - 16 May 2018. The following wards were visited during this inspection:

- Brecon
- Raglan
- Upper Raglan

Our team, for the inspection comprised of a HIW inspector who led the visit, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one lay reviewer.

During this inspection, we reviewed specific documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with Act.

HIW explored how the service complied with the Care Standards Act 2000, requirements of the Independent Health Care (Wales) Regulations 2011 and met the National Minimum Standards (NMS) for Independent Health Care Services in Wales. Where appropriate, HIW also consider how services comply with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Further details about how we conduct independent mental health service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, we found evidence that St Peter's hospital had systems and processes in place to provide safe and effective care. We observed patients being treated with respect and kindness.

We have identified a number of recommendations which will improve the services provided to the patient and staff group.

This is what we found the service did well:

- Interactions between staff and patients were caring and professional
- The hospital had a strong, clinical multidisciplinary team which meant that patients had immediate access to a range of specialities
- Good links had been established with local general practitioners (GPs) and a hospice to support patient care
- Specialist training was provided for staff to ensure patient care could be delivered to the highest standard
- All staff had access to, and were seen to be wearing personal alarms.

This is what we recommend the service could improve:

- Areas of the environment need to be improved
- The provision and suitability of patient information to be improved and displayed on all wards
- Some improvements to the Mental Health Act documentation is required, specifically the recording of statutory consultees[1]

[1] A second opinion appointed doctor (SOAD) is required to consult two people (statutory consultees') before issuing certificates approving treatment. One of the statutory consultees must be a nurse; the other may not be either a nurse or a doctor. Both must have been

discussions with second opinion appointed doctors (SOAD)[2] and the outcomes of hospital manager's[3] reviews should be fully documented

- All clinical rooms must be free of patient belongings and staff food items. In addition, staff need to ensure that cupboards, fridges and trolleys are locked when not in use

- Improved communication is required to ensure all staff are aware of key messages regarding patient care and other important issues.

There were no areas of non compliance identified at this inspection.

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professionally concerned with the patient's medical treatment and neither may be the clinician in charge of the proposed treatment or the responsible clinician (if the patient has one).

[2] An independent doctor appointed by Healthcare Inspectorate Wales who gives a second opinion on whether certain types of medical treatment for mental disorders should be given without the patient's consent.

[3] The organisation (or individuals) responsible for the operation of the Act in a particular hospital. Hospital Managers have various functions under the Act, which include the power to discharge a patient. In practice, most of the hospital managers' decisions are made on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff.

3. What we found

Background of the service

St Peter's Hospital at Chepstow Road, Llandevaud, NP18 2AA was registered with HIW during January 2014 and is currently registered to provide care to a maximum of 33 patients within three separate units as shown below in the registration schedule. The hospital was previously registered as Llanbedr Court.

The 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.

- Brecon Unit - A maximum of 18 persons of the same gender over the age of 30 with a diagnosis of:
    - Huntington's disease
    - Alzheimer's disease, Vascular Dementias, Pick's disease
    - Korsakoff's whose level of functioning requires hospital care
    - Acquired Brain Injury whose needs are compatible with the patient group.
- Raglan Unit - A maximum of 10 persons of the same gender over the age of 30 with a diagnosis of:
    - Dementias
    - Organic disorders
    - Acquired Brain Injury whose needs are compatible with those above
    - Mental illness whose needs can be met in St Peter's Hospital.
- Upper Raglan - A maximum of 5 persons of the same gender over the age of 30 with a diagnosis of:
    - Huntington's disease
    - Alzheimer's disease, Vascular Dementia, Pick's disease

- Korsakoff's whose level of functioning requires hospital care
- Acquired Brain Injury whose needs are compatible with the patient group.

The service employees a staff team which includes a hospital manager, a clinical lead, two unit managers and a team of registered nurses and healthcare support workers. There are also multi-disciplinary team members which include consultant psychiatrists, psychologists, occupational therapists and technicians, dietician, speech and language therapists and a physiotherapist.

The hospital also employs a team of maintenance, catering and domestic staff. The day to day operation of the hospital is supported by a team of administration staff.

The hospital is overall supported by the management and organisational structures of Ludlow Street Healthcare.

Quality of patient experience

We spoke with patients,, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We observed good interactions between staff and patients which were caring and professional. We saw that staff upheld patients' rights and supported patients to be as independent as possible.

St Peter's hospital had established good links with local health care services which supported patient care.

We asked the registered provider to review areas of the environment that require improvement and to review issues raised by staff and patients regarding the number of hospital vehicles which were deemed to be insufficient to facilitate all community leave.

There was some information available for patients on the wards; however this needs to be reviewed to ensure it is appropriate for all patients to read and understand. In addition, the range of information available to patients must be relevant and clearly visible.

Health promotion, protection and improvement

There was a range of health promotion, protection and improvement initiatives available to the patients at St Peter's which assists in maintaining and improving patients' wellbeing. These included risk assessment and management, mobility programme, cognitive rehabilitation, treatment of degenerative neurological conditions, occupational and physio therapies and speech and language therapy.

There was limited information displayed on the wards to help improve patients' health, although it was difficult to ascertain if the information displayed could be understood by the patients due to the language and size of the print. Consideration should therefore be given to displaying information appropriate to the patient group.

