Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection (Unannounced)

Pinetree Court Hospital

Cardiff

Inspection date: 29 – 30 March 2022

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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 Pinetree Court Hospital on the 29 and 30 March 2022.

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

2. Summary of our inspection

Overall we found that patients were provided with a good experience at the service, with safe and effective care provided by a committed multi-disciplinary team.

There was evidence of good management and leadership at the service, which operated within an appropriate governance structure.

We have made several recommendations, particularly related to the hospital environment, in order to fully promote the patient experience and delivery of safe and effective care.

This is what we found the service did well:

- Kind and respectful interactions between staff and patients
- Low use of restrictive practices and reduction in the dosage of antipsychotic medicines
- Evidence of comprehensive care and behavioural support planning.

This is what we recommend the service could improve:

- Aspects of the patient environment and its maintenance
- Aspects of housekeeping
- Aspects of medicines management.

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

3. What we found

Background of the service

Pinetree Court Hospital is registered to provide an independent locked rehabilitation learning disability hospital at 904 Newport Road, Rumney, Cardiff, CF3 4LL

The service has 29 beds:

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

The service employs a staff team which includes a registered manager, a clinical lead, unit managers, a registered nursing team, senior support workers and support workers.

The multi-disciplinary team includes consultant psychiatrists, psychologists, and a therapy, education and vocational team. Access to other professionals, including a dietician, physiotherapist and speech and language therapist is available to support patient needs where required.

The hospital is supported by a team of administrative, catering, domestic and maintenance staff.

At the time of the inspection, the hospital was being managed by the Ludlow Street Healthcare Group. The service was first registered in 2007.

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.

Overall we found that patients were provided with a good experience at the service.

There was a focus on providing patients with meaningful activities within the community and patients expressed their enjoyment of these opportunities.

We identified an improvement in relation to the patient environment which must be reviewed promptly in order to fully promote the patient experience.

We spoke with nine patients during our inspection of Pinetree Court Hospital. Patients were overall happy with their experience at the service, however, we identified themesin the feedback we received in the following areas:

- More comfortable furniture
- Improved spaces for quiet time
- Timeliness of resolving maintenance issues

The service is advised to reflect on these comments in conjunction with their own methods for gaining patient feedback to determine if any further actions are required.

Health promotion, protection and improvement

We found that access to a range of health professionals, including GPs, occupational therapists and dieticians, were available to patients and that these professionals formed part of the overall multidisciplinary team (MDT) at the service.

We reviewed a sample of patient records and found that comprehensive physical health checks had been completed on a regular basis in line with the Welsh

Health Check format[1]. We were told that there was good access to GP services on a weekly basis and that the GP plays an active role within the MDT.

There was a range of group and individual activities available to patients to support their wellbeing. We saw that patients had a timetable covering weekdays and weekends to help them with routine and patients overall expressed a positive opinion about the activities on offer.

There was a particular focus on providing meaningful activities, volunteering and shopping opportunities out in the community to further aid skills and development. This included trips to the rugby, a local spa and volunteering at a local charity shop.

We found education and vocational staff to be enthusiastic in their roles. We noted that changes to the environment for educational classes was in its early stages. These changes have the potential to be an important and useful addition for patients at the service once completed. The service should consider this comment alongside the improvement below related to the environment.

Dignity and respect

We observed kind and responsive interactions between staff and patients at all times. This promoted an overall positive and calm atmosphere within the hospital. Staff we spoke with were enthusiastic in their roles and demonstrated a comprehensive understanding of patient histories and care needs.

We found that efforts had been made to decorate the environment in each of the units. We were told that this is patient led as far as possible and that patients can be involved. We saw examples of creative wall art which helps to provide a more homely feel.

However, we found areas of the service that were either sparse, contained furniture in different states of repair and cleanliness, undergoing renovation or which could otherwise be better utilised. We reviewed a recent audit which support these findings. Staff told us that a significant amount of new furniture had

[1] The Welsh health check has been designed to be an annual health check by doctors and nurses in primary care for people aged 14 years and older with a diagnosed learning disability

already been ordered and that new equipment for the sensory room had also been ordered due to damage in the weeks leading up to the inspection.

We were invited to view some patient bedrooms and were accompanied by the patient and a staff member. We found patient bedrooms were overall personalised to the individual patient. Some bedrooms were lacking in personalisation compared to others, but we were assured that patients were offered the opportunity to personalise their rooms. We observed rooms being painted during the inspection and patients were giving feedback as to the colours they would like.

