Independent Mental Health Service Inspection (Unannounced)

St Peter's Hospital

Ludlow Street Healthcare

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

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, Newport, on the evening of 11 October 2021, and following days of 12 and 13 October 2021. The following sites and wards were visited during this inspection:

- Brecon Unit
- Raglan Unit[1]
- Caldicot Unit[2]

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

During this inspection, we reviewed 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.

[1] Raglan Unit consists of Lower Raglan Unit, Upper Raglan Unit and Raglan Annex

[2] Caldicot Unit is a new addition to the hospital which consists of Lower Caldicot and Upper Caldicot. At the time of our inspection, only Upper Caldicot had been opened and was accommodating patients.

2. Summary of our inspection

We observed staff interacting with patients respectfully throughout the inspection. Patients had good access to psychology, occupational therapy and community activities.

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

We identified some improvements required that were the same as our findings from our previous onsite inspection in May 2018. The registered provider must ensure appropriate action is taken to learn from HIW inspections.

This is what we found the service did well:

- Staff treated patients with dignity and respect
- Patients had access to a range of specialties from a strong multidisciplinary team
- Established governance arrangements were in place that provided oversight to aid improvement
- Advocacy services were available to support patients with aspects of their care
- Suitable protocols were in place to manage risk, health and safety and infection control
- Regular checks were being undertaken of resuscitation and emergency equipment
- High staff compliance for mandatory training modules.

This is what we recommend the service could improve:

- Ensure nursing staff consistently wear the red tabard to indicate they are delivering medication to patients on wards and should not be interrupted

- Staff must ensure cupboards, fridges and trolleys in all clinical rooms are locked when not being directly used
- Pharmacy visits to the hospital should be re-instated to help govern stock controls of controlled drugs and drugs liable to misuse
- All medical equipment throughout the hospital must be maintained appropriately so it remains fit for purpose
- Clinical policies must be developed to help staff appropriately treat and care for patients with acute physical health needs
- Higher numbers of permanent staff are needed to limit the amount of agency staff being used to fulfil staff rotas.

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

3. What we found

Background of the service

St Peter's Hospital is registered to provide an independent mental health service at Chepstow Road, Llandevaud, Newport, NP18 2AA.

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.

The service was first registered in November 2015. The registration schedule for the hospital consists of:

- Brecon Unit - a maximum of 19 persons of the same gender over the age of 30
- Lower Raglan Unit - a maximum of 9 persons of the same gender over the age of 30
- Upper Raglan Unit - a maximum of 5 persons of the same gender over the age of 30
- Raglan Annex – a maximum of 6 persons of the same gender over the age of 30 years
- Caldicot Unit – a maximum of 12 persons of the same gender over the age of 30

The service employees a staff team which includes a hospital director, a clinical lead, a general manager, three unit managers and a team of registered nurses and healthcare support workers. The multi-disciplinary team includes consultant psychologists, occupational therapists and technicians, dietician, speech and language therapists and a physiotherapist.

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 staff interacting and engaging with patients appropriately, and treating patients with dignity and respect.

Patients had access to a wide range of group and individualised activities to support and maintain their health and well-being.

Patients were able to personalise their rooms and positive initiatives had been implemented to help patients with cognitive impairments navigate the wards.

Health promotion, protection and improvement

We saw evidence that appropriate physical assessments of patients have been undertaken monthly. However, we did note in one care plan that a patient had not been weighed for two months due to their agitated state; previous entries showed there had been a significant weight loss over the previous months. The service must consider alternative options to ensure physical health checks can continue to be taken in the best interests of the patient.

Patients were able to access health professionals, such as GPs, as required. Physiotherapists and occupational therapists formed part of the multi-disciplinary team (MDT) at the hospital, and supported patients to engage in a wide range of group and individualised activities to support and maintain their health and well-being. The hospital has a gym that includes fitness equipment which has been adapted to be used by people requiring a wheelchair.