St Peter's employed a mix of registered general, mental health and learning disability nurses, which ensured that the complex care needs of all patients could be met within the hospital.

Patients were able to access GP, dental services and other healthcare professionals in the community and at St Peter's. Access to such appointments was confirmed through conversations with patients and staff. Patient appointments were also documented in their care records.

There was a range of facilities to support the provision of therapies and activities at the hospital which included reminiscence therapy, pet therapy, music therapy, sensory therapies, relaxation and exercise therapies. The hospital staffing included two occupational therapists, two occupational therapy technicians, an activity co-ordinator and a physiotherapist.

The hospital had a dedicated activity centre which could be accessed by all patients from all the wards. The centre provided an inviting space for group and individual activities and therapies. A sensory[4] room, hair and beauty salon, reminiscence room and physiotherapy room were located here. We observed patients using the activity centre, participating in a breakfast group and coffee morning, as well as individuals using the sensory room.

The lounge area within the activity centre provided an opportunity for patients to participate in a range of art and crafts activities. Patients could also watch TV/films and listen to music.

There was a suitable room available on the ground floor for visitors. Staff told us that, on occasions, patients could receive visitors in their bedrooms and where applicable, home visits were organised. Staff also described the arrangements that are put in place to support families for any patient receiving end of life care at the hospital.

The hospital had two vehicles (one car and one mini bus) that were used to facilitate patient access to the community. Discussions with patients and staff

[4] A sensory room is a specially designed room which combines a range of stimuli to help individuals develop and engage their senses. These can include lights, colours, sounds, sensory soft play objects, aromas all within a safe environment that allows the person using it to explore and interact without risk.

however, highlighted that the number of vehicles was insufficient. As a result, there had been occasions when patients had their recreation time rearranged and/or cancelled in order for priority appointments to take place. We therefore recommended that this issue be reviewed to ensure patients get access to the community, in accordance with individual patient's care plan.

Improvement needed

The registered provider should review the frequency of patients having their community access rearranged/cancelled due to the unavailability of a hospital vehicle.

Dignity and respect

We observed staff interact and engage with patients appropriately treating them with both dignity and respect. In addition, we found that staff responded promptly and appropriately to patients thus preventing their behaviours escalating and becoming more challenging. The staff we spoke to were committed to providing dignified care for the patients. Also, the patients that we spoke with told us that they were treated with respect and kindness and were complimentary of the care, treatment and support provided at the hospital.

On each ward, patients had their own bedroom which contained a sink and furniture to store clothing and personal belongings. Patients had access to gender specific toilet and bathing facilities.

During our observation of the environment we noted that the default position for bedroom observation panels was in the closed position. Whilst this meant that anyone passing patients' bedrooms were prevented from seeing inside (which meant that patients' privacy was maintained), patients did not have the ability to open the blinds from inside their room if they wanted to. This meant that they had to ask staff to open the observation panel for them, from outside their room. Consideration should therefore be given to this matter.

Patient information and consent

There was information displayed within the reception/waiting area of the hospital which included advocacy, complaints, HIW registration certificate and corporate information.

On the wards, we saw some information for patients which included advocacy services. However, as mentioned previously, this information was in a format that not all patients would find suitable due to the language used and size of the

text. The range of information could also be improved across all wards to include:

- Visiting times
- Information about the Mental Health Act
- How to raise a concern or complaint
- Information about Healthcare Inspectorate Wales
- The registered provider should also consider displaying information using alternative formats, for example, easy read material.

We were told that the mental health advocate[5] provided regular drop in sessions at the hospital, whereby a representative would attend the hospital on a given day for patients to speak to with or without an appointment.

Improvement needed

The registered provider must ensure that there is information displayed which includes information on the Mental Health Act, how to raise a complaint, visiting times and information about Healthcare Inspectorate Wales.

The registered provider should consider displaying information in different formats to ensure all patients can access information in suitable and understandable formats

Communicating effectively

Through our observations of staff-patient interactions, it was evident that staff ensured they communicated appropriately and effectively with patients. Staff took time to undertake discussions using words and language suitable to the individual patient. Where patients remained unclear, or what was being

[5] Independent help and support with understanding issues and assistance in putting forward one's views, feelings and ideas. A broad group of people which includes independent mental health advocates (IMHAs)

communicated was misunderstood, staff would patiently attempt to clarify what they had said.

Handover meetings took place twice a day between two changing shifts which ensured continuity in relation to patient care and information.

For individual meetings, patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. With patients' agreement, wherever possible, their families and carers were also included in some meetings.

Care planning and provision

There was a clear focus on providing safe and effective care for patients at the hospital. Care was individualised and focused on appropriate treatment and interventions.

Each patient had their own programme of care based on their individual needs such as medication, therapy sessions and activities. These included individual and group sessions, based within the hospital and the community (when required authorisation was in place).

Equality, diversity and human rights

Staff practices aligned to established hospital policies and systems ensured that patients' equality, diversity and rights were maintained.

Mental Health Act detention papers had been completed correctly to detain patients at the hospital. However, the registered provider must implement some improvements to the application of the Act to fulfil its statutory duties under the Act and as set out in the Mental Health Act Code of Practice for Wales 2016. These are described later in the report.

Citizen engagement and feedback

Staff told us that patient meetings take place so patients can provide their feedback on the provision of care at the hospital. However, staff said that generally the same patients attend the meetings. Consideration should be given

to this issue to determine whether alternative approaches could be implemented to encourage views and participation from other patients.

