

# Independent Mental Health Service Inspection Report (Unannounced)

St Peter's Hospital

Iris Care Group

Inspection date: 23, 24 and 25 March 2026

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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 .....	5
2. Summary of inspection.....	6
3. What we found .....	11
• Quality of Patient Experience .....	11
• Delivery of Safe and Effective Care .....	16
• Quality of Management and Leadership.....	27
4. Next steps .....	30
Appendix A - Summary of concerns resolved during the inspection.....	31
Appendix B - Immediate improvement plan .....	32
Appendix C - Improvement plan .....	35

# 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 23, 24 and 25 March 2026. The hospital is operated by Iris Care Group and provides inpatient services for adults with complex and acute mental and physical healthcare needs who require ongoing multidisciplinary assessment, treatment and support.

The service is registered to provide single-gender wards, each of which can admit patients aged over 30 years. The following wards were reviewed during this inspection:

- Brecon Ward - Provides a capacity of nineteen beds
- Upper Caldicot Ward - Provides a capacity of six beds
- Lower Caldicot Ward - Provides a capacity of six beds
- Upper Raglan Ward - Provides a capacity of five beds
- Lower Raglan Ward - Provides a capacity of nine beds.

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

During the inspection we spoke with patients or their families/carers to find out about their experiences of using the service. We also spoke with staff members to find out their views on working for the service.

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

## 2. Summary of inspection

### Quality of Patient Experience

Overall summary:

Patients appeared comfortable in the service and interacted positively with staff, who demonstrated a good understanding of individual needs. Care was supported through regular multidisciplinary input, access to primary and secondary healthcare services, and a range of therapeutic and social activities that promoted engagement and wellbeing. We observed well-organised group activities, with staff adapting approaches to encourage participation, and patients were supported to access community facilities where appropriate.

Staff treated patients with respect and communicated in a clear and supportive way. Patients had access to their own bedrooms, which they were able to personalise, and information about the service was available in accessible formats, including an easy-read patient guide to support patients and families to understand the service and their rights. We also saw examples of reasonable adjustments being made to meet patients' needs, including adapted access and specialist equipment.

Patients and families had some opportunities to give feedback about the care provided, including through meetings and surveys, and information about how to raise concerns was available on the wards.

However, we identified some important gaps in care. Patients were not always consistently supported to maintain their personal hygiene and appearance, with several patients observed wearing clothing with visible food stains. We also found that patient records did not always clearly reflect individual care needs or level of independence. In one case, the care being provided did not match what was written in the patient's records and care plans, meaning staff did not always have clear or up-to-date information about the care needed. Opportunities for patients and families to give feedback outside of planned meetings were also limited.

Overall, patients were being supported in a caring environment with access to appropriate services and activities, but improvements were needed to ensure care was delivered consistently and recorded clearly.

This is what we recommend the service can improve:

- Ensure patients are consistently supported to maintain personal hygiene and appearance

- Ensure patient records and care plans accurately reflect care needs and the care being provided
- Provide more opportunities for patients and families to give feedback outside of planned meetings and surveys.

This is what the service did well:

- Well-structured group activities promoted patient engagement, with staff adapting approaches to support participation
- Effective communication support was in place, including the use of visual aids and tools to help patients understand and engage in their care
- A wheelchair-accessible vehicle was available to support patients to access the community and promote independence.

## Delivery of Safe and Effective Care

Overall summary:

We found that the service had a range of systems in place to support the delivery of safe and effective care. Care was supported through regular multidisciplinary input, access to specialist services and arrangements for monitoring patients' physical health needs.

Patients' nutrition and hydration needs were generally well supported, medicines were largely managed safely in routine practice, and safeguarding systems were well understood by staff, with appropriate arrangements in place to report and respond to concerns.

However, we identified a number of significant issues that reduced assurance that care was consistently safe in practice. We found gaps in medicines management processes following the introduction of a new electronic system, including difficulties accessing Consent to Treatment documentation. This created a risk that medication may not always be administered in line with the correct legal authority and required immediate action during the inspection.

We also identified concerns in several areas of day-to-day practice. Infection prevention and control standards were not consistently maintained, including issues with environmental cleanliness and hygiene practices. This included concerns relating to food hygiene, such as potentially unclean food probes used during meal preparation and service, which increased the risk of cross-contamination. Issues were also identified in the condition and maintenance of the environment. We found gaps in routine safety processes, including the management of oxygen and access to emergency equipment, which reduced assurance that risks were being managed consistently.

Care planning processes were in place and were generally structured in line with the Mental Health (Wales) Measure 2010. However, we identified omissions and inconsistencies, including a missing care plan for one patient and care plans that had not been updated to reflect changes in care, such as the continued reference to covert medication that was no longer being used. This reduced assurance that care was clearly planned and consistently delivered.

We also identified concerns relating to the use of enhanced observations and restrictive practices. Not all patients on enhanced observations had a corresponding, up-to-date care plan in place, and where plans were present, they did not always provide clear guidance for staff. We found inconsistencies in how observation levels were recorded and implemented in practice, and on occasions staff were not observed to be following prescribed observation levels. These issues reduced assurance that risks were being managed safely and consistently.

Overall, while appropriate systems and processes were in place, they were not always consistently applied in practice. Improvements were required to strengthen oversight, improve consistency and support the delivery of safe and effective care.

Immediate assurances:

- Immediate action was required following risks identified with the implementation of the new electronic medicines system, where staff were unable to consistently access Consent to Treatment documentation, reducing assurance that medicines were being administered in line with the appropriate legal authority.

Details of the concerns for patient's safety and the immediate improvements and remedial action taken are provided in [Appendix B](#).

This is what we recommend the service can improve:

- Strengthen infection prevention and control practices, including cleaning processes and environmental cleanliness
- Address environmental maintenance issues to ensure wards are safe and fit for purpose
- Improve medicines management processes, including secure storage, accurate recording and staff understanding of legal requirements
- Ensure emergency equipment and oxygen are stored and accessible in a safe and consistent way
- Improve the implementation and recording of enhanced observations and restrictive practices
- Ensure care plans are complete, up to date and accurately reflect current care and treatment

- Ensure food hygiene practices are consistently followed, including the cleaning, storage and maintenance of food probes and equipment
- Ensure there is robust oversight of patients awaiting DoLS authorisation, including taking effective action where delays persist to mitigate the risk of unlawful deprivation of liberty
- Strengthen audit and quality improvement processes to ensure issues are identified and addressed promptly.

This is what the service did well:

- Patients' legal status was appropriately managed, with Mental Health Act documentation in place and records demonstrating compliance with the Act and Code of Practice
- Care plans reflected a person-centred approach, with a focus on recovery, rehabilitation and maintaining independence
- Safeguarding systems were well established, with staff demonstrating a clear understanding of how to identify and report concerns
- Multidisciplinary working supported the regular review of patients' needs and care.

## Quality of Management and Leadership

Overall summary:

Staff we spoke with during the inspection were positive about their roles and spoke positively about working at the hospital. We received one response through the staff questionnaire which raised some concerns about communication and staff experience; however, as this was a single response, we were not able to triangulate this feedback.

We found that governance and oversight arrangements were in place to support the effective running of the service. There was evidence of regular management involvement in day-to-day operations, supported by a range of governance and communication processes, including meetings and supervision. Staff were able to describe systems for reporting concerns, incidents and risks, and we saw evidence that these were monitored and managed through established processes.

The service had recently appointed a new clinical lead, who was proactive in engaging with the inspection process and supporting improvements during the visit. However, as this was a new role, further time was required to embed leadership oversight and support sustained improvement across the service.

We found that systems were in place to manage complaints and incidents, with evidence that learning was shared with staff. However, feedback from a relative indicated that communication following concerns raised was not always consistent,

and that concerns sometimes needed to be raised more than once before action was taken. While the service responded to this during the inspection, it will be important to ensure improvements are sustained.

Workforce arrangements were generally well managed. Staffing levels were appropriate, with suitable skill mix and low reliance on agency staff. Training compliance was high, and staff had access to development opportunities. However, appraisal compliance was below expected levels, which reduced assurance that all staff were receiving regular performance review and support.

This is what we recommend the service can improve:

- Ensure policies and procedures are consistently reviewed and kept up to date
- Strengthen communication with patients and families following concerns raised
- Ensure appraisal processes are consistently completed for all staff
- Continue to embed governance and leadership arrangements.

This is what the service did well:

- Training compliance was high, supporting staff to carry out their roles safely
- Appropriate workforce recruitment processes were in place, including induction arrangements for agency staff to support safe and consistent practice.

## 3. What we found

### Quality of Patient Experience

#### **Patient feedback**

Due to the complexity of patients' needs, we were limited in the amount of direct feedback we were able to obtain. However, based on our interactions and observations, patients appeared comfortable with staff, who engaged well and were able to demonstrate a good understanding of patients' individual needs.

