Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

St Peter's Hospital

Ludlow Street Healthcare

Inspection date: 17 – 19 October 2022

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at St Peter's Hospital, on the evening of 17 October 2022 and following days of 18 and 19 October.

The following hospital units were reviewed during this inspection:

- Brecon Unit
- Caldicot Unit
- Raglan Unit

Our team, for the inspection comprised of two HIW Inspectors, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer). The inspection was led by a HIW Senior Healthcare Inspector.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found a dedicated staff team that were committed to providing a high standard of care to patients. We saw staff interacting with patients respectfully throughout the inspection. Staff demonstrated a caring, compassionate, and understanding attitude to patients.

This is what we recommend the service can improve

- Re-commence patient community meetings
- On site Advocacy support.

This is what the service did well:

- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff
- Care for patients' physical health needs and individual risks.

Safe and Effective Care

Overall summary:
We found that staff were completing clinical processes and documentation as required. There were established processes and audits in place to manage risk, health and safety and infection control. This enables staff to continue to provide safe and clinically effective care. Legal documentation to detain patients under the Mental Health Act was compliant with the requirements of the legislation.

This is what we recommend the service can improve

- Increase number of personal alarms available for staff and visitors
- For staff to consistently wear red tabards when delivering and administrating medication.

This is what the service did well:

- Medication records and patient records were comprehensive and complete, and we saw evidence of regular audits taking place
- Individual restrictive practice reviews supported learning from incidents and informed up to date positive behavioural support plans.

Quality of Management and Leadership

Overall summary:
We observed a committed staff team who had a good understanding of the needs of the patients at the hospital. There was dedicated and passionate leadership displayed by the hospital director who is supported by a committed multidisciplinary team. Mandatory training, supervision and annual appraisal completion rates were generally high. However, improvements were needed in training compliance for basic life support and safer people handling.

This is what we recommend the service can improve

- Completion rates of certain mandatory training courses
- Review current registered nursing requirements covering Raglan and Caldicot unit.

This is what the service did well:

- We found an effective governance structure in place in terms of regular audit activities and meetings to discuss incidents, findings and issues related to patient care.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Health promotion, protection and improvement

We handed out HIW questionnaires to patients during the inspection to obtain their views on the service provided at the hospital. In total, we received five completed questionnaires, all completed by patients who were at the hospital. Patients who completed a questionnaire rated the care and service provided by the hospital as either very good or good. Some of the questionnaire results appear throughout the report.

We looked at a sample of patient records and saw evidence that patients received appropriate physical assessments upon their admission in addition to their mental healthcare. Patients also received ongoing physical health checks during their stay including health screening and monitoring of longer-term conditions, which were recorded on National Early Warning Score charts and within physical health and wellbeing care plans.

Patients were able to access GP, dental services and other physical health professionals as required. Staff had access to hospital vehicles which enabled staff to facilitate patients' activities and medical appointments in the community.

The furniture, fixtures and fittings at the hospital were appropriate for the patient group. There were up-to-date ligature point risk assessments in place. These identified potential ligature points and what action had been taken to remove or manage these.

The hospital had a business continuity plan in place that included the service's responses to such things as adverse weather, utility failures and outbreaks of infectious disease.

We observed that patients on the units were involved in a range of activities throughout the inspection. These activities included arts and crafts, board games, reading books and watching TV. Patients had access to large outdoor spaces, and during the inspection we observed patients accessing and frequently using this space.

Dignity and respect

We noted that all employees; unit staff, senior management, and administration staff, interacted and engaged with patients appropriately and treated patients with dignity and respect.

The staff we spoke with were enthusiastic about their roles and how they supported and cared for the patients. We saw staff taking time to speak with

patients and address any needs or concerns the patients raised, this showed that staff had responsive and caring attitudes towards the patients.

Some patients had access to en-suite rooms that provided a good standard of privacy and dignity. Patients could lock their rooms, but staff could override the locks if needed. We saw staff respecting the privacy of patients by knocking on bedroom and bathroom doors before entering.