Staff we spoke to told us that they will support any patient who wants to provide feedback or make a complaint. In addition, advocacy[6] services to the hospital provided independent support on behalf of patients and their families to raise concerns and/or feedback. We spoke to an advocate during our inspection visit who confirmed that feedback from senior hospital staff was provided on any issues that were raised.

Our observations on the wards highlighted there was no visible information on how patients and their families could provide feedback and/or make a complaint. We therefore recommended that such information is clearly displayed on all wards.

There was a complaints procedure in place at the hospital. All complaints were logged on a central database, which was accessible by head office staff. Complaint information was discussed at monthly clinical governance meetings to assist in identifying trends, making improvements and disseminating any shared learning.

A review of the complaints information established that the hospital manager was generally 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.

[6] Independent help and support with understanding issues and assistance in putting forward one's views, feelings and ideas. A broad group of people which includes independent mental health advocates (IMHAs)

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Overall, we found that there were systems in place to promote the delivery of safe and effective care to patients.

The hospital environment was generally furnished and decorated to a good standard and on the whole the hospital was well maintained throughout. However there were a few areas we observed that required attention.

We found that the administration of medicines was mostly managed safely but action needs to be taken to remind staff to ensure cupboards, trolleys and fridges are locked when not in use and non clinical items should not be stored in areas where medicines are kept.

Statutory detention documentation showed that an appropriate process had been followed to promote and protect patients' rights as required by the Mental Health Act. Some improvements are however required in relation to recording statutory consultees' discussions with the SOAD and ensuring patients are informed of the decision following a review by the hospital manager.

We found patients had Care and Treatment Plans as required by the Mental Health (Wales) Measure 2010. These were generally well organised and reflected the domains of the Measure. We recommended however, that unmet patient needs are documented for completeness of such plans.

Managing risk and health and safety

St Peter's hospital had processes in place to manage risk and maintain the health and safety of patients and staff. The hospital provided individualised patient care that was supported by managed positive risk taking, both in ward practices and care planning.

There was a level entrance in to the hospital from the hospital car park. Patient areas were on the ground floor and first floor of the hospital; there was a lift available to assist people with mobility difficulties. This meant that patients and visitors could access the premises safely.

Staff wore personal alarms which they could use to call for assistance if required. There were also nurse call points within patient bedrooms so that patients could summon assistance if required.

The furniture, fixtures and fittings at the hospital were appropriate for the patient group. However, one bedroom which was unoccupied at the time of our visit had furniture which created a potential ligature risk. Staff assured us that ligature risk assessments were completed for all patients and any risks would be removed or managed accordingly.

During the first night of our inspection we observed some environmental issues that required attention. One unoccupied bedroom had a damaged electrical socket. This was reported to staff at the time and we were informed the following morning that the socket had been sealed off prior to full repair taking place. Some areas required redecorating, including the quiet room on Raglan ward. The shelf bracket in the hair salon had become loose from the wall and some plaster work was chipped on Raglan ward which needed to be fixed. We observed some carpets/flooring to be stained and some bedroom furniture was chipped. A storage room on lower Raglan ward appeared cluttered with a mixture of staff belongings, patient items, Christmas decorations and continence care items. The room had stained and dirty flooring and there was a used tissue on the shelf. We highlighted these issues at the time and recommended this area was cleaned and used appropriately. Staff told us that the hospital does have a rolling programme of redecoration and that environmental reviews are undertaken. The hospital also had maintenance staff on site that should ensure the above issues identified are addressed promptly.

We saw large clocks in some patient areas; coloured bedroom doors which helped patient's orientation within the ward. Patients had their own memory boxes located next to their bedroom door, which contained photos and other personal items.

Staffing levels during our visit were appropriate for the current patient group; however concerns were raised by staff and patients regarding insufficient staffing levels. We were told that staff who had been allocated to care for patients, who required close observation, were regularly taken away from their planned duties to assist colleagues with patients in other parts of the ward and/or hospital. This meant that patients who should be constantly supervised

were not. In addition, the recording of patient observations had to be completed retrospectively. This matter must be addressed by the registered provider to ensure that patients receive care as planned and to assist staff in recording care and treatment in accordance with professional guidelines.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the system that included the names of patient(s) and staff involved, a description, location, time and length of the incident. Discussions with senior staff confirmed that incidents as well as complaints and safeguarding, were discussed monthly at governance meetings with action being taken by the service as required.

Improvement needed

The registered provider must review the environment to ensure the patient areas identified within this report are repaired and fit for purpose. Specifically, the electric socket must be repaired before the bedroom is allocated to a patient. Plasterwork to be fixed and repainted including the quiet room on Raglan ward. Carpets/flooring should be cleaned and damaged/chipped bedroom furniture should be repaired and/or replaced.

The registered provider must ensure that sufficient staff are available to support patients requiring additional help and that staff are not taken away from observations which may leave wards/individuals vulnerable.

The registered provider must ensure that all paperwork being completed is accurate and is not completed retrospectively. This is in accordance with current professional guidelines.

Infection prevention and control (IPC) and decontamination

The registered provider employs dedicated housekeeping staff at St Peter's hospital. The communal bathrooms, showers and toilets were clean, tidy and clutter free during our inspection. Cleaning equipment was also stored and organised appropriately. Staff also received training in infection prevention and control which had a high compliance rate.