#### **Health promotion, protection and improvement**

We found that there were systems in place to support patients' health and wellbeing. Multidisciplinary team (MDT) meetings were held regularly, which supported oversight of patients' physical alongside their mental healthcare needs.

We saw that a range of therapeutic activities and sessions were available to support patients' wellbeing. Activities observed during the inspection included structured group sessions such as bingo and horse racing, where staff made efforts to engage patients through tailored approaches, including personalised incentives. These sessions were well organised and promoted patient engagement. Staff highlighted that a newly appointed band five staff member had been recruited to support activity provision. We also saw examples of patients being supported to access community facilities on a regular basis, which supported social engagement and independence.

We saw evidence that patients had access to primary and secondary healthcare services. Patients were registered with GPs and dentists, and records indicated that physical healthcare needs were being monitored, including regular health checks and referrals to other services where required.

Our discussions with staff demonstrated that patients' physical healthcare needs were being considered. However, these were not always consistently reflected within the care plans we reviewed during the inspection. For example, one patient's physical healthcare plan detailed the equipment required to support them but did not reference the regular GP access and monthly physical healthcare checks that were being undertaken. This reduced overall assurance that the care plans provided a complete record of each patient's care.

**The registered manager must ensure that care plans accurately reflect all aspects of patients' care, including physical healthcare needs, to support the safe delivery and continuity of care.**

## **Dignity and respect**

We observed staff treating patients with dignity and respect and engaging positively with them. Staff demonstrated a good understanding of patients' individual needs and behaviours, and interactions observed during the inspection were caring and supportive.

However, we identified concerns in relation to the support provided to maintain patients' personal hygiene and appearance. During the inspection, we saw several patients wearing clothing with visible food stains, which indicated that patients were not always being supported or prompted to change their clothing following mealtimes. Staff told us that patients could be supported to change, or that protective measures such as the use of aprons could be considered; however, this did not appear to be applied consistently in practice.

**The registered manager must ensure that patients are consistently supported to maintain their personal hygiene and appearance, including being prompted or assisted to change clothing following meals where required, to promote dignity and wellbeing.**

We also reviewed the care provided to one patient and identified concerns regarding personal care arrangements. Information provided by a relative, alongside a review of records and discussions with staff, indicated that the patient required support with personal hygiene, but this had not always been consistently provided. This included occasions where the patient had not received appropriate personal care, such as support with washing, which had impacted on their dignity and wellbeing. Nursing records relating to the patient's level of independence were inconsistent and did not accurately reflect their needs. Entries described the patient as independent with personal care; however, this did not align with the care being delivered or required.

**The registered manager must ensure that nursing records accurately reflect patients' needs, including their level of independence, so that documentation provides a clear and reliable account of the personal care required and delivered, and that this care is consistently provided in practice.**

Patients had access to their own bedrooms, which they were able to personalise. We saw positive decorative features, including colourfully painted bedroom doors and 'about me' boards, which provided staff with helpful information about patients' preferences and needs. Not all bedrooms had en-suite facilities; however, we were told refurbishment work was underway to provide these, which would improve patients' comfort, privacy and dignity.

### **Patient information and consent**

A patient guide was provided to patients and their families prior to admission. We reviewed the patient guide and noted that it was written in an easy-read format and included pictures, which was appropriate given the cognitive needs of the patient group. The guide included information on raising concerns and the role of HIW, helping patients and families to understand the service and their rights.

We also saw that further information was available to patients across the wards, including details of visiting times and access to advocacy services such as the Independent Mental Health Advocate (IMHA). This supported patients to understand and engage with their care and treatment.

### **Communicating effectively**

We observed staff communicating with patients in a clear and appropriate manner. Staff spoke with patients in a way that was easy to understand and avoided the use of overly complex language, supporting patients to engage with their care and treatment.

We saw that systems were in place to support patients with communication needs. This included the use of clocks and information boards displaying key information, such as the date and weather, which supported patient orientation. We also saw the use of pictorial aids within dining areas to support communication for some patients.

Patients were supported to maintain contact with family members and others using digital communication methods, including telephone and video calls. Staff facilitated this appropriately and adapted arrangements to meet patients' individual needs, including supporting international contact where required.

A range of private spaces were available to allow patients to speak with staff confidentially. There were also systems in place to support the safe use of digital communication, including controls to prevent access to inappropriate content and the sharing of patient information.

We saw evidence that patients were involved in discussions about their care and treatment. Regular multidisciplinary team (MDT) meetings took place, which included patients, their representatives and relevant professionals, supporting a coordinated and person-centred approach to care.

### **Care planning and provision**

Our review of care and treatment plans evidenced that patients had assessments and care plans in place which reflected their needs and supported the delivery of

care. Pre-admission assessments were comprehensive, and ongoing clinical risk assessments were completed and reviewed regularly.

Care and treatment plans were person centred and reflected consideration of patients' individual needs and behaviours. Planned review processes were in place, including regular multidisciplinary team (MDT) meetings and six-monthly Care and Treatment Plan reviews, which involved patients, their representatives and relevant professionals.

Plans were generally structured in line with the Mental Health (Wales) Measure 2010, with care plans organised to reflect the relevant domains. However, we identified some omissions and inconsistencies in how these were applied:

- We could not find a 'Medical and other forms of treatment, including psychological interventions' care plan in place for one patient, which is considered a fundamental component of inpatient care
- One care plan referred to covert medication being administered; however, discussions with staff confirmed this was no longer applicable. This did not provide assurance that care plans were being updated in a timely manner to reflect the care being delivered.

**The registered manager must ensure that all required care and treatment plan domains, in line with the Mental Health (Wales) Measure 2010, are in place and that care plans are kept up to date to accurately reflect the care and interventions being provided.**

Further information on the quality of care and treatment plans can be found in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section later in the report.

### **Equality, diversity and human rights**

We found that arrangements were in place to support equality, diversity and human rights. Staff had completed equality and diversity training, and policies were in place to support practice that recognised and respected individual needs. Staff described an open culture, where patients were treated as individuals and their needs were considered as part of care planning.

We saw examples of reasonable adjustments being made to meet patients' individual needs. The environment had been adapted to improve accessibility, including the installation of a drop kerb to support wheelchair access. Patients had also been provided with additional equipment, such as pillows and specialist aids, to support their comfort and physical health needs.

Patients were supported to access the community where appropriate, including through the use of a wheelchair-accessible hospital van, which enabled patients with mobility needs to participate in activities and maintain independence.

### **Citizen engagement and feedback**

Patients and their families had some opportunities to provide feedback on their experiences of care. Information about how to make a complaint was available, including posters on the wards. More structured engagement arrangements were in place, including fortnightly patient meetings, multidisciplinary reviews and surveys used to gather feedback on areas such as activities and food. However, a suggestion box was available but not being used, and this limited opportunities for patients to provide feedback outside of these structured sessions. The service should consider how it can strengthen these arrangements.

# Delivery of Safe and Effective Care

## Safe Care

### Environment

The hospital environment was generally accessible for patients with mobility difficulties. Wards were laid out to allow wheelchair access, with lifts, wide corridors and accessible bathroom facilities in place.

We were told that Raglan Ward was currently being refurbished to improve its overall appearance and condition. However, the condition and maintenance of other areas of the environment also required improvement. We identified a range of issues relating to fixtures and fittings, including unsealed sinks, worktops and cupboards in poor condition, and worn or broken furniture. These concerns were most evident on Brecon ward, where the environment was notably poorer in condition. Overall, these findings reduced assurance that the environment consistently supported safe and effective care.

**The registered manager must ensure that a comprehensive programme of environmental improvement is implemented to address identified maintenance and safety issues across all wards.**

### Managing risk and health and safety

The service had systems in place to support the management of risk and health and safety, including the use of risk assessments and established arrangements for incident reporting and governance oversight. Ligature cutters were available and staff were aware of their location, and ligature risk audits were being undertaken. Staff were also observed to be wearing personal safety alarms, and call bells were accessible to patients.

However, despite these arrangements, we identified a number of issues which fell below expected standards and indicated reduced attentiveness to routine safety and assurance processes. Examples included a dirty temperature probe cover, unsecured clinical and sluice rooms with doors left open, inappropriate items stored within clinic rooms, and out-of-date patient information displayed on wards.

**The registered manager must ensure that robust and consistent safety and assurance processes are embedded across all wards. This should include strengthening oversight of routine checks, ensuring these are completed accurately and consistently, and reinforcing staff accountability for maintaining safe environments and adherence to expected standards.**

We also identified issues relating to the management of oxygen, including out-of-date oxygen cylinders stored alongside in-date cylinders, which could lead to confusion, and oxygen not stored in line with recommendations set out in the local fire risk assessment.