Each bedroom door had a vision panel which enabled staff to undertake observations from the corridor without opening the door to minimise any potential disruption to patients sleeping. During our tour of the hospital, we positively noted that the vision panels were closed by default to protect the privacy of patients as people passed the rooms.

Patients were able to personalise their rooms and store their own possessions. Personal items were risk assessed on an individual basis for the safety of each patient.

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

Patient information and consent

Written information was displayed on the units for patients and their families. We saw that posters displayed information about advocacy services and how patients could provide feedback on the care they received on the units.

Information on visiting times was also displayed. We saw that there was clear signage within the units in both Welsh and English.

The registered provider's statement of purpose also described the aims and objectives of the service. This document was up to date and contained all the relevant information required by the regulations. Registration certificates from Healthcare Inspectorate Wales and information on how to raise a complaint were on display.

Communicating effectively

During the inspection we observed staff engaging and communicating in a positive way with patients.

The hospital used pictorial aids to support the care and treatment of patients. These pictorial aids were personalised and included information cards for dining, patient orientation prompts, safe handling guidance, and communication guides. This was highlighted as an area of good practice during the inspection because it assisted patients with cognitive impairments to communicate and recall important information about themselves.

Care planning and provision

Each patient had their own individual activity planner, this included individual and group sessions based within the hospital and community (when required authorisation was in place).

Throughout the inspection we observed patients participating in individual and group activities within the hospital.

We saw evidence that multidisciplinary reviews were being undertaken with patients fully involved in the process. We also saw that care plans were person centred with support provided in a structured way to enable patients to achieve individual goals. Our findings showed clear evidence of multidisciplinary involvement in the care plans; this helped support the hospital in being able to deliver comprehensive care to the patients.

A handover meeting was being held every weekday morning for nursing staff to update the multi-disciplinary team (MDT) on any concerns, issues or incidents that had taken place the day before. We attended a handover meeting during the inspection and saw that staff showed a good level of understanding of the patients they were caring for and that discussions focused on what was best for the individual patient.

Equality, diversity and human rights

Established hospital policies and systems ensured that the patients' equality, diversity, and rights are maintained. Mental Health Act detention papers had been completed correctly to detain patients at the hospital.

Citizen engagement and feedback

Surveys were undertaken to allow patients to provide feedback on the provisions of care at the hospital. Information was also available to inform relatives and carers on how to provide feedback.

Patient community meetings were not taking place on a regular basis, we were told that a new activities co-ordinator had been employed and plans were in place to re-commence patient meetings.

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

A sample of informal and formal complaints we reviewed showed that an independent person was assigned to investigate the complaint and actions were taken in line with the organisation's complaints policy to ensure that complaints were dealt with appropriately at the hospital.

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety

Access to the hospital site was secured by the main hospital gate, with entry gained via an intercom to reception. Entry on and off each unit was secured by electronic locks that needed a swipe card.

Staff wore personal alarms which they could use to call for help if needed. However, we were told that there were occasions where not all staff had access to personal alarms. We spoke to the hospital director who confirmed that new alarms had been ordered and that there would be a sufficient supply for staff and visitors.

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

We saw evidence of various risk assessments that had been conducted including, ligature point risk assessments and fire risk assessments. We were told of the environmental checks that are completed and saw evidence of the weekly manager checks across the units.

There were weekly audits of resuscitation equipment; staff had documented when these had occurred to ensure that the equipment was present and in date.

The hospital had a business continuity plan in place, this is regularly updated, and staff confirmed they were aware of the policy and how to escalate any concerns.

Infection prevention and control (IPC) and decontamination

We found suitable IPC arrangements in place at the hospital. A range of up-to-date policies were available that detailed the various infection control procedures to keep staff and patients safe. Regular audits had been completed to check the cleanliness of the environment and check compliance with hospital procedures.

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

The registered provider employed dedicated housekeeping staff for the hospital. Throughout the inspection we saw that overall, the hospital was visibly clean and free from clutter. However, we noted that the medication trolley on Brecon unit required cleaning.

We saw evidence to confirm that the hospital conducted necessary risk assessments and updated relevant policies and procedures to meet the added demands of the COVID-19 pandemic. Staff we spoke to were aware of infection

control obligations. We also examined COVID-19 documents, which supported staff to ensure they remained compliant with policies and procedures.