Generally, throughout our visit we observed the hospital to be visibly clean and free from clutter. However, on Brecon ward during our night visit there was a strong smell of urine, which was reported to staff at the time.

Laundry facilities were available on site which were in working order and well maintained. Each ward had their own laundry trolley and the industrial washing machines and dryers had settings suitable for contaminated washes.

There were hand hygiene products available in relevant areas of the hospital. Staff also had access to infection prevention and control and decontamination personal protective equipment (PPE) when required.

There were sluice rooms on each ward and cleaning schedules in place throughout the hospital. Contract cleaners are used to undertake deep cleaning.

There were suitable arrangements in place for the disposal of waste. Appropriate bins were available to dispose of medical sharp items. These were not over filled.

Nutrition

At the time of our visit, St Peter's hospital were working in partnership with an external catering provider to deliver a different dining experience for the patient group. Discussions with staff highlighted that the new dining experience will enable patients to choose their food on the day (for lunch and evening meals) rather than making their food choices a day in advance. Staff told us that food will be served on each ward and will allow patients to have exactly what they want because there will be more choice and provision.

The hospital was waiting for equipment and pictorial menus before being able to fully deliver the new dining experience.

During our visit, we observed some mealtimes and saw that patients were given a choice of what they wanted to eat. Staff told us that patients were provided with a choice of meals on a rolling four-week menu. Some wards displayed the four week menu but it was hard to distinguish which week was applicable and this issue was confirmed with staff when discussed with them. This meant that patients were not provided with clear information about this important aspect of care.

The menus varied seasonally through the year and this will continue with the new dining experience.

Patient feedback on the meals and menu options were being collated and this will assist in the review of the new dining experience and menu options. The patients we spoke with during our inspection generally spoke positively about the food provided at the hospital.

There was a kitchen on each of the wards that patients could access with staff for drinks and snacks throughout the day and night.

An occupational therapy kitchen was situated within the activity centre and provided patients opportunities to prepare and make food, either as part of a group or individually.

St Peter's hospital had a dedicated dietician and a speech and language therapist. Both professionals were involved in assessing and reviewing patients' needs on a regular basis and where applicable, would make referrals. Staff at St Peter's hospital were supported by the dietician and speech and language therapist in delivering specialist feeding processes and with knowledge of how to deal with patients' swallowing problems. Families/carers were also given information on specialist feeding and how to deal with their relative's swallowing difficulties, so that they could support them when on leave.

Medicines management

We reviewed all of the hospital clinics and the physiotherapy room and found that, in general, medicines management was safe and effective.

Overall, the administration of medication was managed safely with medication being stored securely within cupboards and locked medication trolleys. The hospital’s process is to take prescribed medication to patients in a secure box and we observed this being adhered to. However, we noted during both the night and day visit that staff were not locking cupboards or the medication trolley when leaving the clinical room. Although the clinical room was locked this must still be addressed as there remains a risk of unauthorised access to medication, thus resulting in there being potential harm to patients.

We also identified some out of date medication and tablets that were loose within a box. We asked that staff dispose of these at the time of our visit.

There was regular pharmacy input and audit undertaken that assisted the management, prescribing and administration of medication at the hospital.

There was evidence that there were regular temperature checks of the medication fridges within each clinic room to ensure that medication was stored at the manufacturer's advised temperature.

There were appropriate arrangements for the storage and use of Controlled Drugs. We found these were accurately accounted for and checked daily.

We found that random and inappropriate items were being stored within the clinical rooms, including patient belongings and staff storing food items. This was discussed with staff at the time and we recommended that all inappropriate items were removed.

There were occasions whereby a patient had refused to take the medication at the time prescribed to them. It was noted that staff would try to administer this later in the day. However, there was no evidence to corroborate that this course of action had been discussed or was in fact supported by the MDT. We therefore recommend that this issue be addressed and that any medication being given outside the times documented on the prescription charts be supported by a MDT decision confirming this practice.

Improvement needed

The registered provider must remind staff to ensure cupboards, fridges and trolleys are locked when not being used.

The registered provider must ensure that clinical areas are not used to store inappropriate items including patient belongings and staff food.

The registered provider must ensure that prescribed medication is administered in accordance with written instructions from medical staff.

Safeguarding children and safeguarding vulnerable adults

There were established processes in place to ensure that the hospital safeguarded vulnerable adults and children, with referrals to external agencies being made as and when required.

Medical devices, equipment and diagnostic systems

There were regular clinical audits taking place at the hospital and checks of resuscitation equipment which were undertaken when required. At the time of our visit, we saw that the blood pressure machine and temperature machine were overdue calibration[7], both due in December 2017 and one oxygen saturation machine was not working.

The hospital had five oxygen cylinders in total, including one small cylinder in the emergency bag. We noted that two cylinders were empty and one nearly empty but were advised that replacements had been ordered. We recommend

[7] If you calibrate an instrument or tool, you mark or adjust it so that you can use it to measure something accurately.

that new Oxygen cylinders are ordered as and when they become empty thus ensuring that there are sufficient cylinders available to cope with emergencies.

Improvement needed

The registered provider must ensure medical equipment is maintained appropriately so it is fit for purpose. Specifically the blood pressure and temperature machine require calibration and one oxygen saturation machine to be repaired.