**The registered manager must ensure that oxygen cylinders throughout the hospital are stored, managed and monitored in line with fire safety guidance and local risk assessment requirements.**

### **Infection prevention and control (IPC) and decontamination**

We found that the service had arrangements in place to support infection prevention and control (IPC). Personal protective equipment was available across wards and staff were observed to use this appropriately. Staff reported that IPC training was undertaken, and there was evidence that some areas of the environment, including bathrooms and communal spaces, were clean and well maintained. Facilities were available to support barrier nursing when required.

However, we identified a number of concerns which reduced assurance that IPC standards were consistently embedded in practice. Cleanliness was not maintained to a consistent standard across all areas. Ongoing cleanliness issues were observed in the kitchen on Raglan Annex, including visibly dirty surfaces, dust accumulation and compromised areas which required a deep clean. While some cleaning had been undertaken following this being highlighted, further work was required to ensure sustained improvement. We also observed environmental issues, including dirty sealant and signs of mould, as well as furniture and surfaces which were not maintained in a condition that supported effective cleaning.

There were also gaps in cleaning processes and oversight. Cleaning schedules were not consistently completed, with gaps identified in records and uncertainty as to whether schedules reflected all required cleaning tasks. Despite records indicating cleaning had taken place, some areas remained visibly unclean. We also found instances where patient bedrooms had not been cleaned consistently, including over weekends, with some floors noted to be sticky. There was no evidence that alternative arrangements had been made when patients declined cleaning.

In addition, staff adherence to IPC practices was inconsistent. We observed that nurses were not consistently bare below the elbow, which does not align with expected standards for infection prevention. Staff we spoke with were unable to consistently identify who held responsibility for IPC oversight. Strengthening leadership and visibility in this area would support improved governance and consistency of IPC practice.

**The registered manager must ensure that IPC standards are consistently implemented and effectively overseen across all wards, including improving environmental cleanliness, strengthening cleaning processes, and ensuring staff adhere to infection prevention requirements.**

### **Nutrition**

Overall, the service generally met patients' nutritional and hydration needs, with systems in place to assess, monitor and support individuals. We saw evidence that appropriate assessments were completed on admission, including nutrition and choking assessments. Access to specialist support, including dietetics and speech and language therapy, was available where required, and modified diets were provided to meet clinical needs such as swallowing difficulties. Nursing records confirmed that nutritional screening and weight monitoring were routinely undertaken, with monthly reviews and multidisciplinary input supporting patients' physical health needs.

Dining environments were generally appropriate, and patients were encouraged to eat in communal areas where possible. More independent patients were able to access kitchen facilities under supervision. Patients were offered choice in what, when and where they ate, with flexible mealtimes and encouragement from staff to promote intake. Staff were observed to be caring and supportive, with a good understanding of individual preferences.

Menus were available and offered a reasonable variety. However, some patients reported dissatisfaction, and options for those on restricted diets were limited. We were also told by a relative that food was not always reoffered if initially declined. In addition, menu displays were not always easily accessible due to small print.

**The registered manager must ensure that patients are consistently supported to meet their nutritional needs. This should include reviewing processes for offering alternative meals where food is declined, ensuring menu information is accessible and easy to read, and that suitable options are available for patients with restricted or specialist diets.**

We saw evidence that patients' food and fluid intake was monitored daily. However, during our review of nursing records, it was not always easy to locate and review intake records on the electronic system.

**The registered manager must ensure that systems for recording and monitoring patients' nutritional intake are clear, accessible and support effective oversight, including ensuring staff can easily access and review food and fluid records.**

We also identified environmental and food safety concerns. Although staff were using food probes during meal service, these were not stored in a clean condition and were kept in a visibly dirty container. Cleaning wipes stored alongside the probes were dry, and we were not assured they were being used. In addition, food labelling equipment, including stickers and storage boxes, was unclean and required replacement.

**The registered manager must ensure that effective food hygiene and safety practices are consistently followed when handling, serving and storing food. This must include ensuring that food probes are appropriately cleaned and stored in a clean, dry condition, and that all food-related equipment is maintained in a clean condition and replaced when required.**

### **Medicines management**

Overall, medicines were generally managed safely, with appropriate systems in place for storage, administration and oversight. We saw evidence that controlled drugs were managed in line with guidance, including appropriate recording, secure storage and regular stock checks. Medicine trolleys and fridges were secured, and keys were appropriately managed by nursing staff. Temperature monitoring was taking place; however, some gaps in recording were identified. While medicines were mostly stored securely, we found that some cupboards, including those used to store supplement drinks, were not always locked.

**The registered manager must ensure that medicines are stored securely at all times and that temperature monitoring records are fully completed, with no gaps, to provide assurance that medicines are stored safely and in line with policy.**

We reviewed medication administration records and found that, while patient identification and legal status were appropriately recorded, administration was not always documented contemporaneously. We identified a delay of up to two hours in recording the administration of a topical treatment on one occasion. We also found an instance where medication had not been administered and the reason for this had not been clearly documented.

**The registered manager must ensure that medicines administration records are completed contemporaneously and that reasons for non-administration are clearly documented.**

HIW had previously sought assurance following medication errors identified at the hospital. During this inspection, staff told us that a new electronic medicines management system had been introduced in March 2026 to improve oversight and reduce risk. While this was a positive step, we were not assured that its

implementation had been supported by sufficient staff training, oversight or governance, or that staff were consistently administering medication in line with the appropriate legal authority under the Mental Health Act. During the inspection, two nurses were unable to locate Consent to Treatment certificates on the system and instead relied on an out-of-date paper folder on the ward. This created a risk that medication could be administered without confirming the correct legal authority, meaning patient rights may not be fully protected. Although some local actions had been taken to improve access to documentation, this did not provide assurance of a consistent or sustainable system, or that staff were fully familiar with its use.

Further information on our concerns and the immediate improvements and remedial action taken by the service are provided in [Appendix B](#).

We observed that patients were involved in decisions about their medicines where possible. However, we did not see evidence of accessible medication information, such as easy read leaflets, to support patients' understanding of their treatment.

**The registered manager should ensure that appropriate and accessible information about medicines is available to patients, including easy read formats where required.**

#### **Safeguarding children and safeguarding vulnerable adults**

Arrangements for safeguarding appeared effective, with systems in place to protect patients and manage concerns appropriately. Patients told us they generally felt safe on the ward and were able to raise concerns with staff. Staff demonstrated a good understanding of their roles and responsibilities in relation to safeguarding. They were able to describe how to identify and report concerns and knew how to access safeguarding procedures. Staff were also aware of the whistleblowing process and told us they would escalate concerns appropriately and complete the required documentation. Training compliance for safeguarding was good, which supported staff knowledge and confidence in managing concerns.

We found that safeguarding processes were supported by clear systems for reporting and oversight. Safeguarding concerns were recorded on an electronic system, with oversight provided by senior staff through a central dashboard. There was evidence that concerns were investigated and that learning was shared with staff through handovers, training and communication processes. We saw an example of a recent safeguarding incident relating to a patient receiving the wrong type of drink. This had been appropriately investigated, and action had been taken to reduce the risk of recurrence, including improved labelling processes.

### **Medical devices, equipment and diagnostic systems**

Overall, appropriate emergency equipment was available across the hospital, and we saw evidence that regular checks were being undertaken to ensure equipment was safe and in date. We did note that resuscitation flowcharts displayed in clinical areas were out of date; these were updated during the inspection following feedback.

However, we identified inconsistencies in the storage and accessibility of emergency equipment across the hospital, which reduced assurance that it could be accessed quickly and consistently. On some wards, equipment arrangements were shared, requiring staff to travel between locations, while on others, essential equipment and key documentation, such as DNACPR forms, were stored in separate areas. On Upper Raglan, staff described needing to access multiple locations, including the clinic room and nursing office. These arrangements appeared complex and may delay a timely and effective response in an emergency situation.

**The registered manager must review emergency equipment arrangements to ensure they are consistent and easily accessible across all wards, supporting a timely and effective response in an emergency.**

### **Safe and clinically effective care**

Overall, the service had some systems in place to support the delivery of safe and clinically effective care, with access to a full multidisciplinary team and a range of therapeutic activities for patients. Staff told us they generally had sufficient time to deliver care and described a collaborative team approach, with access to relevant policies and guidance to support practice.

We found that positive behaviour support (PBS) plans were in place; however, improvements were required to ensure that restrictive practices, including enhanced observations, were consistently applied in line with policy and individual patient needs. Not all patients on enhanced observations had corresponding care plans, and where these were in place, they did not always include clear guidance on managing risks, including the use of physical interventions.