On arrival at the hospital visitors and staff had to show proof of recent negative Lateral Flow Test (LFT) or complete one on arrival.

We saw staff encouraging patients to practice good hand hygiene such as washing hands before mealtimes and hand gel dispensers were available for both staff and patients to use.

Nutrition

Patients were supported to meet their dietary needs, a dietician worked at the hospital to support staff and patients with nutritional requirements.

Patients are provided with a variety of meals from a rotating menu. Hot meals are always available. Staff told us that patients with specific/ special diets were catered for.

Some patients at the hospital were receiving the nutrients and fluids they required through a percutaneous endoscopic gastrostomy feeding tube. Staff we spoke with stated that they would benefit from additional training in this area to further develop their competencies and refresh their knowledge and skills.

Medicines management

Relevant policies, such as medicines management and rapid tranquillisation, were in date and available to staff electronically on computers in the clinic rooms.

There was good evidence of staff ensuring that patients had individualised medication management plans. We found clinical staff and the local GP had worked together to ensure decisions about medication were person centred and regularly reviewed to check they continued to be right.

A range of easy read medication information leaflets were available for patients to access.

We found the clinic rooms to be clean and tidy with individual patient medications and stock medications stored appropriately. Medication fridges were locked when not in use. There was evidence that there were regular temperature checks of the medication fridge and clinic rooms to ensure that medication was stored at the manufacturer's advised temperature.

There were arrangements in place on the units for the storage and use of Controlled Drugs and Drugs Liable to Misuse. Records we viewed evidenced that twice-daily checks were conducted with nursing signatures confirming that the checks had been conducted.

The Medication Administration Records reviewed were fully completed by staff. We saw several medication rounds, and saw that staff undertook these

appropriately and professionally, interacting with patients respectfully and considerately.

There was a mixed response from staff when we asked if staff always wear the red tabards when administrating medication. It is important that staff remain consistent with this protocol.

Safeguarding children and safeguarding vulnerable adults

We found processes in place to help ensure that staff at the hospital safeguarded patients appropriately. We saw that incidents had been subject to internal investigations and had also been referred to external safeguarding agencies.

We saw evidence that safeguarding is included at monthly clinical governance meetings as a standing agenda item to help identify any themes and lessons learned. Safeguarding is also part of the daily morning meeting agenda.

During discussions with staff, they were able to explain the process of making a safeguarding referral.

All staff had access to a patient safeguarding checklist which reminded them of the actions needed to be taken when a safeguarding issue is found.

Medical devices, equipment and diagnostic systems

There were regular clinical audits undertaken at the hospital and we saw evidence of regular auditing of resuscitation equipment. Staff had documented when these had occurred to ensure that the equipment was present and in date.

During staff discussions, it was clear that staff were aware of the locations of ligature cutters in case of an emergency. There were up-to-date safety audits in place, including ligature point risk assessments.

Safe and clinically effective care

We found governance arrangements in place that helped ensure that staff provided safe and clinically effective care for patients.

There was an established electronic system in place for recording, reviewing, and monitoring patient safety 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. Any use of restraint was documented, including who was involved and the body positions of each staff member involved in the restraint.

When restraint or verbal de-escalation are used there is an incident form completed; the incident is then discussed at governance meetings and any lessons learned are shared with staff. Debriefs take place following incidents and this process is used as a learning and reflective practice technique supported by psychology.

The clinical director robustly checked incidents and undertook work to find any patterns or trends linked to incidents or restraints. Statistical analysis is produced and then discussed and reviewed in governance meetings.

There was good evidence of learning from incidents with information guides available to staff. The hospital director and multidisciplinary team had evidence of detailed route cause analysis and there was evidence that these reviews had been summarised for staff to enhance the learning opportunities.

Records management

Patient records were a combination of paper files that were stored and kept within the locked nursing office and electronic information, which was password protected. We saw staff storing the records appropriately during our inspection.

It was clear that staff from across the multi-disciplinary teams were writing detailed and regular entries that provided a live document on the patient and their care.

We saw that staff were completing care documentation and risk assessments in full.