The registered provider must ensure that sufficient oxygen cylinders are available with sufficient levels of oxygen within them to administer to patients in an emergency.

Safe and clinically effective care

Overall, we found governance arrangements in place that helped ensure that staff provided safe and clinically effective care to patients. The outcome of governance arrangements at the hospital fed through to the wider Ludlow Street Healthcare governance arrangements which facilitated a two-way process of monitoring and learning.

Records management

Patient records were a mixture of paper files and electronic records. The electronic records were password protected to prevent unauthorised access and breaches in confidentiality, and the paper files were stored and maintained within each ward's nursing office. However, during our night visit, a patient's file was left in the board room. Although the door was locked, patient information should always be returned to the ward when it has been finished with, and kept securely.

We reviewed a sample of patient records across the wards. It was evident that staff from across the multidisciplinary teams, were writing detailed and regular entries which provided a live document about each patient and their care.

In general, of the records we reviewed, we found documented, clear accountability and evidence of how decisions relating to patient care were made. The records were of a good standard in terms of accuracy, completeness and legibility.

Mental Health Act Monitoring

We reviewed the statutory detention documents of four patients across three wards, which included Raglan, Upper Raglan and Brecon.

The four sets of statutory documentation verified that the patients were legally detained at St Peter's hospital. It was evident that detentions had been applied and renewed within the requirements of the Mental Health Act and reflected the Code of Practice. Copies of legal detention papers were available within patient files.

Consent to treatment certificates were kept with the corresponding medication record. This meant staff administering medication could refer to the certificate to ensure that medication was prescribed under the consent to treatment provisions of section 58 of the Mental Health Act.

We saw that advocacy services were integral to the hospital service and independent advocacy was made available to all patients and their families.

The patient risk assessments we reviewed were detailed and completed appropriately. Section 17 leave[8] forms had risk assessments and conditions for leave were clearly documented.

We identified some issues that we asked the registered provider to review to ensure full compliance with the Act. These included:

- There was not always a recording of the statutory consultee's discussions with the Second Opinion Appointed Doctor (SOAD) process. The 2016 Mental Health Code of Practice for Wales, paragraphs 25.56 - 25.62 provides guidance for statutory consultees and the recording of their discussions which would help evidence the practice at the hospital
- Some of the wards did not have copies of the Code of Practice (English and Welsh versions to be available)

[8] While a patient is detained in a hospital they can only leave hospital lawfully by being granted leave of absence in accordance with section 17 of the Mental Health Act 1983.

- Following a managers hearing panel, there was not a signature and date on the record to indicate that the patient had been informed of the outcome/s

- Within two care and treatment plans (CTPs), we saw reference to patients being on section 17 leave and subject to a Deprivation of Liberty Safeguard (DoLS) which is an amendment to the Mental Capacity Act. It is inappropriate to be subject to both and therefore required amending[9].

The Mental Health Act manager regularly attends the All Wales Mental Health Act Administrators Forum. This provides the opportunity to meet and engage with other Mental Health Act administrators across Wales to discuss common themes, issues and experiences whilst reflecting on existing practice assisting them to remain up to date with current changes in legislation, case law and practice. In addition, the manager was completing a post graduate course in mental health law, which will provide the organisation and patients with additional knowledge.

Improvement needed

The registered provider must ensure that both statutory consultees complete a record of their discussion with the SOAD and provide a clear rationale that underpins their decision.

The registered provider must ensure that the chairman of the hospital managers review panel informs the patient of the outcome and signs and dates the record or alternatively if a staff member informs the patient of the decision the same applies. If the patient has limited understanding then this must be recorded.

The registered provider must ensure that all wards have copies of the Code of Practice for Wales in both English and Welsh.

[9] Informal patients are not subject to leave requirements under section 17. A patient who is not detained has the right to leave, other than those patients subject to authorisation under the Deprivation of Liberty Safeguards. However, patients may be asked by staff to inform them when they want to leave the ward.

The registered provider should raise awareness with staff of the requirements of section 17 leave of the Mental Health Act and Deprivation of Liberty Safeguards in relation to patients leave.

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

We reviewed the care plans of two patients.

There was evidence that care co-ordinators had been identified for the patients and where appropriate family members were involved in care planning arrangements. The Care and Treatment Plans reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed.

Of the records we reviewed, we saw a wide range of physical health assessments had been undertaken to monitor and review patients' physical health. There was one oral assessment for one patient which had not been completed. The registered provider must ensure that all the required physical health documentation is completed as required.

It was evident from the records we reviewed, that staff were not clearly documenting any unmet needs a patient may have whilst being cared for at the hospital, despite this area being discussed at multi disciplinary team (MDT) meetings. It is important that unmet needs are documented so that these can be regularly reviewed by the multi-disciplinary team to look at options for meeting those needs.

Risk assessments were documented which clearly set out the identified risks associated with the delivery of safe and effective care to patients, and how to mitigate and manage them.

The care and treatment plans we reviewed documented whether the patient had been involved in their care and treatment plan and if they had capacity to agree to the treatment plan. In addition, there was evidence to support the efforts made by staff to ensure that the nearest relative and family member had been involved in patients' care and treatment planning (if the patient wished this to happen).