**The registered manager must ensure that all patients requiring enhanced observations have a corresponding, up-to-date care plan in place that clearly outlines identified risks and provides detailed guidance for staff, including the appropriate use of physical interventions where necessary.**

In addition, we identified inconsistencies in how enhanced observations were implemented and recorded. Prescribed observation levels included generic descriptions such as “within arm’s length” or “line of sight when settled”, which lacked clarity and did not clearly define expectations for individual patients.

Records did not always provide sufficient detail to demonstrate that observations were being carried out consistently. On two occasions during the inspection, we observed that staff were not adhering to the prescribed observation levels, reflecting the ambiguity in how these levels were interpreted in practice. Furthermore, there was no clear evidence that observation levels were reviewed daily in line with policy or discussed routinely during safety huddles or multidisciplinary meetings.

**The registered manager must ensure that enhanced observations are clearly defined, individualised and consistently implemented, with sufficient detail to support staff in safely managing risks. Observation levels must be reviewed regularly in line with policy and clearly documented.**

We also identified concerns regarding the management and oversight of restrictive practices. In one incident involving prolonged supine restraint and the administration of intramuscular medication, there was no evidence of post-incident physical health monitoring, senior clinical oversight or escalation to the responsible clinician. There was also limited evidence of debrief or learning following the incident.

**The registered manager must ensure that all incidents involving restrictive practices are appropriately monitored, recorded and subject to effective clinical oversight, including post-incident physical health checks, escalation where required and opportunities for debrief and learning.**

#### **Participating in quality improvement activities**

Overall, the service demonstrated that a range of quality improvement activities were in place, including local audits, incident reporting, feedback mechanisms and performance monitoring. These processes supported oversight of the service, with evidence that learning from incidents and concerns was shared through governance arrangements and used to inform improvements and staff development where appropriate.

However, our findings across the inspection indicated that these systems were not always effective in identifying issues or driving sustained improvement. We identified a number of concerns during the inspection, including areas relating to medicines management, observations and emergency equipment, which had not been identified through existing audit processes. This reduced assurance regarding the effectiveness of current quality improvement arrangements and their ability to provide robust oversight of clinical practice.

**The registered manager must ensure that quality improvement and audit processes are reviewed and strengthened to ensure they are effective in**

**identifying issues, driving improvement and providing robust oversight of service quality and patient safety.**

### **Records management**

Patient records were maintained electronically using the Nourish system, which was password protected to prevent unauthorised access and maintain confidentiality. However, during the inspection, we reviewed the Nourish system and found it difficult to navigate. It was not always straightforward to locate key information, including daily records and accounts of care, and this often relied on the knowledge and confidence of individual staff members. Staff were not always able to easily retrieve or demonstrate patient records in a timely way.

Some areas of the system contained incomplete or unused sections, and there was a lack of clarity about where specific information should be recorded. This meant that patient information was not always presented in a clear or consistent way and reduced assurance that staff could easily access a contemporaneous account of care.

We did not experience the same level of difficulty navigating records on Nourish within another service operated by the same organisation, which suggests there may be opportunities for shared learning to improve consistency and usability across services.

**The registered manager should review how the electronic record system is used to support staff in recording, locating and reviewing patient information, with a view to improving consistency, navigation and accessibility of records.**

### **Mental Health Act monitoring**

We reviewed a sample of three detained patient records and found that patients were appropriately detained under the Mental Health Act, with the required legal documentation in place to support this. Overall, records demonstrated compliance with the Act and the Code of Practice, providing assurance that patients' legal status was appropriately applied.

We saw evidence that capacity assessments were being undertaken and recorded appropriately, with relevant documentation in place to support clinical decision-making. This was a positive improvement since our previous inspection at the hospital. However, it was not always clear whether patients who lacked capacity had been supported to apply for a tribunal, or whether applications had been made on their behalf.

**The registered manager must ensure that patients who lack capacity are appropriately supported to exercise their rights under the Mental Health Act,**

**including access to tribunal processes, with clear evidence of this recorded in patient records.**

We reviewed Section 17 leave arrangements and found that leave was appropriately risk assessed, with clear conditions documented for staff and patients. There was also evidence that patients were involved in decisions regarding their leave where possible, supporting a person-centred approach.

However, we found that MHA documentation was stored across multiple systems, including a shared drive and Nourish. This made it difficult to locate key information in a timely way and, in some cases, staff were unable to easily access or demonstrate relevant documentation during the inspection.

**The registered manager must ensure that all Mental Health Act documentation is stored in a consistent and accessible manner, so that staff can easily locate and review relevant information to support safe and lawful practice.**

We observed that advocacy referrals were being made and that an independent advocate visited the service regularly. However, discussions with staff indicated that understanding of patients' entitlement to advocacy was inconsistent, and that access to advocacy was not always proactively promoted, with reliance on staff referrals in some cases.

**The registered manager should ensure that all staff have a clear understanding of patients' entitlement to advocacy and that access to advocacy is consistently promoted and facilitated for all eligible patients.**

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

We reviewed four care and treatment plans and found that patients had detailed pre-admission assessments and ongoing clinical risk assessments in place. Care coordinators had been identified, and there was good evidence of regular multidisciplinary team involvement, including monthly reviews and planned six-monthly Care and Treatment Plan reviews. These processes supported a coordinated approach to care planning, with involvement from patients, their representatives and external professionals where appropriate.

We saw good examples of person-centred care plans that reflected patients' preferences, behaviours and individual needs. Care plans demonstrated a focus on recovery, rehabilitation and maintaining independence, which was positive given the complexity of the patient group. There was also evidence that patient views were incorporated into care planning where possible. Discharge planning was

considered through established review processes and included input from relevant professionals.

However, we identified inconsistencies in how care plans were maintained and updated. While the layout of care plans broadly reflected the domains of the Mental Health (Wales) Measure 2010, these were not always fully completed or consistently applied in practice. Some care plans did not clearly evidence unmet needs or how these would be reviewed and progressed. In addition, care plans were not always updated in a timely manner to reflect changes in care. For example, one care plan continued to reference the use of covert medication despite this having been withdrawn, which reduced assurance that documentation accurately reflected the care being delivered.

**The registered manager must ensure that care and treatment plans are complete, consistently applied and kept up to date, clearly reflecting patients' current needs, interventions and any changes in care. Care plans must also identify unmet needs and include clear plans for review and progression.**

We also found variation in how consistently care planning standards were applied across the service. Although local audits had identified similar issues, there was limited evidence that effective action had been taken to address these findings and drive improvement.

**The registered manager should ensure that clear standards are established for care and treatment planning, including defining the minimum required documentation, and that audit processes are used effectively to monitor compliance and drive sustained improvement.**

### **Mental Capacity Act and Deprivation of Liberty Safeguards**

We reviewed arrangements relating to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) and found that, where applications had been completed, appropriate processes had been followed and documentation demonstrated compliance with relevant legislation and guidance.

However, we identified a significant backlog of patients awaiting assessment for a standard DoLS authorisation. At the time of the inspection, five patients were awaiting assessments and did not have a current legal framework in place to support their care. This meant that these patients may have been subject to a deprivation of liberty without the appropriate legal authority, which raised concerns regarding the protection of their rights. This issue had also been identified at the previous inspection, and while the service had continued to escalate concerns to the local authority, the position had not been resolved.

While responsibility for completing DoLS assessments and granting authorisations sits with the local authority, the provider remains responsible for ensuring that any deprivation of liberty is lawfully authorised. In the absence of a legal framework, this presents a potential legal and human rights risk for patients. It is therefore important that the service strengthens oversight of patients awaiting authorisation, ensuring risks are appropriately monitored and escalated while a legal framework is not in place.

**The registered manager must ensure there is robust and consistent oversight of patients who may be subject to a DoLS without a current legal framework, including considering alternative actions where standard escalation has not been effective. This should include proactive engagement with the local authority and clear documentation of how risks are assessed, monitored and reviewed.**

# Quality of Management and Leadership

## Staff Feedback

Staff we spoke with during the inspection were positive about their roles and spoke positively about working at the hospital. No concerns were raised during these discussions about morale or job satisfaction.

We received one response to the staff questionnaire. The feedback included some concerns relating to communication and staff experience within the service. As this feedback was based on a single response, we were not able to triangulate these concerns with other evidence gathered during the inspection. However, it highlights the importance of maintaining an open culture where staff feel able to raise concerns and are confident that these will be listened to and responded to appropriately.

## Governance and accountability framework

We found that systems and processes were in place to support governance, leadership and accountability within the service. We were told that senior staff maintained oversight of day-to-day operations, including regular visits to clinical areas and engagement with staff. Unannounced visits were undertaken in line with regulatory requirements, and there were mechanisms in place to review key documents such as the Statement of Purpose and Patient Guide.

Governance arrangements were supported through a range of meetings and communication processes, including clinical governance meetings and handovers, which provided opportunities for information sharing and oversight. We saw evidence that staff were receiving regular supervision, with good compliance rates, providing assurance that staff were being supported and performance monitored.