Mental Health Act Monitoring

We reviewed the statutory detention documents for four patients at the hospital.

All patient detentions were found to be legal according to the legislation and well documented. Overall, the records we viewed were well organised, easy to navigate and contained detailed and relevant information.

Robust systems of audit were in place for management and auditing of statutory documentation and the Mental Health Act forms part of the clinical governance meetings.

All staff have Mental Health Act training as part of induction programme and specific Mental Health training is part of staff mandatory training modules. The Mental Health Act manager is also a member of the All-Wales Mental Health Act Manager's forum.

There was no evidence that copies of section 17 leave forms are given to patients. 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. However, from the records we viewed it was clear that discussions had been held and that patients had been involved in their care and treatment.

In two patient records we noted that there was evidence that the Second Opinion Approved Doctor had consulted with the two statutory consultees, however, there was no record of their views and agreement.

A review of patient records also highlighted that there was limited involvement from advocacy services. There was some evidence that they attend and meet with

patients when requested, however, they did not appear to be routinely involved in Multidisciplinary meetings, case reviews or managers reviews. In addition, some of the patients who completed the questionnaires indicated that they would like to see an advocate.

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

Prior to this inspection taking place, a review of five patients records commenced due to notifications received of patients becoming unwell and being admitted to local general hospitals. The review of these records did not indicate any immediate concerns. However, the review of the records highlighted that staff were not always recording the timings of significant events, such as the times G.P. and ambulances were requested. It is important that timings are logged and recorded in patient records so that an accurate audit trail of events is documented.

During the inspection we reviewed the care plans of six patients. We reviewed a sample of care files and found that they were maintained to a good standard. Entries were comprehensive and recognised assessment tools were used to monitor mental and physical health.

Paper records were generally cross referenced to electronic records. Entries in both versions were comprehensive, and recognised assessment tools were used to monitor mental and physical health. However, we did identify an area of concern in one patients paper record.

The paper record 'yellow file' included a signed Do Not Attempt Resuscitation Record for the patient. However, the electronic Multidisciplinary minutes on the electronic record identified that the patient was for 'Active Resuscitation'. The Active Resuscitation date was the most recent following a review of the patient's capacity at the general hospital. This was subsequently reviewed at a best interest meeting which confirmed that the patient now had capacity and that they were for Active Resuscitation.

This was immediately addressed, and the correct paperwork was checked to correspond with both records. This was dealt with as an immediate issue which was identified, escalated, and resolved during the inspection. Further details can be found in Appendix A. It is important that the registered provider continues to perform audits on patient records to ensure that this issue does not reoccur. The registered provider should also ensure that there is a robust system in place for reviewing patients who return from hospital and updating their notes with any changes.

There was clear evidence of multidisciplinary involvement in care plans, which reflected the domains of the Mental Health (Wales) Measure.

Management of patients' behaviours were reflected in their care plans and risk management profile, along with staff training to use skills to identify risks. Overall, the nursing documentation viewed was very good and physical assessments were well completed.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental capacity assessments were being undertaken as required, when DoLS referrals were made.

All records evidenced that the correct procedures had been followed relating to DoLS applications. It was evident that the processes were being applied appropriately.

As highlighted in the Mental Health Act section of this report, the hospital needs to actively promote advocacy services and ensure that they are accessible for patients when required and more available for patients when required.

Quality of Management and Leadership

Governance and accountability framework

We found that there were well-defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. This was achieved through a rolling programme of audits and established governance structure, which enabled key/nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

There was dedicated and passionate leadership displayed by the hospital director who was supported by a committed multidisciplinary team. During meetings we attended it was positive to see discussion and debates taking place amongst the staff. During the meetings we attended staff demonstrated that they cared for the patients and staff and valued their views and opinions on how to make improvements.

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

Dealing with concerns and managing incidents

As detailed earlier, there were established processes in place for dealing with concerns and managing incidents at the hospital.

Arrangements were in place to disseminate information and lessons learned to staff from complaints and incidents at the hospital and the wider organisation. This helps to promote patient safety and continuous improvement of the services provided.