Improvement needed

The registered provider must document patients' unmet needs so these can be clearly reviewed and options looked at for meeting those needs.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Independent Health Care Regulations and National Minimum Standards.

We saw good management and leadership at St Peter's which was supported by Ludlow Street Healthcare. We observed a committed staff team who had a good understanding of the needs of the patients at the hospital.

There was a strong, clinical multidisciplinary team in place. However, consideration needs to be given to ensuring all disciplines are included in MDT meetings and that information about patient care and treatment is communicated to all staff.

Staff recruitment was undertaken in an open and fair process with appropriate employment checks being carried out prior to, and regularly during ongoing employment.

Staff had access to specialist training, which was specific for the patient group they were caring for and there were systems in place for regular supervision. However, appraisals need to be completed for all staff on an annual basis.

Governance and accountability framework

Overall, there were well defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit and its established governance structure which enabled key/nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care. Those arrangements were recorded so that they could be reviewed.

St Peter's hospital registered manager confirmed that there were open and constructive links between the hospital and the registered provider. This assisted with the delivery of care to patients.

Through our conversations with staff, observing multidisciplinary (MDT) team meetings and reviewing patient records there was evidence of strong MDT team-working. The multidisciplinary (MDT) staff we spoke to, also commented favourably on MDT working stating they felt their views were listened to and respected by other members. However, these meetings did not include healthcare support workers. The registered provider should consider inviting healthcare support workers to these meetings so they can contribute to discussions and feel actively involved in patient care.

During the observed MDT meetings no patients were present. Staff reported that patients were rarely invited. Consideration should be given to inviting patients to these meetings so that they can be actively involved in discussions about their care and treatment.

We found that staff were committed to providing patient care to high standards. However, concerns were raised by a number of health care support workers who felt that key changes to patient care, usually arising from MDT discussions, were not being communicated to them. Staff reported that they did not always feel involved fully in patient care.

It was positive that, throughout the inspection, the staff at St Peter's hospital were receptive to our views, findings and recommendations.

Improvement needed

The registered provider needs to review how communication amongst all staff grades and disciplines can be improved so that everyone feels actively involved in patient care. This would also ensure that any potential risk created by staff not being aware of changes in patients care, is avoided.

Dealing with concerns and managing incidents

As detailed earlier in the report, there were established processes in place for managing incidents at the hospital and these were monitored locally at St Peter's and corporately through reporting mechanisms.

There were systems in place for concerns to be reported and reviewed, but improved information for patients and families needed to be displayed.

Workforce planning, training and organisational development

We reviewed the staffing levels at St Peter's hospital, and that stated within their statement of purpose[10]. It was positive to note that the MDT was well established and included the hospital manager, two responsible clinicians, a psychologist and two occupational therapists. There was also an established team of administrative, housekeeping, kitchen and maintenance staff at the hospital.

The statement of purpose does need to be updated to reflect the current registered manager and responsible individual, as well as updating the number of staff for each discipline.

At the time of our visit, the registered provider had four registered nurse vacancies which were being filled in the interim by bank and/or agency staff. It was evident that the registered provider was attempting to fill the vacancies on a permanent basis. The hospital used bank and agency staff to provide cover at St Peter's hospital. Staff said they would use block bookings where applicable to assist in providing patients with consistency of care. One agency nurse we spoke to told us that she had been working at St Peter's for a few years and it was the only healthcare setting she chose to work in as she enjoyed her work there, felt valued and supported. This reinforced the discussions we had with managers that every effort was made to provide continuity and consistency when employing agency staff.

We reviewed the mandatory training statistics for staff at St Peter's and found a high compliance rate. The area that required improvement was the break and escape[11] training which was at 66% compliant. The hospital also provided specialist training to ensure staff had specific knowledge and skills to care and treat the patient group.

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[10] Every service provider is required by law to have a Statement of Purpose and it should include specific details about the service, what treatments are provided, to who (age), by whom and any equipment used. For more information visit hiw.org.uk

[11] Break and escape training is designed to equip staff with the skills necessary for breakaway and safe escape from an aggressive situation where defusing and de-escalation techniques have failed and they have been physically assaulted.

There were systems in place for staff to receive an annual appraisal and regular supervision. However the staff we spoke to had not received an appraisal and there was no system in place to monitor this. Supervision was being carried out and recorded.

Improvement needed

The registered provider needs to update the statement of purpose to reflect details of the current registered manager and responsible individual as well as updating the numbers of staff in each discipline. The updated document must be sent to HIW.

The registered provider must ensure all staff receive a documented, annual appraisal.

Workforce recruitment and employment practices

Staff explained the recruitment processes that were in place at St Peter's. 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) check[12] were undertaken and professional qualifications checked.

All staff received an induction prior to commencing work on the wards at the hospital. Agency staff completed an induction at the hospital prior to starting their shift; the completion of the induction being signed by a member of staff and the agency staff member.

DBS checks were completed after each three year period of employment and systems were in place to monitor professional registrations are up to date.

Staff had access to an internal guardian to which they could report any issues they felt unable to communicate to hospital staff. A poster was displayed in the staff room. However, very few staff we spoke to were aware of this initiative. The registered provider should consider ways of making this initiative better

[12] The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

known to all staff as an additional avenue of being able to safely report concerns.