The service had recently appointed a new clinical lead. The clinical lead was present during the inspection and was proactive in engaging with the inspection process, responding to feedback and supporting the service to take forward immediate actions where required. However, as the role was newly established, further time will be required to embed processes and support ongoing service improvement, including addressing the areas identified during this inspection.

We found that a range of suitable policies and procedures were in place and reviewed as required. However, we identified that one policy relating to reducing restrictive practices was out of date at the time of the inspection.

**The registered manager must ensure that all policies and procedures are kept up to date and reviewed in line with organisational requirements, including those relating to reducing restrictive practices.**

### **Dealing with concerns and managing incidents**

We found that systems were in place to support the management of concerns, complaints and incidents within the service. Patients, families and carers were able to raise concerns through a range of routes, including speaking directly to staff, contacting senior management or using formal complaints processes. Information about advocacy support was available to assist individuals in raising concerns where required.

Complaints were recorded and reviewed, with oversight provided by senior staff. There was evidence that complaints were monitored to identify themes and trends, and that outcomes were shared with individuals in line with the service's procedures.

However, we spoke with one relative who told us that, while they felt able to raise informal concerns about their family member's care, communication following this could be improved, as they did not always receive updates on the outcome of issues raised. The relative also indicated that action was not always taken in response to their concerns, and that they had needed to raise issues on more than one occasion. This feedback was shared with the service during the inspection, and we were provided with assurance that action had been taken to improve communication. It will be important for the service to ensure that this approach is embedded and sustained.

Systems were in place for reporting and managing incidents and near misses. Staff described using an electronic reporting system, with incidents reviewed by senior management and discussed through governance processes. Learning from incidents was shared with staff through a range of mechanisms including handovers, supervision sessions and internal communications.

Staff were aware of the whistleblowing process and described how concerns could be raised, including through the Speak Up Guardian. Arrangements were also in place to support staff involved in incidents or complaints, including wellbeing support and supervision.

### **Workforce recruitment and employment practices**

We found that appropriate arrangements were in place to support workforce recruitment and employment practices. Pre-employment checks were undertaken centrally, with employment records held and reviewed by the organisation's recruitment and human resources teams. Staff had access to job descriptions, and

there were processes in place to ensure that employment information was maintained and kept under review.

We found that staffing levels appeared appropriate during the inspection, with a suitable skill mix in place to meet the needs of patients. Staff confirmed that staffing levels were generally sufficient, including consideration of patient acuity and observation levels when planning rotas.

There was evidence of workforce planning systems in place, including the use of electronic rota systems and oversight from a central team to manage staffing levels, unplanned absences and service demand. Staff turnover and sickness levels were reported to be low, and the use of agency staff was minimal, which supported continuity of care.

### **Workforce planning, training and organisational development**

We found that arrangements were in place to support staff induction, training and development across the service. New starters completed a structured two-week induction programme, with additional role-specific training where required. Agency staff were also required to complete an induction before commencing work, supporting safe and consistent practice.

Staff had access to a range of training and development opportunities. Mandatory training programmes were in place and delivered through an electronic system, with training requirements tailored to individual roles. Senior management had oversight of training compliance through a central monitoring system, supported by a corporate learning and development team responsible for monitoring performance and coordinating training activity.

We found that compliance with mandatory training was high, providing assurance that staff had the knowledge and skills required to deliver care safely. There were also systems in place to support supervision and appraisal processes, with oversight arrangements in place to monitor compliance. However, appraisal compliance was below expected levels, with only 59 percent of staff having received an appraisal. This reduced assurance that all staff were receiving regular performance review and development opportunities in line with organisational expectations.

**The registered manager should ensure that appraisal processes are consistently completed for all staff, in line with organisational requirements, to support ongoing professional development and effective performance management.**

## 4. Next steps

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

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

The improvement plans should:

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

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

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

The improvement plan, once agreed, will be published on HIW's [website](#).

## Appendix A - Summary of concerns resolved during the inspection

The table below 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
Significant cleanliness concerns were identified in the kitchen area on Raglan Annex, including visibly dirty surfaces and poor environmental hygiene.	There was a risk that inadequate infection prevention and control standards could lead to cross-contamination and impact patient safety, particularly in relation to food preparation.	The concern was raised with senior staff at the time of the inspection.	The service took immediate action to clean the area during the inspection. Further assurance was provided that additional cleaning and oversight arrangements would be implemented.

## Appendix B - Immediate improvement plan

**Service:** St Peter's Hospital

**Date of inspection:** 23, 24 and 25 March 2026

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

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1. The hospital did not ensure that essential healthcare records, specifically Consent to Treatment documentation required under the Mental Health Act, were accurate, accessible and consistently stored.	The service must provide assurance that it has established a safe, accurate and reliable system for storing, accessing and maintaining Consent to Treatment documentation and associated medication records. This should include confirmation of how the service has ensured the accuracy, completeness and accessibility of all current documentation, and how staff are being supported to use the Ashtons system consistently.	Regulation 23	<p>All Consent to Treatment documentation for relevant individuals was uploaded to Ashton's E-Works system during the HIW inspection.</p> <p>The documentation is audited monthly by MHA coordinator and Nursing team through clinic audits. CO2/CO3 has subsequently been highlighted in the report.</p> <p>The medication records and administration is audited weekly and a deep dive conducted quarterly by the Quality Lead for Hospitals. Two additional points have been inserted for consistency of recording in the Quality Audit.</p> <p>The Nurse medication competency tool has been updated to reflect the</p>	Various	April 2026

				<p>Ashton's system, and all nurses are currently being re assessed by the Clinical Lead with completion end date being 17/04/2026.</p> <p>Immediate information was also circulated to all nurses outlining expectations and also informing them of CO2/CO3 now in Ashton's E-Works.</p> <p>Ashton's pharmacist also completes a weekly pharmacy audit which reviews medication prescription, administration and usage, and MHA compliance.</p>		
2.	<p>Staff were unable to consistently locate and access Consent to Treatment documentation following the introduction of the Ashtons system, creating uncertainty about where definitive records should be stored and increasing the risk of inconsistent or inaccurate medication</p>	<p>The service must provide assurance that governance, training and oversight arrangements for the Ashtons system are robust, including how staff competence, data accuracy, record-keeping practice and future system changes will be managed, monitored and audited to prevent recurrence.</p>	Regulation 23	<p>Training was facilitated prior to implementation of the system for all nurses. Following the training, all nurses were given access to e-works e-learning training and Medicine Management and side effects of medication. Angharad Davies (Clinical Lead) is working with Ashton's to ensure 100% completion of this training.</p> <p>Following inspection all nurses are being re assessed against their medication competencies (attached above) with specific focus on the Ashton's system.</p>	Various	April 2026

<p>information being used.</p>			<p>Following implementation on the 17/03/26 the RC and Clinic Nurse identified errors and immediately rectified following a full audit of the current and previous system and medication scripts to ensure 100% accuracy.</p> <p>Further training has also been provided to all nurses (bar 3 who are on A/L and who will receive on their return) by Dr Grzegorzak around the administration of medications under the MHA</p> <p>From learning if there were any future changes the project plan would build in test time prior to go live to ensure 100% audit completed.</p> <p>Currently the Consultant Psychiatrist is overseeing all entries made to the system to ensure full accuracy.</p>		
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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): Sarah House**

**Job role: Operations Director**

**Date: 01 April 2026**

## Appendix C - Improvement plan

**Service:** St Peter's Hospital

**Date of inspection:** 23, 24 and 25 March 2026

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they are taking to address these areas.