Workforce planning, training and organisational development

The staffing levels appeared appropriate to support the safety of patients within the hospital at the time of our inspection. However, we were unclear on the level of support, visibility and supervision for staff from the registered nurses covering Raglan and Caldicott Unit. Both units were separated by locked doors and only one registered nurse was covering the two clinical areas. The registered provider must provide assurances that comprehensive and robust risk assessments are in place documenting staffing requirements and risk assessment for staffing of both units.

Staff showed strong team working and appeared motivated to provide dedicated care for patients. Most staff we spoke with were positive about the support they received from colleagues. However, some staff indicated that they would like to see a more visible presence on the units from the senior management team.

Staff we spoke with were positive about the support they received from colleagues, and leadership by their managers.

We saw evidence of staff annual appraisals in staff files and there was evidence of regular staff meetings.

We reviewed staff training. Whilst it was clear that the unit managers were monitoring this, there were deficiencies in mandatory training. Training figures for safer people handling were 68%, basic life support 71%. The registered provider must ensure staff are supported to attend training and that training compliance is scrutinised on a regular basis by senior management to ensure compliance. It was positive to note that additional training courses were arranged for staff to support and assist them in caring and understanding the complex needs of patients who require additional support at the hospital.

Workforce recruitment and employment practices

It was clear 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) checks were undertaken, and professional qualifications checked.

Therefore, we were assured that recruitment was undertaken in an open and fair process.

Newly appointed staff undertook a period of induction under the supervision of the heads of care.

The hospital had a clear policy in place for staff to raise any concerns. Occupational health support was also available for staff to access.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
Do not attempt resuscitation held in patient paper files, Active Resuscitation held in patient electronic file	Staff less familiar with the individual patient may have withheld CPR based on the documentation in the paper file.	Immediately brought to the attention of the hospital director and clinical director to remove the relevant paperwork and ensure that all other patient records were checked to confirm that electronic and paper file DNAR / Active Resuscitation are correct.	All patients' records were checked whilst on site and this was followed up with documented audit checks on patient records. All of which were correct. The service has confirmed that ongoing regular audits will continue.

Appendix B - Immediate improvement plan

Service: St Peter's hospital

Date of inspection: 17 - 19 October 2022

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No Immediate Improvements				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: St Peter's Hospital

Date of inspection: 17 - 19 October 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	Standard/ Regulation	Service action	Responsible officer	Timescale
The registered provider must ensure that regular patient meetings take place.	5. Citizen engagement	Patients' meetings are held by the activity co-ordinators on the first of every month. (TOR attached for reference) All of the MDT have been informed about their attendance as part of the TOR and the patient meeting has been added to all of the team electronic diary's. Patient meeting conducted on 1/11/22 (Meeting Minutes attached for reference)	Olivia Ferrari	Meetings have re commenced on 4.11.22 and 1.12.22 and booked monthly going forward.

The registered provider must ensure that Advocacy regularly visit the hospital to enable patients to have independent support and help.	18. Communicating effectively	Advocacy posters are present in all notice boards across St Peters Hospital and accessed inline with patient needs and meetings. Newport's Advocacy service have been contacted to request twice monthly visits at St Peters. (This service available pre covid)	Olivia Ferrari	January 2023
The registered provider must ensure that there are sufficient supplies of personal alarms for staff and visitors.	22. Managing risk and health and safety	A total of 21 alarms were ordered on 15/09/22, they have now been received and have been allocated to units. A tracking sheet was introduced so that GM James Ford would be able to track alarms and keys.	James Ford	December 2022
The registered provider must ensure that the medication trolley on Brecon Unit is cleaned.	13.Infection prevention and control (IPC) and decontamination	Medication trolley was cleaned immediately and a poster reminding staff if ensuring the trolley is clean at the end of every medication round was	Olivia Ferrari	December 2022

		added into every medication clinic. Twice a month audits also completed within every unit and the cleanliness of the clinic room is reviewed and recorded. Nurse meeting booked for 30/11/22 where the cleanliness of the medication clinics and trolleys has been added to the agenda. Minutes of this meeting can be made available following 30.11.22		
The registered provider must ensure that staff administering medication continue to wear the red tabard	7.Safe and clinically effective care	Medication tabards are worn on all medication rounds across St Peters Hospital. This is audited by the Hospital Director and Quality Assurer lead, Paul Sutton. Medication tabards are audited as part of the managers walk around audit (Copy attached for reference)	Olivia Ferrari	December 2022