The lounge areas on the wards provided patients with a number of useful resources, such as board games, DVDs and books. During the inspection we saw patients participating in arts and craft activities. Large outdoor spaces were accessible outside the wards, and we observed patients using these spaces regularly during the day times. Staff had access to a car and a minibus to facilitate activities in the community for patients that were authorised to leave the hospital, such as visits to the garden centre or to play golf.

Improvement needed

The registered provider must ensure regular physical health checks of patients are completed to help identify any concerns in a timely manner.

Dignity and respect

Throughout the inspection we observed staff treating patients appropriately and with dignity and respect. The staff we spoke with demonstrated a good level of understanding of the patients they were caring for. Staff showed a responsive and caring attitude by taking the time to speak with patients to understand their needs or any concerns the patients raised.

Each patient had their own bedroom which offered adequate storage, and patients were able to personalise their room with pictures and posters. Positive initiatives had been implemented to help patients with cognitive impairments, such as personalised orientation boxes outside their room, which helped aid navigation and reduce confusion. We saw staff respecting the privacy of patients by knocking the door before entering. We were told that some patients have their bedroom locked at night on Raglan. The service should consider whether this is too restrictive to patients who may wish to come out in the night for any reason, particularly considering the bedrooms do not have toilets.

Each bedroom door had an observation panel, which enabled staff to undertake observations without having to open the door and potentially disturb patients that may be asleep. Patients are not able to open or close the blind covering the observation panel from within their bedroom. We were told that blinds are adjusted in accordance to the preference of each patient. However, we noted that each observation panel throughout the hospital seemed to be in the closed position by default. The service should check that staff are aware of the preference of each patient in relation to this matter, and adhere to their wishes.

There were suitable arrangements for telephone access on each of the wards. A wireless phone was available at all times for patients to make and receive calls in the privacy of their room.

Patient information and consent

A patient information guide was available to patients and their relatives/carers that sets out what they can expect from their stay at the hospital.

The registered provider's statement of purpose[3] also described the aims and objectives of the service. We saw that both documents were up to date and contained all the relevant information required by the regulations.

Registration certificates from HIW were on display in the reception area. However, these needed to be updated to outline the conditions of registration for the new Caldicot Unit. The hospital director arranged for the registration certificates to be updated during the inspection. Information about how to contact advocacy services and HIW was on clear display on the wards.

Suitable rooms were available at the hospital for patients to meet ward staff and other healthcare professionals in private. We were told a mental health advocate regularly visits the hospital to provide information to patients and support with any issues they may have regarding their care.

Essential information about the patients at the hospital was kept inside a handover file on each ward. We were told that Patient Status at a Glance boards[4] are due to be installed on each ward to make the information clearer and more visible to staff.

Communicating effectively

It was evident that staff attempted to communicate appropriately and effectively with patients, the majority of which have significant cognitive impairments. We observed staff informing patients of what was happening and taking the time to explain care tasks to patients ahead of doing them.

Many patients required constant support, and staff were attentive to their needs and engaged in activities together.

During our review of the compliments and complaints file we noted that some relatives/carers of patients at the hospital had raised concerns about reduced communication to them during the COVID-19 pandemic when visiting

[3] A statement of purpose is a legally required document that includes a standard set of information about a provider's service.

[4] A board that provides staff with a quick reference to essential information about the individual patients being cared for on the ward.

arrangements were suspended in line with government guidance. The service should ensure families of patients are kept better informed if restrictions are re-introduced in future.

Care planning and provision

The care plans we reviewed during the inspection were person centred, with each patient having their own programme of care based on their individual needs. These included individual and group sessions, based within the hospital and the community (when required authorisation was in place).

There was evidence of regular multidisciplinary involvement in the development of care plans and their reviews, which helped the hospital to deliver support in a structured way. However, while care plans discussed the likes and dislikes of patients, we found a lack of focus on setting individual recovery, rehabilitation and independence goals to aspire patients towards an eventual discharge from the hospital.

We saw that the contact details of relatives/carers had been identified and recorded in the care plans where appropriate to do so.