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1. Care plans were not always reflective of the care being delivered to patients.	The registered manager must ensure that care plans accurately reflect all aspects of patients' care, including physical healthcare needs, to support the safe delivery and continuity of care.	Health promotion, protection and improvement	<p>The service supports individuals with complex and often rapidly changing mental and physical health needs. While care is delivered in accordance with patients' assessed needs, we recognise that documentation must consistently reflect these changes to provide a clear and contemporaneous record of care requirements and interventions.</p> <p>The registered manager will ensure that care plans are reviewed regularly and updated promptly by the primary nurses. Monthly Nourish audits are in place which are overseen by the Practice lead. The clinical lead completes monthly spot checks of the system to ensure compliance is of a high standard and to monitor the quality and accuracy</p>	Practice Lead and Clinical Lead with oversight from the Hospital Director.	July 2026

				of care plans, ensuring they remain person-centred, reflective of current practice, and support the safe and effective delivery of care.		
2.	Patients were not consistently supported to maintain their personal hygiene and appearance, with multiple patients observed in clothing with visible food stains, presenting a risk that dignity and wellbeing were not consistently maintained.	The registered manager must ensure that nursing records accurately reflect patients' needs, including their level of independence, so that documentation provides a clear and reliable account of the personal care required and delivered, and that this care is consistently provided in practice.	Dignity and respect	<p>All patients are supported with their personal care needs, dignity, and appearance in accordance with their assessed needs and individual care plans.</p> <p>As a service, we support individuals with highly complex mental health needs, many of whom can experience significant distress, anxiety, or behavioural escalation when personal care is offered or delivered. For patients who find personal care particularly challenging, detailed person-centred care plans and behavioural support strategies are being developed to guide staff in providing additional reassurance, engagement, and support.</p> <p>These plans will outline individual triggers, preferred approaches, levels of independence, and the interventions required to encourage and facilitate personal care.</p> <p>The Practice lead is completing a full audit of nourish to ensure this is reflected. The registered manager</p>	Practice lead and Clinical lead, with Hospital Director oversight.	July 2026

				will continue to monitor care records and practice to ensure documentation provides a clear and reliable account of care delivered and that personal care needs are consistently met in line with individual care plans through monthly spot audits.		
3.	Patient records did not consistently reflect individuals' care needs or level of independence, presenting a risk that required care may not be clearly understood or consistently delivered.	The registered manager must ensure that nursing records accurately reflect patients' needs, including their level of independence, so that documentation provides a clear and reliable account of the personal care required and delivered.	Dignity and respect	The nourish audit tool has been reviewed and a new format is being utilised to ensure that these areas are being identified throughout, while also understanding that our patients need fluctuate.	Practice Lead	Ongoing
4.	We identified a missing care plan and an out-of-date care plan, which did not provide assurance that patients would consistently receive care aligned to their assessed needs.	The registered manager must ensure that all required care and treatment plan domains, in line with the Mental Health (Wales) Measure 2010, are in place and that care plans are kept up to date to accurately reflect the care and interventions being provided.	Care planning and provision	A new audit format has been implemented to provide greater oversight of documentation quality and to ensure records accurately reflect the care required and delivered. This includes consideration of changes in patients' needs over time, ensuring care plans and nursing records remain current, person-centred, and reflective of individual levels of independence. Ongoing audits and management spot checks will be undertaken to	Practice lead, Clinical Lead and Hospital Director.	Aug 2026

				monitor compliance and ensure documentation remains clear, accurate, and consistent.		
5.	Environmental maintenance issues, particularly poor condition of fixtures and fittings on Brecon ward, reduced assurance that the environment consistently supported safe and effective care.	The registered manager must ensure that a comprehensive programme of environmental improvement is implemented to address identified maintenance and safety issues across all wards.	Environment	<p>A comprehensive environmental review of Brecon Ward has been completed to identify areas requiring repair, replacement, or refurbishment. The hospital is currently undertaking a phased programme of ensuite refurbishment works across all wards to improve the quality, safety, and suitability of the care environment. Brecon ward forms the final phase of this programme and is scheduled to receive the same enhancements already completed in Upper Raglan and the current work ongoing in Lower Raglan.</p> <p>In the interim, identified maintenance issues relating to fixtures and fittings have been added to the maintenance action plan and prioritised according to risk. Repairs have been completed where possible, with outstanding works monitored through the site's maintenance tracker. Regular environmental audits will be implemented by the general manager to ensure the ward environment remains safe, well-</p>	General Manager	Ongoing due to ensuite works.

				<p>maintained, and supportive of effective care delivery.</p> <p>Any maintenance concerns identified are escalated promptly and monitored through to completion.</p>		
6.	<p>Routine environmental and operational standards were not consistently maintained across the service, reducing assurance in day-to-day practice.</p>	<p>The registered manager must ensure that robust and consistent safety and assurance processes are embedded across all wards. This should include strengthening oversight of routine checks, ensuring these are completed accurately and consistently, and reinforcing staff accountability for maintaining safe environments and adherence to expected standards.</p>	<p>Managing risk and health and safety</p>	<p>To strengthen environmental oversight and ensure ongoing compliance, the General Manager has implemented fortnightly environmental audits across the service. These audits provide additional management oversight of the environment and support the timely identification and resolution of any areas requiring attention.</p> <p>All senior staff have access to the maintenance reporting system and are responsible for promptly reporting and escalating any environmental concerns identified within their areas of responsibility. This approach promotes accountability and ensures that maintenance issues are addressed in a timely manner.</p> <p>During the inspection, the kitchen worktop in Brecon was identified as requiring attention. This issue was immediately escalated through the appropriate channels, and</p>	<p>General Manager</p>	<p>July 2026</p>

				quotations have since been obtained to facilitate the necessary remedial works. Progress will continue to be monitored through the maintenance and environmental audit processes to ensure completion within agreed timescales.		
7.	Issues were identified in the management of oxygen, including out-of-date cylinders stored alongside in-date stock and storage arrangements not in line with local fire risk assessment guidance.	The registered manager must ensure that oxygen cylinders throughout the hospital are stored, managed and monitored in line with fire safety guidance and local risk assessment requirements.	Managing risk and health and safety	<p>The expired oxygen cylinder identified during the inspection was removed immediately, and assurance was sought from the Head of Health and Safety regarding the storage arrangements for oxygen within the service. Following review, assurance was provided to the inspector on the day of inspection that the existing storage arrangements were considered safe and compliant.</p> <p>Notwithstanding this assurance, the service has taken additional steps to further strengthen safety measures. An external oxygen storage cage has since been ordered to enhance the secure storage of oxygen cylinders and ensure continued compliance with best practice standards.</p>	General Manger and Hospital Director.	July 2026
8.	IPC standards were not consistently embedded in practice, with	The registered manager must ensure that IPC standards are consistently implemented and	Infection prevention and control (IPC)	Since the inspection, a revised cleaning regime has been implemented to strengthen environmental cleanliness and	General Manager, House keeping	July 2026

	issues identified in environmental cleanliness, adherence to cleaning processes, and staff compliance with infection prevention requirements.	effectively overseen across all wards, including improving environmental cleanliness, strengthening cleaning processes, and ensuring staff adhere to infection prevention requirements.	and decontamination	infection prevention measures across the service. In addition, a structured kitchen cleaning rota has been introduced to ensure that all kitchen areas are cleaned consistently and that responsibilities are clearly allocated.  It was identified that some cleaning schedules required updating. The General Manager is currently undertaking a comprehensive review of all cleaning schedules in collaboration with the Head of Housekeeping to ensure they accurately reflect current practice, clearly define responsibilities, and provide assurance that all required cleaning tasks are completed, monitored, and recorded appropriately.		
9.	Inconsistent practices were identified in supporting patients' nutritional needs, including limited options for restricted diets, inaccessible menu information and reports that alternative meals	The registered manager must ensure that patients are consistently supported to meet their nutritional needs. This should include reviewing processes for offering alternative meals where food is declined, ensuring menu information is accessible and easy to read, and that suitable options are available for	Nutrition	Easy-read menu boards were in place at the time of inspection and are routinely updated by ward staff to reflect the meal options available at each mealtime. To further strengthen this process and ensure information remains accurate and up to date, kitchen staff have been assigned responsibility for checking the menu boards each morning and confirming that they accurately reflect the day's menu choices.	General Manager and Catering team in collaboration with Apetito	Completed and ongoing monitoring.

<p>were not always offered.</p>	<p>patients with restricted or specialist diets.</p>		<p>The service is committed to supporting patient choice and ensuring that individual dietary preferences and needs are accommodated. Where a patient chooses not to have the meal offered, alternative food options are always available. This provision extends to out-of-hours periods, ensuring that patients have access to suitable food and refreshments at all times.</p> <p>Specialist dietary requirements are supported through our partnership with Apetito, a recognised provider of nutritionally balanced meals designed to meet a wide range of clinical and specialist dietary needs. While the range of options available for some specialist diets can be more limited than standard menus, we work closely with Apetito to ensure that available choices are regularly reviewed and that any new suitable meal options are incorporated into the menu as they become available.</p> <p>This approach helps to ensure that patients requiring specialist diets continue to have access to safe, appropriate, and nutritionally balanced meal choices that meet</p>		
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				their individual needs and preferences.		
10.	Systems for recording and monitoring patients' food and fluid intake were not always clear or easy to access, limiting effective oversight.	The registered manager must ensure that systems for recording and monitoring patients' nutritional intake are clear, accessible and support effective oversight, including ensuring staff can easily access and review food and fluid records.	Nutrition	A meeting has been arranged to review the implementation of Nourish across Iris Care Group, with a specific focus on how food and fluid intake is recorded, accessed, and monitored. This review will consider how current reporting can be adapted to provide clearer oversight of nutritional intake and ensure staff can easily access and review food and fluid records. Any agreed changes will be implemented through the Nourish reporting process, with oversight from the management team to ensure records are clear, accessible, and support timely review of patients' nutritional needs.	Practice Lead and Clinical Lead	Aug 2026
11.	Environmental and food safety concerns were identified, including unclean food probes and labelling equipment, and lack of assurance that appropriate cleaning processes	The registered manager must ensure that effective food hygiene and safety practices are consistently followed when handling, serving and storing food. This must include ensuring that food probes are appropriately cleaned and stored in a clean, dry condition, and that all food-related equipment is	Nutrition	Reassurance was given on the day of inspection, The containers containing the probes and labels were cleaned and feedback was given to the inspectors on the day. Following on from the inspection we identified the cleaning schedules required updating. The General Manager is currently undertaking a comprehensive review of all cleaning schedules in collaboration	General manager	July 2026