A small number of patient bedrooms had access to en-suite facilities. However shared toilet and bathrooms facilities were provided on each of the units for the majority of patients. Whilst this is not fully conducive towards maintaining a dignified experience, we found that bathroom facilities were clean. One shower room on Juniper Unit was out of use at the time of the inspection.

We noted that signs were placed on patient doors reminding staff on the need to knock before entering. This further helped to promote patient dignity on the units.

Improvement needed

The service must ensure that the environment is maintained to a good standard and is utilised appropriately to meet the holistic and therapeutic needs of all patients.

Patient information and consent

We found a range of patient focused information was located throughout the hospital, this included information relating to how to make a complaint, advocacy services, the role of HIW and how to make contact, safeguarding and speaking up.

However this was largely positioned away from the main unit areas. We were advised that this is because posters are easily pulled from the walls. The information available between the three units was inconsistent. The service is advised to ensure that patient information is reviewed and consistent across all ward areas as far as possible.

Communicating effectively

We observed staff communicating with patients according to their needs and in a clear and effective manner.

We found that patient information provided upon admission and available throughout was written in a suitable format, which included use of photo symbols and appropriate wording. This explained what patients could expect during their admission at the service and how care and treatment might be provided.

We also noted that easy read material relating to medication was available for patients to request to help with understanding the purpose of the medication.

Care planning and provision

We found that there was a good focus on providing patients with rehabilitative care. This was particularly noticeable through the use of access to the community on an individual and group for activities, volunteering and shopping.

This was supported by clear evidence of multidisciplinary team input into the creation and on-going review of patient care plans. Staff that we spoke to demonstrated a good understanding of the patients and of their current care and treatment needs.

Equality, diversity and human rights

We reviewed a sample of records of those patients who had been detained under the Mental Health Act. We found that the documentation had been completed correctly and to a good standard. Further information on patients under the Act can be found in the Mental Health Act Monitoring section of this report.

We confirmed that patients are invited to take part of in their MDT meetings and that the involvement of family members or advocates was encouraged and had taken place.

We found that there was a dedicated family visiting space and that patients had access to mobile phones on a risk assessed basis in order to maintain contact with families.

Citizen engagement and feedback

We found that regular patient feedback meetings are held which helps patients to voice their views and opinions on a range of topics, including what they would like to see more or less of, meal options and activities. The meeting minutes appeared to be in an appropriate format to ensure understanding.

We saw examples of opportunities provided for families to provide their feedback on the service. Questionnaires had been posted out to families and they were encouraged to provide their views on a range of areas.

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 safe and effective care was provided to patients at the service.

It was positive to find evidence of comprehensive care and behavioural support planning and input from a range of professions at MDT meetings.

It was notable to find a low use of restrictive practices at the service and a decrease in the use of anti-psychotic medication in patients following their admission.

We have made some recommendations in order for the service to further promote the delivery of safe and effective care.

Managing risk and health and safety

Overall we found the outside and interior of the premises to be in generally good condition, however, we found that improvements could be made to the ward areas in in order to maximise the therapeutic benefit to patients.

We observed some maintenance issues during the course of the inspection. Some staff and patients expressed disappointment that these issues were not always resolved in a timely manner. Whilst we acknowledge that only one person is responsible for maintenance of the estate, the service must ensure that maintenance issues are resolved in a prompt manner.

The environment was not entirely free from ligature risks. However there were up-to-date ligature risk assessments which identified potential ligature points and what actions had been taken to mitigate the associated risks.

We noted that there was secure access to and from the exterior of the hospital and when entering and leaving the ward areas. Staff had access to key fobs and personal alarms were worn to request assistance if necessary.

Improvement needed

The service must ensure that maintenance issues are acknowledged and responded to in a prompt manner.

The service is advised to continue to remove ligature risks as part of its on-going maintenance programme.

Infection prevention and control (IPC) and decontamination

We found that cleanliness was maintained to a satisfactory level throughout the hospital and it was positive to note a number of housekeeping staff working throughout the hospital. However, we noted that more thorough and effective cleaning was required in a number of patient areas, including patient toilets, bedrooms and communal kitchen surfaces, floors and appliances.

We reviewed the cleaning schedules and found a number of gaps which indicated that cleaning was not being completed and documented on a consistent basis. The service must ensure that cleaning is completed to the required standards.

Training records indicated that compliance with IPC training was good with completion at 90 per cent and above.

We noted that personal protective equipment (PPE) was being used appropriately and that hand hygiene stations were positioned in suitable locations through the hospital.

We confirmed that reusable medical equipment in the clinical area were cleaned appropriately after each use and that sharps were disposed of in appropriate containers within the clinic room.