Improvement needed

The registered provider must ensure care plans have a better focus on recovery and rehabilitation goals to enable patients to work towards discharge back into the community.

Equality, diversity and human rights

During the inspection we reviewed a sample of patient records of individuals that had been detained at the hospital under the Mental Health Act. We found that relevant documentation had been completed to correctly detain patients at the hospital. Further information on our findings on the legal documentation is detailed in the Mental Health Act Monitoring section of this report.

The hospital had established policies to help ensure that the patients' equality and diversity were respected, and their human rights maintained. Regular ward meetings were held to review and discuss practices to minimise the restrictions on patients based on individual patient risks.

Citizen engagement and feedback

Patients were able to provide feedback on the care provided at the hospital, and raise any concerns, at regular patient meetings. We saw that a terms of reference had been produced that set out the purpose of these meetings. We were told that one of the patients had been identified as a patient advocate, who would act on behalf of other patients to share feedback should they not wish to do so themselves.

A complaints procedure was in place at the hospital. We were told that a copy of the procedure is provided to patients and their relatives/carers on admission. However, we noted that no visible information was displayed on the wards to inform patients and their families how to provide feedback and/or make a complaint. Given the length of stay at the hospital for some patients, the hospital may wish to consider ensuring such information is clearly displayed to make the procedures more accessible.

There was an established system in place for recording, reviewing and monitoring complaints. We reviewed the complaints file and saw that concerns had been responded to timely and appropriately, and noted that no significant concerns had been raised.

Delivery of safe and effective care

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

Patient care plans were being maintained to a good standard and in line with the criteria set out in the Mental Health (Wales) Measure.

There were established processes in place to suitably manage potential risks, health and safety and infection control.

Legal documentation to detain patients under the Mental Health Act was compliant with the requirements of the legislation.

Some improvements were needed to ensure the safe management and oversight of medication.

Clinical policies and protocols need to be developed to help staff appropriately treat and care for patients with acute physical health needs.

Managing risk and health and safety

St Peter's Hospital had processes in place to manage and review risks to help maintain the health and safety of patients, staff and visitors at the hospital. The hospital entrance was accessible to everyone, and secured to prevent unauthorised access.

The Raglan and Caldicot Units were split over two floors, and lifts were available to assist people with mobility difficulties. However, on the first night of the inspection we found that the lift on Raglan was out of order. We spoke to the hospital director who confirmed it had been escalated as an issue, and provided assurance to us that in the event of an emergency, personal emergency evacuation plans would be used for each patient that had been agreed, and were known, by the local fire service. We saw that engineers arrived on site to fix the lift on the last day of the inspection.

The hospital provided a clean and comfortable environment for patients, and furniture and fixings were appropriate for the patient group. We saw that a health and safety audit had recently been completed by the hospital director.

Each completed audit is submitted to the central team at Ludlow Street Healthcare to monitor compliance.

We were told that staff prepare for patient admissions by choosing a ward best matched to the patients' needs, and if necessary will adapt the environment to manage risks individual to the patient. There were up-to-date ligature point risk assessments in place for each ward. These identified potential ligature points and what action had been taken to remove or manage these.

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.

Infection prevention and control (IPC) and decontamination

Throughout our visit we observed the hospital to be visibly clean and tidy. Cleaning equipment was stored and organised appropriately. Staff confirmed that cleaning schedules were in place to promote regular and effective cleaning of the hospital. However, we noted on the first night of our inspection that the clinic room on Brecon had spilled medication that required cleaning.

Arrangements were in place with an external contractor to appropriately dispose of clinical waste. However, on the first night of our inspection we found a number of full clinical waste bins in the clinic room on Brecon. We raised this with the hospital director who arranged for the clinical waste to be removed, and posters to be displayed to remind staff to regularly remove waste from the room when required.

We found robust procedures were in place to help control the risk of transmitting COVID-19 throughout the hospital. Visitors are required to have their temperature taken, and complete a COVID-19 screening checklist, before being admitted inside the hospital. Staff and patients have their temperatures checked daily and staff undertake regular Lateral Flow Tests (LFTs).