The hospital had reinstated primary team days for each ward. These provided staff with time off the ward, which enabled them to spend time together, sharing any learning and completing training. The primary team days should help those staff who told us about the difficulties there has been accessing computers to complete training.

Given the areas for improvement identified during this inspection, consideration should be given to ensuring that there are more effective and proactive arrangements in place at the service to monitor compliance with relevant regulations and standards. Whilst no specific recommendation has been made in this regard, the expectation is that there will be evidence of a notable improvement in this respect at the time of the next inspection.

4. What next?

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 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.

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a non-compliance notice. The issuing of a non compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

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.

5. How we inspect independent mental health services

Our inspections of independent mental health services are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of independent mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards
- Comply with the Care Standards Act 2000
- Comply with the Independent Health Care (Wales) Regulations 2011
- Meet the National Minimum Standards for Independent Health Care Services in Wales.

We also consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within independent mental health services.

Further detail about how HIW inspects mental health and independent services can be found on our 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 – Improvement plan

Service: St Peter's Hospital

Ward/unit(s): Raglan, Upper Raglan & Brecon

Date of inspection: 14 - 16 May 2018

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	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The registered provider should review the frequency of patients having their community access rearranged/cancelled due to the unavailability of a hospital vehicle.	Regulation 15 (1) (a)	Documentation has been placed on each unit to enable staff to record when and why community access has not taken place. Unit Managers to check document is completed contemporaneously and accurately Registered Manager to report finding to local Governance to ensure any remedial actions are recorded and	Unit Managers Registered Manager	Monthly as of August Governance meeting

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		addressed		
The registered provider must ensure that there is information displayed which includes information about the Mental Health Act, how to raise a complaint, visiting times and information on Healthcare Inspectorate Wales.	Regulation 9 (1) (g) & 19 (2) (b) (i) 24 (3) (a) (b) (c) Code of Practice for Wales (Revised 2016)	All information required will be displayed and will also be available, where requested, in a format suitable to the individual requesting the information. This means there will not be too much information on display which can be overwhelming for this patient group. The service user guide provides information on all areas identified other than the Mental Health Act which will be provided individually	Registered Manager	August 31st 2018
The registered provider should consider displaying information in different formats to ensure all patients can access information in suitable and understandable formats.	Regulation 19 (1) (g)	See above -Regulation 19 (1) (9g)	Registered Manager	August 31st 2018
Delivery of safe and effective care				
The registered provider must review the environment to ensure the areas identified within this report are repaired and fit for purpose.	Regulation 15 (1) (b) & 26 (2) (b)	All areas identified in need of repair were addressed by registered manager.	Registered Manager	August 31st

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Specifically, the electric socket must be repaired before the bedroom is allocated to a patient. Plasterwork to be fixed and repainted including the quiet room on Raglan ward. Carpets/flooring should be cleaned and damaged/chipped bedroom furniture repaired and/or replaced.		New carpets fitted in Lower Raglan lounge (16.07.18) staircase to Upper Raglan (24.07.18) Brecon Unit - 2 bedrooms (16.05.18) fitted with new flooring Plasterwork completed on the 16.04.18 Quiet room repainted 17.06.17 Electric socket completed 15.07.18 Schedule of further flooring and furniture replacement being prepared with Estates.		
The registered provider must ensure that sufficient staff are available to support patients requiring additional help and that staff are not taken away from observations which may leave wards/individuals vulnerable.	Regulation 15 (1) (a) (b) & 20 (1) (a)	It was reported by the Registered Manager to Inspectors that the way in which observations were carried out had recently changed and would continue to evolve over the next few months. Some staff have had difficulty in understanding that patients are on variable observations which do not always require a member of staff at all times, freeing that staff member to	Senior Management Team	Commenced on LowerRaglan 16.8.18 Full Hospital site by end of September

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		complete other duties. The fully revised method of care delivery has been introduced in Lower Raglan, staff now work in small teams, who are available to assist with those patients who require extra support. This will be fully introduced across the hospital site in the next few months.		
The registered provider must ensure that all paperwork being completed is accurate and is not completed retrospectively. This is in accordance with current professional guidelines.	Regulation 23 (1) (a) (i)	The hospital has had focused visits from QAIT and Company Directors prior to and after the HIW inspection where documents pertaining to patient care, including observation forms were viewed and no issues were identified. This issue was raised during the Inspection by a staff member who did not fully understand the new observation process and recording of the same. When checked the records were completed within the required time - frame and not retrospectively. The way in which observations should be carried out and recorded will be a	All staff in a supervisory role (Senior Support Workers Senior Nurses/Nurses Unit Manager Clinical Lead Registered Manager	September 2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		focus in August and September supervisions, handovers and primary team days to ensure staff fully understand and can fully explain what any observation they are involved with.		
The registered provider must remind staff to ensure medicine cupboards, fridges and trolleys are locked when not being used.	Regulation 15 (5) (a)	A full Nurse meeting was held on…… Nurses were reminded of their responsibility and accountability in regard to medication management. (NMC guidelines) Registered Manager/Clinical Lead Manager/Unit Managers and Director of Operations will carry out ad hoc checks across shifts to ensure compliance	Operations Director Senior Management team	Monthly as of July 2018
The registered provider must ensure that clinical areas are not used to store inappropriate items including patient belongings and staff food.	Regulation 15 (1) (b) & (5) (a)	A full Nurses meeting was held on the 14.06.18.and all nurses were reminded of their responsibility and accountability for ensuring clinical rooms are fit for purpose at all times Registered Manager/Unit Managers and Director of Operations will carry out ad hoc checks across shifts to ensure	Director of Operations Registered Manager Unit Managers Nurses	Monthly as of July 2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		compliance.		
The registered provider must ensure that prescribed medication is administered in accordance with written instructions from medical staff.	Regulation 15 (1) (a) (b) (c) & (5) (a)	A full Nurses meeting was held on 14.06.18 Nurses were reminded of their responsibility and accountability in regard to medication management (NMC guidelines) Registered Manager/Unit Managers and Director of Operations will carry out ad hoc checks across shifts to ensure compliance	Director of Operations Registered Manager Unit Managers Nurses	Monthly as of July 2018
The registered provider must ensure medical equipment is maintained appropriately so it is fit for purpose. Specifically, the blood pressure and temperature machines require calibration and one oxygen saturation machine needs to be repaired.	Regulation 15 (2)	Equipment identified has been added to the weekly checklist. A review of equipment requiring calibration or replacement is underway	Clinical Lead/Manager	31st August 2018
The registered provider must ensure that sufficient oxygen cylinders are available with sufficient levels of oxygen within them to administer in a patient emergency.	Regulation 15 (2)	The Hospital maintains 3 large oxygen cylinders and a small cylinder in the emergency grab bag which is adequate to meet requirements. There were 2 empty cylinders on site awaiting		Hospital site was compliant with supplies necessary to