Improvement needed

The service must ensure that cleaning is completed to a high standard in all areas and that this is appropriately documented.

Nutrition

We found that patients were offered a variety of meal choices and that a rotating menu was displayed to let patients know of the options in advance.

Patients told us that they generally liked the food choices available and that there was an option for a takeaway each month which they enjoyed. Staff told us that

snacks are encouraged to be bought and consumed by patients when they are in the community in order to promote healthier eating. This aims to prevent large quantities of snacks being brought back to and consumed at the setting.

In the sample of patient records that we reviewed, we confirmed that specific dietary needs had been identified and catered for and that malnutrition universal screening tool[2] (MUST) reviews had recently been completed to ensure the on-going nutritional needs of patients are met. Dietetic and speech and language therapist input was used by the service, for example to assess patients at risk of choking.

It was positive to note that kitchen staff often attend the patient meetings to get feedback from patients. One patient told us that they would like to see staff have meals with the patients to encourage a shared eating experience.

Medicines management

We found the clinic room to be spacious, clean and appropriately stocked and all cupboards and fridges were locked. We confirmed that controlled drugs were also secured and their use was appropriately recorded.

We found that medication trollies were kept within the nursing office on each ward. During medication rounds we found that red aprons were generally in use to indicate that the medication administrator should not be disturbed. However, the location of the medication dispensing does not lend itself well to avoid disturbances, e.g. from patients, other staff members and telephones ringing. The service must explore if alternative locations could be used to avoid the risk of potential medication errors.

Medication charts were found to be completed to a good standard using an electronic system which enabled the service to monitor the administration of medication according to its policy.

[2] '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.

We advised the service to consider expanding the use of individualised medication management plans, e.g. if there be a need to adjust care plans as a result of medication side effects.

We confirmed that the use of antipsychotic medication was prescribed based on clinical need, discussed as part of the patients MDT meeting and written into their care plan as appropriate. It was positive to note that some patients requiring these medications had their prescriptions reduced to minimal dosages following a successful period of admission at the service.

We also confirmed that as and when required medication was agreed for each patient based on clinical need, as part of their MDT discussion and was written into their care plans. Guidelines for the administration of medication relating to each patient was readily accessible in each patients clinical file.

We noted that use of appropriate pain management and drug side effect tools were in use by the service.

It was positive to note that the weekly internal audits by the clinical lead were completed and that these were supplemented by regular external pharmacy audits. The clinical lead described good working relations with the external pharmacy team.

Improvement needed

The service must explore if alternative locations could be used to prepare and dispense medication to avoid any risk of potential medication errors.

Safeguarding children and safeguarding vulnerable adults

We confirmed that there was a local safeguarding procedure in place and this included a local speak up point of contact within the organisation for staff to raise any concerns.

We confirmed that all but one member of staff had completed adult safeguarding training. There we no open safeguarding cases at the time of the inspection, but we reviewed recent cases and found that these had been referred to the local authority and notified to HIW as appropriate.

Medical devices, equipment and diagnostic systems

We confirmed that regular checks of the equipment found within the clinic room were completed and that equipment was maintained and cleaned as required.

This included regular checks of the emergency resuscitation and oxygen kit and we found that this equipment was readily accessible to all staff in the clinic room in the event of a medical emergency.

Safe and clinically effective care

There was a patient observation and challenging behaviours policy in place and we found suitable processes to review these based on a how a patient presented.

We observed two occasions where patient behaviours escalated, but we were assured by the way in which staff de-escalated both situations skilfully and appropriately.

The number of restrictive practices, such as restraints, required to be used by the service remained exceptionally low. We were told that this is the lowest number of restrictive practices used by the service in six years and found that the least restrictive principle was adhered to.

We reviewed one incident involving a restraint of above 15 minutes and found that there was a clinical need. It was positive to note that a restrictive practice review was completed immediately after the incident. The review contained a good level of detail and staff and patient debriefings were held. Evidence of MDT review was confirmed.

Participating in quality improvement activities

We found that there were suitable arrangements in place to help monitor the quality of care provided to patients at the service. A broad range of information relating to quality and safety is discussed at regular internal meetings and oversight is provided by the Ludlow Street Healthcare group.

The service completed a range of clinical audits at regular intervals on topics which included record keeping, physical health and medication management. We reviewed a sample of these audits and found them to be overall positively scored.

Records management

Patient records were maintained through an electronic and paper based system. Overall we found that records to be maintained to a good standard and provided a comprehensive view of the patient.

However we found that the overall accessibility and navigation of records could be streamlined. The current system relies on knowledge of how and where to access records, something which may be difficult for new members of staff or those unfamiliar with the systems in place. The service advised us that they were

already exploring new record management systems and hope that this will be improved in the near future.