We observed staff wearing face masks on the wards, and staff did not highlight any issues relating to access to other Personal Protective Equipment during our discussions. Multiple hand gel dispensers were available on each ward. We were told that throughout the pandemic staff received up to date advice and guidance on COVID-19 via regular meetings, information boards, and emails.

We saw evidence that relevant policies were in place that detailed the various infection control measures in place at the hospital. Regular audits had been completed to check the cleanliness of the wards and wider environment. The hospital director also undertook regular checks of the wards to help identify any

areas for improvement so that action could be taken to enhance patient experience at the hospital.

We saw a high staff compliance rate for training in infection prevention and control.

Nutrition

We saw that patients' dietary needs had been assessed using the Malnutrition Universal Screening Tool (MUST)[5]. A full time dietician was also available at the hospital to assess whether patients require a specialist care plan to meet their nutritional needs. Patients are provided with a variety of meals from a three week rotating menu. Hot meals are available at all times of the day and night. Staff told us that patients with specific/special diets were catered for. A healthy eating and tasting club has been set up to allow patients and staff to sample potential meals.

Kitchen areas had signs showing information about meals and snacks available, and posters displaying healthy eating guidelines.

We were told that the hospital had recently changed to a new meal supplier, which provides more visually appealing puréed food for patients that require it, which we noted as a positive initiative.

Some patients at the hospital were receiving the nutrients and fluids they required through a percutaneous endoscopic gastrostomy (PEG)[6] feeding tube. However, the setting did not have a policy that detailed the safe management of PEG feeding.

[5] MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

[6] A PEG feeding tube is a way to give food, fluids and medicines directly into the stomach by passing a thin tube through the skin and into the stomach.

Improvement needed

The registered provider must develop a policy that defines the management and standards expected when using PEG feeding tubes to ensure all patients receive safe and appropriate care.

Medicines management

We reviewed the hospital's clinic arrangements and found that on the whole the management of medicines was safe, but that some improvements were needed.

Patients had individualised medication management plans that outlined the possible side effects, and documented discussions held with patients to support their understanding. We saw that daily temperature checks of the medication fridge and clinic rooms were being completed to ensure that medication was stored at the manufacturer's advised temperature. Relevant policies, such as medicines management and rapid tranquillisation, were in date and available to staff. Reviews of medication were being undertaken and discussed and documented in MDT meetings.

Medication Administration Records (MAR)[7] charts were being completed electronically. We reviewed a sample of MAR charts and found they were being completed to a good standard. Charts contained the patient's name, photograph, and were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. We saw evidence of regular audits of the electronic system being undertaken by the clinical lead at the hospital, who notified staff when errors or gaps had been identified.

During the inspection we saw one nurse wearing a red tabard that indicated to other staff and patients that they were in the process of delivering medication to patients on the ward, and that they should not be interupted. This was a

[7] A Medication Administration Record is the report that serves as a legal record of the drugs administered to a patient by a health care professional. The Medication Administration Record is a part of a patient's permanent record on their medical chart.

positive initiative introduced to support staff during medication rounds, which we observed to be complex, and help reduce the potential of medication errors. However, the wearing of such tabards was inconsistent throughout the inspection, with not all staff wearing them while delivering medication.

During our visits to the clinic room on Brecon throughout the inspection, we found the medication trolley to be unlocked on one occasion, and the medication fridge to be unlocked on two occasions, when staff had left the room. Although the clinic room was locked, there remains a risk of unauthorised access to medication, resulting in there being potential harm to patients. The issue of unlocked trolleys was identified during our previous onsite inspection of the hospital in May 2018, and actions must be taken by the service to prevent the continuation of this unsafe practice.

We looked at the arrangements in place at the hospital for the storage and safe use of controlled drugs and drugs liable to misuse. Records we viewed evidenced that twice daily stock checks were conducted with the appropriate nursing signatures certifying that the checks had been carried out.