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		collection on the day of Inspection		cover an emergency
The registered provider must ensure that both statutory consultees complete a record of their discussion with the SOAD and provide a clear rationale that underpins their decision.	Code of Practice for Wales (Revised 2016) 25.56 - 25.62	All SOAD records will be viewed by a Senior Manager following SOAD visit and checked for completion before inserting into relevant file It is worth noting that the Inspector in discussion with the organisation Mental Health Act Manager stated this was a problem across Wales and not specific to Ludlow Street Healthcare	Registered Manager Clinical lead/Manager Unit Mangers	July 31st 2018
The registered provider must ensure that the chairman of the hospital managers review panel informs the patient of the outcome and signs and dates the record or alternatively if a staff member informs the patient of the decision the same applies. If the patient has limited understanding then this must be recorded.	Code of Practice for Wales (Revised 2016) 38.42 - 38.44	All Hospitals Managers had previously been emailed to remind them of their accountability and responsibility to inform patients of outcomes and record same. As original forms as are retained centrally the Mental Health Act Manager or representative will ensure a record is complete following reviews prior to filing.	Registered Manager Mental health Act Manager	July 31st2018
The registered provider must ensure that all wards have copies of the Code of Practice for	Code of	All wards had copies of the Code of Practice for Wales revised 2016 in	MHA Manager	July 31st

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Wales in both English and Welsh.	Practice for Wales (Revised 2016) Introduction xiii	English at the time of the visit. A copy of the Code of Practice in the Welsh language is available on site for those individuals who would prefer to read this in Welsh We also have Welsh speakers within the organisation who are available to translate when required.		2018
The registered provider should raise awareness with staff of the requirements of section 17 leave of the Mental Health Act and Deprivation of Liberty Safeguards in relation to patients leave.	Code of Practice for Wales (Revised 2016) Chapter 27 (27.4)	All staff will receive information in regard to the requirements of both section 17 leave under the MHA and community access under DoLs Staff have been reminded to archive redundant documentation in order to avoid future confusion	Registered Manager Mental health Act Manager	As of 31st August 2018
The registered provider must document patients unmet needs so these can be clearly reviewed and options looked at for meeting those needs.	Regulation 23 (1) (a) (i)	A section has been added to the multi-disciplinary meeting document which will identify any unmet needs, the reason for the unmet needs, a rationale if the need cannot be met and any other plans to address the identified unmet needs.	Multi-disciplinary team.	As of MDT Meetings July 2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
The registered provider needs to review how communication amongst all staff grades and disciplines can be improved so that everyone feels actively involved in patient care. This would also ensure that any potential risk created by staff not being aware of changes in patients care, be avoided.	Regulation 19 (2) (e)	It is expected that the revised way of working will improve communication between all staff. The re-introduction of primary team days will ensure changes to care delivery are fully discussed, agreed and communicated to the wider team An MDT communication folder has been introduced to enable staff who unable to attend an MDT to raise patient care issues and receive written response/actions	Registered Manger Unit Managers Psychology Multi Disciplinary Team	July 31st 2018
The registered provider must ensure all staff receive a documented, annual appraisal.	Regulation 20 (2) (a)	The PDR process is being been rolled out across the service and all staff will receive an annual appraisal commencing Autumn 2019	All staff in a supervisory role (Senior Support Workers Senior Nurses/Nurses Unit Manager Clinical Lead	Commenced June 1st 2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
			Registered Manager	
The registered provider needs to update the statement of purpose to reflect the current registered manager and responsible individual as well as updating the numbers of staff in each discipline. The updated document must be sent to HIW.	Regulation 8 (a) & (b)	Document revised and forwarded to HIW	Registered manager	Complete sent with improvement plan.

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): Lisa Dutka

Job role: Nominated Registered Manager

Date: 20.07.18