		Nurse meeting booked for 30/11/22 where tabards has been added to the agenda. Minutes of this meeting can be made available following 30.11.22		
The registered provider must ensure that section 17 leave forms have a space for patients to sign. If patient lacks capacity to consent this should be recorded.	20. Records	Patients section 17 leave is taken from patients likes and dislikes (This list completed by patients and patient's families) Communication sent out to all MDT members to remind them of completing clear documentation around patients' capacity of input into their own section 17. Nurse meeting booked for 30/11/22 where recordings of patients input into their section 17 leave is clearly noted has been added to the agenda. Minutes of this meeting can be made available following 30.11.22. Section 17 need to be embedded into Hospital Director local	Olivia Ferrari	December 2022

		governance report for December 2022.		
The registered provider must ensure that the SOAD documents decisions and discussions that take place.	20. Records	SOAD discussions and over all process continues to take place within St Peters Hospital and is overseen by the responsible clinician and Lisa Knott (Mental Health administrator) As part of the reassurance being provided, a process map of this process has been created and this cascaded through St Peters governance and clinical effectiveness forums	Olivia Ferrari	December 2022
The registered provider must ensure that staff record and document timings in patients records when GP's and ambulances are contacted	20. Records	Timings of GP clinics are noted on the GP records which are managed by the clinical lead. The GP clinic template is completed, this indicating date of need added to GP clinic and date seen by GP. Within the SNOS file, there is an ambulance communication sheet which indicates that all	Olivia Ferrari	December 2022

		communication with the Welsh ambulance service requires clear time noting. Nurse meeting booked for 30/11/22 where recorded times of secondary support such as WAST and GP services has been added to the agenda. Minutes of this meeting can be made available following 30.11.22 To audit this moving forward, a Quality of notes audit will review any documentation that notes around GP services and ambulance communication. This audit is embedded within the periodic audit timetable attached above.		
The registered provider must provide information on how they	20. Records	DNAR audit was created in October 2022 and completed and	Olivia Ferrari	December 2022

will continue to audit patient records for DNAR and active recus status.		evidence as part of the inspection. DNAR audit has been embedded into the Periodic Audit Time Table for St Peters Hospital and to be completed every 3 months. DNAR change of information is also part of the morning meeting template and any changes are noted within this forum and actions allocated to ensure oversight.		
The registered provider must ensure that staff have access to regular training to support them with PEG feeding	25.Workforce planning, training, and organisational development	PEG training is provided by Acute training solutions and this session has been re booked for December 2022 and January 2023 and booked annually.	Olivia Ferrari	January 2023
The registered provider must ensure that a comprehensive and robust risk assessment has taken place regarding nurse staffing	25.Workforce planning, training, and organisational	Raglan is registered as a single unit and Caldicot is also registered as a single unit with two separate gender wards. The levels that are provided by day and night are consistent with the	Olivia Ferrari	December 2022

requirements across Caldicott and Ragan Units	development. Workforce	way in which both units have been registered. Staff (Including qualified staff) carry alarms which notify all staff on any incident and response attends within 20-30seconds. A comprehensive risk assessment is in place for nursing staff on both individual units as noted in the action column.		
The registered provider must ensure mandatory training is completed and improvements are made in compliance figures for basic life support and safer people handling.	25.Workforce planning, training, and organisational development	Mandatory training is tracked and monitored on a monthly basis at local and corporate governace forums. Currently mandatory training stands at 84% and is projected at the level of 85% which is required by our own internal policy standard by the end of January 2023. Mandatory training percentage is currently impacted by a large number of recent new starters, all of whom have 6 months to complete mandatory training.	Olivia Ferrari	December 2022

		We have recently contracted with manual handling and First Aid training specialists to provide twice monthly training sessions in addition to our own internal training resource to address compliance moving forward.		

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: Hospital Director

Date: 1st December 2022