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 a sample of three statutory detention documents for patients currently admitted at the hospital and we spoke to three patients within the scope of Mental Health Act monitoring.

We saw examples of how patients are reminded of their rights under the Act and how they can access suitable support, for example advocacy services. However, as noted on page eleven, we advise the service to ensure that this information is clearly displayed in all ward areas.

All records were found to be compliant with the Act and associated Code of Practice. The records were easy to navigate, clear and concise. The Mental Health Act Administrator was knowledgeable and maintained a robust system for the implementation, monitoring and evaluation of records against the requirements of the Act.

No patients were on Section 17 leave at the time of the inspection. However we confirmed that previous leave of absence forms were signed by the Responsible Clinician and that the leave had been risk assessed. Conditions for leave were clear, which had received input from the patient. We recommend that the service ensures that patients sign this document to demonstrate their awareness and understanding of the conditions. This should involve families where appropriate.

All staff undertake Mental Health Law training as part of their mandatory training. Compliance rates were positively scored at 90% completion.

Improvement needed

The service should ensure that patients sign the conditions of their Section 17 leave document to demonstrate their awareness and understanding. This should involve families where appropriate.

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

We reviewed a sample of three patient care plans and found that they were completed to a good standard and which reflected the domains of The Mental Health (Wales) Measure. It was positive to note that MDT meetings aligned itself to the domains of the Measure and provided a comprehensive review, with the involvement of all relevant professionals within the service.

It was pleasing to find that the positive behavioural support (PBS) plans reflected knowledge of patients demonstrated by staff. The sample of PBS plans that we reviewed were comprehensive, individualised and demonstrated a strong knowledge of each patient, including their preferences, needs and goals.

However in the sample of records that we reviewed we found that a care and treatment plan was not available on all occasions, despite efforts evidenced by the service to request these from the relevant Health Board. The service must ensure that there is a process in place for following up on requests for care and treatment plans.

Improvement needed

The service must ensure that there is a process in place for following up on requests for care and treatment plans (CTPs) from the relevant Care Co-ordiantor.

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.

Overall we found evidence of good management and leadership at the service, which was operating within an appropriate governance structure.

Staff overall provided positive feedback about their experience of working at the service and it was positive to see that training compliance rates were of a good standard.

The service should continue to monitor its agency usage and make efforts to ensure that a permanent staffing structure exists.

We distributed a HIW questionnaire for staff to complete. In total we received 20 responses. Staff responses were generally positive in all areas, with more than three quarters of staff telling us that they recommend their hospital as a place to work and that they would be happy with the standard of care provided for their friends or family.

Governance and accountability framework

We found that the clinical lead and ward manager demonstrated a strong commitment towards supporting staff and providing patients with safe and effective care. Management were receptive of our views and findings throughout the course of the inspection.

There were a number of governance committee meetings to support the effective running of the hospital and communication between hospital teams. Minutes of these meetings were maintained and contained a good level of detail.

Daily morning meetings helped the service to manage risk appropriately, topics discussed at the meeting included: patient incidents, observations and staffing levels for the day ahead.

It was positive to note that visits from the Responsible Individual took place on a regular basis and that these were completed at various times throughout the day, evening and night. The report produced by the Responsible Individual was comprehensive and provided a good oversight of the service.

There was clear line of management and accountability throughout the service. All but one staff member who completed a questionnaire told us that their immediate manager encourages team work, provides clear feedback on their work and is supportive in a personal crisis. All respondents expressed the opinion that senior managers were committed to patient care.

Almost three quarters of staff told us that senior managers involve staff on important decisions and two thirds expressed an opinion that senior managers act on staff feedback.

Dealing with concerns and managing incidents

We found suitable governance processes in place to investigate and respond to concerns and incidents. This included appropriate policies and use of an electronic system to record all incidents, accidents and near misses.

All staff told us that if they were concerned about unsafe practice they would know to report it. However all but two staff told us that they would feel secure when raising concerns about patient care or others.

All but one staff expressed an opinion that their organisation encourages them to report errors, near misses or incidents and all but two told us that their organisation treatments staff who are involved in incidents fairly. However a third of staff told us that they are not given feedback about changes made in response to errors, near misses or incidents.

Workforce planning, training and organisational development

We reviewed the staffing establishment at the service alongside the current number of patients admitted and their observation levels. The establishment appeared suitable to meet patient need at the time of the inspection.

We noted that there was still a high degree of agency use at the service, in particular of support workers. We were told that this figure had reduced slightly in recent months and that the service block books agency staff in an effort to maintain familiarity with patients.