However, during the inspection we observed an administration error where the wrong stock number was signed for. We were told that onsite visits by the external pharmacy that supply controlled drugs to the hospital have stopped since the onset of COVID-19. The re-introduction of these visits should be explored to help provide more assurance that any stock control issues would be identified in a timely manner.

Improvement needed

The registered provider must ensure, and monitor, that staff members consistently wear the red tabard when delivering medication to patients on wards.

The registered provider must remind staff to ensure cupboards, fridges and trolleys are locked when not being directly used. Regular checks also should be implemented to monitor and ensure ongoing compliance.

The registered provider must co-ordinate with the external pharmacy to investigate the re-introduction of on-site visits to help improve governance arrangements regarding stock controls of controlled drugs and drugs liable to misuse.

Safeguarding children and safeguarding vulnerable adults

We found processes in place to help ensure that staff at the hospital safeguarded patients, and saw evidence that referrals were being made to external agencies as and when required.

We saw that compliance among staff with safeguarding training was relatively high at 72 per cent.

Medical devices, equipment and diagnostic systems

We saw evidence of regular checks being undertaken of resuscitation and emergency equipment. Staff had documented when these had occurred to ensure that the equipment was present and in date. We noted that some emergency equipment, such as defibrillators, were located inside the clinic rooms, which not all staff have access to. While the hospital site is relatively small, and defibrillators are accessible from other wards, defibrillators must be accessible in a timely manner to all staff in the event of an emergency. We spoke with the hospital director who arranged for the defibrillators to be moved to each nursing office during the inspection.

We saw a large quantity of oxygen cylinders being stored in one room inside the hospital. We were told that these were brought in as a precautionary measure during the pandemic in case patients began having breathing difficulties. We spoke to the hospital director about the potential risks associated with storing such a large amount in one place, who arranged for the cylinders to be moved and stored in a more appropriate located on the wider hospital estate.

During our checks of the medical equipment available at the hospital, we were unable to tell whether some equipment was currently in use, or whether they had been decommissioned. For example, there were no markings on a chair weighing scale, or blood glucose monitors, to indicate whether they had been recently calibrated[8], or were indeed working at all. This is a similar finding to our previous inspection in May 2018, and again action must be taken to ensure all medical equipment is checked and calibrated as per manufacturers guidelines.

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

Improvement needed

The registered provider must review the location of all its defibrillators and provide assurance to HIW that they are accessible in a timely manner, and to all staff, in the event of an emergency.

The registered provider must ensure that all medical equipment throughout the hospital is maintained appropriately so it remains fit for purpose and provides accurate readings.

Safe and clinically effective care

We found safe and therapeutic responses were in place to manage challenging behaviour and promote the safety and well-being of patients. Principles of positive behavioural support were being used as a primary method of de-escalation. We were told that regular checks were undertaken to ensure care was being provided in line with the Positive Behavioural Support policy.

Staff would observe patients more frequently if their behaviour became a cause for concern. The care plans we reviewed showed discussions had taken place place between the MDT to determine levels of observations. An up to date observation policy was in place and we observed suitable observations taking place on the wards.

We saw that any use of restraint was documented, which included details such as date, location and duration of the intervention, and which staff members were involved. We were told that debriefs and reflective practice take place with staff following incidents and a debrief folder is kept on each ward to help support shared learning.

We noted during the inspection that some patients at the hospital had acute physical health issues. However, we did not find clinical policies or protocols in place that would help staff to manage such issues.

Improvement needed

The registered provider must ensure that clinical policies and protocols are developed to help staff appropriately treat and care for patients that may present with acute physical health needs (for example, diabetes management, recognising and responding to sepsis presentation).

Participating in quality improvement activities

We found arrangements were in place to help assess and monitor the quality of the services and care being provided to patients. Clinical governance information in relation to safety and performance of the hospital was collated by staff at the hospital and submitted to the central team at Ludlow Street Healthcare to be monitored corporately. We were told that learning from other Ludlow Street Healthcare settings was shared to ensure a consistent approach to improvement.