	were consistently followed.	maintained in a clean condition and replaced when required.		with the Head of Housekeeping and kitchen team to ensure they accurately reflect current practice, clearly define responsibilities, and provide assurance that all required cleaning tasks are completed, monitored, and recorded appropriately.		
12.	Medicines were not always stored securely and temperature monitoring records contained gaps, reducing assurance that medicines were stored safely	The registered manager must ensure that medicines are stored securely at all times and that temperature monitoring records are fully completed, with no gaps, to provide assurance that medicines are stored safely and in line with policy.	Medicines management	<p>At the time of the inspection, evidence was provided to inspectors demonstrating that weekly clinic room audits are undertaken by the Practice Lead, Clinical Lead, or Hospital Director. These audits include checks on the secure storage of medicines, temperature monitoring records, and compliance with medicines management procedures. Any issues identified are documented, with actions implemented and monitored through to completion.</p> <p>To strengthen assurance, staff have been reminded of their responsibilities regarding the secure storage of medicines and the completion of temperature monitoring records. Weekly audits will continue to be undertaken, with any gaps or areas of non-compliance escalated promptly for review and corrective action.</p>	Practice Lead, Clinical lead	Ongoing

				Medication competencies have also been reviewed for all nurses.		
13.	Medicines administration was not always recorded contemporaneously, and reasons for non-administration were not consistently documented.	The registered manager must ensure that medicines administration records are completed contemporaneously and that reasons for non-administration are clearly documented.	Medicines management	<p>At the time of inspection, inspectors were informed that the hospital had recently transitioned to a new electronic medicines administration system. A structured programme of support and supervision has been implemented to ensure all nursing staff are competent and confident in using the system, including the timely and accurate recording of medicines administration and the documentation of reasons for any non-administration.</p> <p>In addition, weekly medicines management audits are undertaken by Ashtons to provide independent oversight of medicines administration records. Any omissions, delays in recording, or failures to document reasons for non-administration are identified through the audit process and addressed promptly through supervision, competency discussions, and, where required, additional training. Ongoing audit and management oversight will ensure medicines administration records are completed contemporaneously</p>	Clinical Lead	Ongoing

				and in line with organisational policy and best practice.		
14.	Patients were not always provided with accessible information about their medicines, potentially limiting their understanding and involvement in treatment.	The registered manager should ensure that appropriate and accessible information about medicines is available to patients, including easy read formats where required.	Medicines management	Easy read documentation for medication to be completed for patients to enhance patient care.	Clinical lead.	Aug 2026
15.	Inconsistent and complex arrangements for the storage of emergency equipment across wards reduced assurance that they could be accessed quickly to support a timely response in an emergency.	The registered manager must review emergency equipment arrangements to ensure they are consistent and easily accessible across all wards, supporting a timely and effective response in an emergency.	Medical devices, equipment and diagnostic systems	<p>Assurance was provided during the inspection that the hospital maintains a comprehensive range of emergency equipment strategically located throughout the service. All emergency equipment is stored in designated locations, and staff are familiar with its location and access requirements through induction, training, and routine practice.</p> <p>Whilst the existing arrangements were deemed sufficient, we have taken proactive steps following the inspection feedback to further enhance accessibility to emergency equipment. Additional equipment has been ordered to create two further emergency response bags, resulting in each unit having its own dedicated emergency bag. This will</p>	Hospital Director	Aug 2026

				increase the total number of emergency bags available across the hospital to five, providing enhanced readiness and ensuring that emergency equipment is immediately accessible in all clinical areas.		
16.	Not all patients on enhanced observations had corresponding care plans, and those in place did not consistently provide clear guidance on managing risks, including the use of physical interventions.	The registered manager must ensure that all patients requiring enhanced observations have a corresponding, up-to-date care plan in place that clearly outlines identified risks and provides detailed guidance for staff, including the appropriate use of physical interventions where necessary.	Safe and clinically effective care	<p>Following the inspection, a review of all patients subject to enhanced observations is being undertaken to ensure that a corresponding care plan is in place and accurately reflects their current needs and risks. Care plans will be updated to provide clear guidance for staff regarding identified risks, the rationale for enhanced observations, and the interventions required to maintain patient safety.</p> <p>Where there is a foreseeable risk that physical intervention may be required, care plans will include clear guidance regarding the circumstances in which physical intervention may be used, in line with individual risk assessments, PCCPs, and organisational policy.</p> <p>Nursing staff have been reminded of the requirement to ensure care plans are reviewed and updated in</p>	Practice Lead	July 2026

				<p>response to changes in presentation, risk, or observation levels.</p> <p>Compliance is monitored through regular care plan audits, clinical oversight, and multidisciplinary review processes to ensure care plans remain current, person-centred, and provide staff with clear guidance to support safe and consistent practice.</p>		
17.	<p>Enhanced observations were not always clearly defined or consistently implemented, with ambiguous recording and evidence of staff not adhering to prescribed observation levels.</p>	<p>The registered manager must ensure that enhanced observations are clearly defined, individualised and consistently implemented, with sufficient detail to support staff in safely managing risks. Observation levels must be reviewed regularly in line with policy and clearly documented.</p>	<p>Safe and clinically effective care</p>	<p>Following the inspection, enhanced observation documentation has been transferred onto the Nourish electronic care record system to improve the consistency, accessibility, and oversight of observation records. This change has been implemented to support clearer recording of observation levels, identified risks, required staff actions, and the rationale for enhanced observations.</p> <p>Observation care plans and risk management documentation are being reviewed to ensure they provide clear, individualised guidance for staff. Nursing staff have been reminded of their responsibilities in adhering to prescribed observation levels and ensuring observations are recorded</p>	<p>Clinical Lead</p>	<p>Aug 26</p>

			<p>accurately, contemporaneously, and in sufficient detail.</p> <p>Observation levels are reviewed regularly in line with organisational policy and clinical need, with any changes documented within Nourish and communicated through handovers, safety huddles, and multidisciplinary team reviews. Management oversight and audit processes have been strengthened through the use of electronic reporting, enabling improved monitoring of compliance and timely identification of any areas requiring further action.</p>			
18.	<p>Restrictive practice incidents were not always subject to appropriate monitoring, clinical oversight or post-incident review, reducing assurance that patient safety and learning were effectively supported.</p>	<p>The registered manager must ensure that all incidents involving restrictive practices are appropriately monitored, recorded and subject to effective clinical oversight, including post-incident physical health checks, escalation where required and opportunities for debrief and learning.</p>	<p>Safe and clinically effective care</p>	<p>Assurance was provided to the inspectors at the time of the inspection regarding the incident in question, including the actions taken and the clinical oversight that had been applied.</p> <p>Following the inspection, the process for recording, reviewing, and monitoring incidents involving restrictive practices has been reviewed and strengthened through the implementation of Healthcare Guardian, providing enhanced oversight, monitoring, and governance of incidents. This supports the timely identification of</p>	<p>Senior Management Team</p>	<p>Completed with ongoing review.</p>

			<p>themes, trends, actions, and learning opportunities.</p> <p>Staff have been reminded of the requirement to complete all post-incident documentation, including physical health observations, patient and staff debriefs, and escalation to senior clinicians where required.</p> <p>All incidents involving restrictive practices are reviewed by the clinical leadership team through daily handovers, weekly Quality and Safety meetings, and governance processes to ensure appropriate oversight and identify any emerging themes, trends, or opportunities for learning. Where restrictive practices have been used, evidence of physical health monitoring, patient debrief, staff debrief, and clinical review is expected and monitored through audit processes.</p> <p>Any omissions or areas of non-compliance are addressed promptly through supervision, reflective practice, and additional training where required. This strengthened oversight provides assurance that restrictive practice incidents are effectively monitored, reviewed, and used as opportunities to promote patient safety, reduce the</p>		
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				use of restrictive interventions, and support continuous quality improvement.		
19.	Quality improvement and audit processes were not always effective in identifying issues or driving improvement, reducing assurance that risks and areas for improvement were identified proactively.	The registered manager must ensure that quality improvement and audit processes are reviewed and strengthened to ensure they are effective in identifying issues, driving improvement and providing robust oversight of service quality and patient safety.	Participating in quality improvement activities	<p>Following the inspection, a review of the hospital's quality assurance and audit processes has been undertaken to ensure they provide effective oversight of service quality, patient safety, and regulatory compliance. Existing audit systems have been strengthened to improve the identification of themes, trends, and areas of non-compliance, enabling earlier intervention and more effective monitoring of improvement actions.</p> <p>The implementation of Healthcare Guardian has enhanced the organisation's ability to monitor incidents, track actions, identify learning opportunities, and provide greater assurance through improved reporting and governance oversight. In addition, audit outcomes, incidents, complaints, and patient feedback are reviewed through daily handovers, weekly Quality and Safety meetings, monthly governance meetings, and senior management oversight processes.</p>	Senior Management Team	Ongoing review