We found that the senior support worker role contributed positively towards activities within the service, in supporting patients with nutritional needs and supporting new colleagues.

There were two nurse and sixteen support worker vacancies at the time of the inspection.

We reviewed mandatory training records for staff and found a good rate of compliance in all areas. All staff respondents told us that they had received training in health and safety, fire safety, mental capacity and safeguarding.

We asked staff to comment on training they would find useful, they told us:

Physical intervention training
Trauma focussed and informed care
Restraint reduction and PBS update
Appraisal and revalidation peer support
DBT and CBT therapy training

All but one of the respondents agreed that training helped them do their job more effectively. All respondents told us that training helped them stay up-to-date with professional requirements and deliver a better patient experience.

All but one staff member told us that they had an annual appraisal in the last twelve months.

Workforce recruitment and employment practices

We reviewed a sample of staff files and found that all staff had undergone appropriate pre-employment checks. This included conducting interviews, obtaining references, and completion of disclosure and barring service (DBS) checks to help to ensure the suitability of staff.

We confirmed that all new staff, including bank and agency staff, receive an induction which covered a breadth of areas. This induction document was signed off by a member of management to demonstrate competence.

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 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
-	-	-	-

Appendix B – Improvement plan

Service: Pinetree Court Hospital

Date of inspection: 29-30 March 2022

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 service must ensure that the environment is maintained to a good standard and is utilised accordingly to meet the holistic and therapeutic needs of all patients.	10. Dignity and respect	There is a Pinetree Hospital environmental improvement plan in place that has also been shared with QAIS	J Nolloth D Lawrence S Jackson	6 months to a year En suite work 3-4 years
Delivery of safe and effective care				
The service must ensure that maintenance issues are acknowledged and responded to in a prompt manner.	22. Managing risk and health and safety 12. Environment	All maintenance requests are submitted on to the estates data base. The maintenance person checks this daily and will triage the work that is submitted.	J Nolloth D Lawrence S Jackson	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The service is advised to continue to remove ligature risks as part of its on-going maintenance programme.	4. Emergency Planning Arrangements	If the request involves ordering new equipment/ furniture or planned work to structure fixtures and fittings, then this will be escalated by the maintenance person and or the Hospital director to the estates department who will place an order or arrange for contractors to visit. Unit managers complete monthly environmental audits Furniture requests are submitted to estates on a furniture request form. We have a new maintenance person on site Ligature checks are completed daily as part of the daily paperwork on the units. Unit managers		Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		complete ligature risk assessments every 3 months or more often if a new risk is identified. Fish knifes are audited 3 monthly by Clinical lead and are available on both Larch and Juniper in downstairs and upstairs nursing offices these are clearly signposted and checked weekly by staff on the		
The service must ensure that cleaning is completed to a high standard in all areas and that this is appropriately documented.	13. Infection prevention and control (IPC) and decontaminati on	A meeting was held with the head housekeeper and the housekeeping team and cleaning schedules for the hospital were explored and amended. Head house keeper will ensure oversight and audit areas on a daily basis Weekly walk around with hospital manager to ensure oversight and actions of audits are occurring.	J Nolloth C Prance	Completed
The service must explore if alternative locations could be used to prepare and dispense medication to avoid any risk of potential medication errors.	15. Medicines management	Hospital manager has explored the environment to look for a solution	J Nolloth Estates team	6 months

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		and an alternative location to prepare and dispense medication. 2 potential areas have been identified but will need to be surveyed and risk assessed. These areas will also need to be assessed by the maintenance / estates team as structural work will have to be undertaken in order to ensure that they are able to convert the rooms in to appropriate areas for the purpose of preparing and dispensing medication. In the interim period there is a protocol in place for the dispensing of medication from the offices that all nurses are aware of.	Clinical lead C Wilson	
The service should ensure that patients sign the conditions of their Section 17 leave document to demonstrate their awareness and understanding. This should involve families where appropriate.	Mental Health Act monitoring	A new form has been devised in easy read format in order for patients to be empowered to identify and assess their own risks before accessing the community. This includes a section that	J Nolloth	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		asks if anyone has raised concerns about them or their behaviour recently (incorporating families)		
The service must ensure that there is a process in place for following up on requests for care and treatment plans (CTPs) from the relevant Care Co-ordiantor.	Mental Health (Wales) Measure 2016	A written process has been devised in order to ensure that follow up prompts and requests for care and treatment plans are undertaken on a regular basis until they are received	J Nolloth	Completed

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): **J Nolloth**

Job role: **Hospital Manager**

Date: **26.05.2022**