The hospital director had been newly appointed to the role, and told us about plans to develop the service provision and other aspects of the hospital. This included the addition of step-down facilities to be built on the hospital site in the coming years to facilitate quicker discharge for patients from the hospital.

Information management and communications technology

Alongside paper patient records, the hospital used electronic systems to document some parts of patient care and to complete MAR charts and statutory detention paperwork. The electronic systems were password protected to prevent unauthorised access and breaches in confidentiality.

Both electronic systems provided the hospital with a range of quality information on individual patient care. We spoke with the hospital director about the potential benefits of undertaking more analysis of the information to help identify trends and track progress, which may be helpful for MDT discussions on patient care.

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.

Records management

The paper and electronic versions of the patient records we reviewed during the inspection were comprehensive and well organised, which made it easy to navigate through the sections.

It was evident that MDT professionals were writing detailed and regular entries that provided up to date information on the patient and their care.

We saw that staff were completing care documentation and risk assessments in full. Further information on our findings in relation to patient records and care plans is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Mental Health Act Monitoring

We reviewed the statutory detention documents of three patients; all records were found to be compliant with the Mental Health Act and Code of Practice. Paper records were being kept on the ward, and electronic versions were being maintained by the Mental Health Act Administrator. The records we viewed were well organised, easy to navigate and contained detailed and relevant information. The electronic system contained alerts to ensure relevant dates were not missed, which we noted as good practice.

We saw that Section 17 Leave[9] was suitably risk assessed and determined the conditions and outcomes of the leave for each patient. However, we noted the documentation did not contain a section for the patient to sign the form to indicate their involvement and agreement with the terms of their leave.

There was evidence of nearest relative or advocacy services involvement in discussions around the detention of patients with cognitive impairments. We saw that improvements had been made with regards to Mental Health Act administration since our last inspection. We found better compliance with the Second Opinion Appointed Doctor (SOAD) process, and all wards now had copies of the Mental Health Act Code of Practice.

The Mental Health Act Administrator appeared well organised and knowledgeable about their role. We were told that the administrator regularly attends the All Wales Mental Health Act Administrators Forum to keep up to date with any changes in legislation, and discuss common themes, issues and experiences

Robust systems of audit were in place for the management and auditing of statutory documentation. We also noted that Mental Health Act discussions form part of the local governance meetings.

All staff undertake Mental Health Act training as part of their mandatory training programme, and we saw that compliance was high among staff at 80 per cent.

[9] Section 17 leave allows the detained patient leave from hospital.

Improvement needed

The registered provider must ensure that Section 17 Leave form includes a section for patients to sign to indicate their agreement. If the patient lacks capacity to consent, this must be recorded.

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

We reviewed the care plans of a total of three patients. We found that they were maintained to a good standard and in line with the criteria set out in the Mental Health (Wales) Measure. Paper records cross referenced well to electronic records. Entries in both versions were comprehensive, and recognised assessment tools were used to monitor mental and physical health.

There was evidence of completed risk assessments that clearly sets out the risks identified, and the specific plan to mitigate and manage the risks. The care plans set out psychological treatment interventions for patients and who had responsibility for their delivery. We found that the proposed interventions met the identified needs of patients and saw evidence that intervention had changed in the care plan following periods of review by the MDT.

We were told that advocacy services and relatives/carers are involved to help develop and review care plans for patients with cognitive impairments.

Mental Capacity Act and Deprivation of Liberty Safeguards

We saw appropriate use of the Mental Capacity Act and Deprivation of Liberty Safeguards processes being used where relevant. However, during our review of patient records we found that the documentation associated with the Mental Capacity Act did not appear to be as well organised as the documentation associated with the Mental Health Act. In one instance, a Mental Health Act assessment that had been undertaken on a patient to help determine whether the Deprivation of Liberty Safeguards framework applied, was unable to be located for 24 hours. The service should ensure all legislative documentation at the hospital is filed appropriately.

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.

Established governance arrangements were in place to provide oversight of clinical and operational issues.

Recruitment was undertaken in an open and fair process with appropriate employment checks being carried out prior to employment.

Staff were committed and we observed the multidisciplinary team working well together to provide individualised care.

The hospital must continue ongoing efforts to employ higher numbers of permanent staff to provide a consistent level of care to patients.

Governance and accountability framework

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

We found established governance arrangements in place at the hospital level to provide oversight of clinical and operational issues. Audit activities and monitoring systems and processes were in place to ensure the hospital focussed on continuously maintaining standards.

Agendas for senior management team and local governance meetings showed a wide range of standing items to help ensure that the hospital focussed on all aspects of the service. Further oversight of the performance of the hospital is managed corporately through the Ludlow Street Healthcare central governance teams, and we were told that there is open and constructive communication between the hospital director and registered provider.

Throughout the inspection we saw evidence that the MDT worked well together and were focussed on providing the best individualised care for patients. The new hospital director was open and transparent throughout the inspection, and during our tour of the hospital it was clear that they were familiar to the patients, evidencing that they had spent time getting to know the patients on an individual basis.

Dealing with concerns and managing incidents

There was an established electronic system in place for dealing with concerns and recording, reviewing and monitoring incidents. Regular incident reports were produced and reviewed at the hospital level, and at a corporate level, to help identify trends and patterns of behaviour.

We were told that complaints, incidents and safeguarding issues at the hospital are discussed at local governance meetings, with any learning shared with all staff. This helps to promote patient safety and continuous improvement of the service provided.

Workforce planning, training and organisational development

Staffing levels were appropriate to maintain patient safety within the wards at the time of our inspection. However, it was clear from discussions with staff that maintaining appropriate staffing levels has been a challenge for the service over the previous months.

We were told that regular agency staff who were familiar with working at the hospital and the patient group have been used to cover any staffing shortfalls. The hospital director told us about initiatives taking place to recruit permanent staff, and that interviews were taking place shortly for a number of vacant support worker posts. This is similar to our findings from our Quality Check of the hospital undertaken in February 2021. Since then, Upper Caldicot has been opened, and Lower Caldicot will be opened at some point in the future. The service must ensure they have a long term plan to have higher numbers of permanent staff who understand the risks of the patients and how to engage with and support patients to help keep them safe.

We reviewed the mandatory training statistics for staff at the hospital and found that completion rates were generally high. Senior managers had oversight of course completion rates and individual staff compliance details via the hospital's electronic employee management system. We were told that all staff have annual appraisals every January, and have regular clinical supervision sessions with senior members of staff.

Improvement needed

The registered provider must continue ongoing efforts to source access to higher numbers of permanent staff to limit the amount of agency staff being used, particularly in anticipation of Lower Caldicot being opened in the future.

Workforce recruitment and employment practices

A recruitment policy was in place that set out the arrangements to be followed to ensure recruitment followed an open and fair process. Prior to employment staff references were received, Disclosure and Barring Service (DBS) checks were undertaken and professional qualifications checked.

Newly appointed staff are required to attend a two week induction course to learn about the company and complete their mandatory training. Where required, nursing staff also have to complete physical intervention training before starting their roles on the wards.

We saw posters displayed around the hospital informing staff of their ‘speak up guardian’. The guardian was a Ludlow Street Healthcare employee, who staff were able to contact to confidentially raise any issues or concerns they may have about issues at the hospital. A whistleblowing policy was also in place should staff wish to raise any concerns directly with the hospital director, registered provider or an alternative appropriate body if required.

There were good systems in place to support staff welfare. Occupational health, and an employee assistance programme, were available to assist staff with many aspects of work and personal life, including a short course of free independent counselling sessions.

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, measurable, 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 summarises 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): Brecon, Raglan and Upper Caldicot

Date of inspection: 11 – 13 October 2021

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 must ensure regular physical health checks of patients are completed to help identify any concerns in a timely manner.	3. Health promotion, protection and improvement	Monthly health clinics are facilitated and evidenced through Care Partner, which includes blood taking, ECG monitoring etc. There is also a weekly GP clinic on site again recorded on Care Partner. There is also baseline observation completion if a patient is presenting as unwell to establish if further investigations are required. These are recorded in Care Partner through the nursing / psychiatric notes.	Sian Middleton (Clinical Lead) RC's External GP	Already in situ
The registered provider must ensure care	8. Care planning	All patients are on a discharge pathway	MDT minutes	Already in

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
plans have a better focus on recovery and rehabilitation goals to enable patients to work towards discharge back into the community.	and provision	which is discussed monthly in their MDT minutes. Patient Pathways are also discussed monthly in the Head of Department meeting. SPH's consistently works with the commissioners and families to support with discharge back to locality where possible.	HOD minutes CPA reports	situ
Delivery of safe and effective care				
The registered provider must develop a policy that defines the management and standards expected when using PEG feeding tubes to ensure all patients receive safe and appropriate care.	14. Nutrition	Policy has been drafted and is currently with the Policy Working Group for ratification. There is also detailed care plans in relation to specific needs such as diabetes etc.	Olivia Ferrari Policy Working Group	30/01/20
The registered provider must ensure, and monitor, that staff members consistently wear the red tabard when delivering medication to patients on wards.	15. Medicines management	This has been addressed in the Nurse Meeting on the 01/12/2021 and posters are now displayed in the clinic rooms and spot audits are being undertaken to monitor.	Sian Middleton (Clinical Lead)	01/12/21
The registered provider must remind staff to ensure cupboards, fridges and trolleys are locked when not being directly used. Regular checks also should be	15. Medicines management	Clinic audits now include this check. Addressed in Nurse Meeting 01/12/21. Spot audits undertaken by Clinical Lead	Sian Middleton (Clinical Lead) Nursing Staff	01/12/21

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
implemented to monitor and ensure ongoing compliance.		to monitor on going compliance daily.	(audits)	
The registered provider must co-ordinate with the external pharmacy to investigate the re-introduction of on-site visits to help improve governance arrangements regarding stock controls of controlled drugs and drugs liable to misuse.	15. Medicines management	The audits are being reintroduced on week commencing 20/12/21	Boots pharmacist	24/12/21
The registered provider must ensure that all medical equipment throughout the hospital is maintained appropriately so it remains fit for purpose and provides accurate readings.	16. Medical devices, equipment and diagnostic systems	BMI calibration and monitoring implemented. Clinical Lead monthly audits includes monitoring and checks completed on medical equipment.	Sian Middleton (Clinical Need)	13/12/21
The registered provider must ensure that clinical policies and protocols are developed to help staff appropriately treat and care for patients that may present with acute physical health needs (for example, diabetes management, recognising and responding to sepsis presentation).	7. Safe and clinically effective care	NEWS2 implemented for sepsis. E-learning will be implemented when NHS sepsis link is sent through (hopefully licences will be received by 20/12/21). Ongoing training and specialists introduced as required for e.g. Diabetic Nurse Specialist	Sian Middleton (Clinical Lead) Olivia Ferrari (Hospital Director)	20/12/21
The registered provider must ensure that Section 17 Leave form includes a section	20. Records	Addressed in local governance, Heads of Department Meeting and handovers.	Olivia Ferrari	01/12/21

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
for patients to sign to indicate their agreement. If the patient lacks the capacity to consent, this must be recorded.	management	Communication also circulated to teams via email.		
Quality of management and leadership				
The registered provider must continue ongoing efforts to source access to higher numbers of permanent staff to limit the amount of agency staff being used, particularly in anticipation of Lower Caldicot being opened in the future.	25. Workforce planning, training and organisational development	Recruitment Numbers – to date and forward planning. The ongoing recruitment plan is adhered to which is overseen by the Recruitment Team.	Ceri Ashdown (Recruitment Manager)	May 2022

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): Olivia Ferrari

Job role: Registered Manager / Hospital Director

Date: 16 December 2021