				Where audits identify areas requiring improvement, clear action plans are always developed, monitored, and reviewed through governance structures to ensure actions are completed and improvements are sustained.		
20	The electronic patient record system was difficult to navigate, with inconsistent use and unclear structure reducing assurance that staff could easily access and review up-to-date patient information.	The registered manager should review how the electronic record system is used to support staff in recording, locating and reviewing patient information, with a view to improving consistency, navigation and accessibility of records.	Records management	<p>Following the inspection, a review of the use of the Nourish electronic patient record system will be completed to see how we can adapt what we have in place in line with other Iris Care services to see how we can learn from them. This will improve consistency, accessibility, and oversight of patient records.</p> <p>Since inspection we have included enhanced observation records into Nourish to provide a more centralised and accessible record for staff.</p> <p>The hospital has also identified opportunities to further optimise the use of Nourish and has arranged discussions with the wider Iris Care Group and system providers to review current functionality, reporting capabilities, and record structures. The aim of this review is to improve navigation, ensure key patient information can be easily located and reviewed, and promote</p>	Practice lead, Clinical Lead and Hospital Director in collaboration with IT and Nourish.	Sep 26

			<p>a more consistent approach to documentation across the service.</p> <p>Staff continue to receive support, supervision, and competency-based training in the use of the electronic record system to ensure records are completed accurately and consistently. Audit processes have also been reviewed to provide greater oversight of documentation quality and to identify any areas where additional support or system improvements may be required.</p>			
21.	<p>It was not always clear that patients who lacked capacity were supported to exercise their rights under the Mental Health Act, including access to tribunal processes.</p>	<p>The registered manager must ensure that patients who lack capacity are appropriately supported to exercise their rights under the Mental Health Act, including access to tribunal processes, with clear evidence of this recorded in patient records.</p>	<p>Mental Health Act monitoring</p>	<p>Assurance was provided to inspectors during the inspection that the process for supporting patients to understand and exercise their rights under the Mental Health Act is reviewed regularly, taking into consideration the specific needs and presentation of the patient population at St Peter's Hospital.</p> <p>Following inspection staff have been reminded of their responsibilities to ensure that all patients, including those who may lack capacity, are provided with appropriate support to access and engage with Mental Health Act processes, including applications to the Mental Health</p>	<p>Senior Management Team</p>	<p>Completed</p>

				<p>Tribunal and access to Independent Mental Health Advocacy services.</p> <p>Care records and Mental Health Act documentation is reviewed to ensure there is clear evidence of discussions regarding patients' rights, the support offered, and any actions taken on their behalf where they lack capacity to make specific decisions.</p> <p>Staff have been reminded of the importance of recording these discussions and interventions contemporaneously to provide a clear audit trail of the support provided.</p> <p>Patients' rights are discussed and reviewed through multidisciplinary team meetings, Mental Health Act reviews, and care planning processes to ensure ongoing consideration of their legal rights and access to appropriate support. Compliance is monitored through clinical audits and management oversight, with any identified gaps addressed through supervision, reflective practice, and additional training where required.</p>		
22.	Mental Health Act documentation was not stored	The registered manager must ensure that all Mental Health Act	Mental Health Act monitoring	At the time of inspection, inspectors were informed that the hospital had recently transitioned to a new	Clinical Lead	Complete during inspection.

<p>consistently, making it difficult for staff to locate key legal information in a timely manner.</p>	<p>documentation is stored in a consistent and accessible manner, so that staff can easily locate and review relevant information to support safe and lawful practice.</p>	<p>electronic medicines management system, which includes the secure storage of Mental Health Act documentation, including all CO2 and CO3 forms. During the inspection, the Senior Nurse on duty was able to provide evidence of all relevant Mental Health Act documentation for patients. By the second day of the inspection, the Responsible Clinician had ensured that all required documentation had been uploaded to the electronic system, and paper-based folders were subsequently removed from the clinical areas to promote a single, consistent storage location.</p> <p>To further strengthen compliance, medication and system competencies have been completed with all nursing staff to ensure they understand how to access and review key Mental Health Act documentation within the electronic system. Additional support and supervision have been provided to the nurses identified during the inspection as being unable to locate this information. Ongoing competency assessments, supervision, and management oversight will ensure that Mental Health Act documentation is stored</p>	<p>Ongoing monitoring.</p>
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				consistently and remains readily accessible to support safe, lawful, and effective practice.		
23.	Staff understanding of patients' entitlement to advocacy was inconsistent, and access to advocacy was not always proactively promoted.	The registered manager should ensure that all staff have a clear understanding of patients' entitlement to advocacy and that access to advocacy is consistently promoted and facilitated for all eligible patients.	Mental Health Act monitoring	<p>Information regarding advocacy services is displayed prominently across all units and within communal areas to ensure that both patients and staff are aware of how to access and refer to advocacy services. This information includes clear guidance on patients' rights to independent advocacy and the referral process.</p> <p>Access to advocacy is routinely discussed within multidisciplinary team meetings, ward rounds, and daily handover meetings to ensure that patients are regularly offered support and that any identified advocacy needs are acted upon promptly. These discussions provide ongoing assurance that patients are aware of their entitlement to advocacy and are supported to access these services where appropriate.</p> <p>In response to the inspection findings, additional emphasis will be placed on ensuring all staff have a clear understanding of patients' rights to advocacy through supervision, team meetings, and ongoing training. This will support a</p>	Senior Management team	Completed

				consistent approach to promoting, facilitating, and documenting access to advocacy services for all eligible patients.		
24.	Care and treatment plans were not always complete or consistently updated, reducing assurance that they accurately reflected patients' current needs, interventions and unmet needs.	The registered manager must ensure that care and treatment plans are complete, consistently applied and kept up to date, clearly reflecting patients' current needs, interventions and any changes in care. Care plans must also identify unmet needs and include clear plans for review and progression.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	<p>Following the inspection, a review of care and treatment planning processes is being undertaken in collaboration with patient external care teams, to ensure care plans accurately reflect patients' current needs, risks, interventions, and progress. Care plans are being reviewed with clinical teams to ensure they are complete, person-centred, and updated in response to changes in presentation, treatment, identified risks, and care requirements.</p> <p>The Nourish audit tool has also been reviewed and revised to strengthen oversight of care planning documentation and support the identification of gaps, unmet needs, and overdue reviews.</p> <p>Staff have been reminded of their responsibilities to review and update care plans contemporaneously and ensure that unmet needs, barriers to progression, and planned actions are clearly documented. Care plans are reviewed through multidisciplinary team meetings, ward rounds, and</p>	Senior Management Team	Sep 26 and ongoing

			<p>clinical review processes to ensure they accurately reflect patients' current needs and treatment goals.</p> <p>The hospital works closely with commissioners, external professionals, community teams, and other partner agencies to develop, review, and progress care and treatment plans. This collaborative approach helps ensure that identified needs, including unmet needs and discharge planning requirements, are recognised and addressed through coordinated care planning and regular review.</p> <p>Ongoing audit, supervision, and governance processes provide assurance that care and treatment plans are consistently applied, regularly reviewed, and accurately reflect patients' needs, interventions, progress, and any changes in care, whilst supporting effective care planning, recovery, and progression throughout admission.</p>			
25	Care planning and documentation standards were not applied consistently, and audit processes had	The registered manager should ensure that clear standards are established for care and treatment planning, including defining the minimum	Monitoring the Mental Health (Wales) Measure 2010: Care	Assurance was provided during the inspection that the hospital's care planning framework is structured in accordance with the requirements of the Mental Health (Wales) Measure 2010 and that care plans	Senior Management Team	Sep 26 and ongoing

<p>not driven effective improvement in care plan quality.</p>	<p>required documentation, and that audit processes are used effectively to monitor compliance and drive sustained improvement.</p>	<p>planning and provision</p>	<p>within Nourish are designed to reflect the Welsh standards for care planning and care and treatment provision.</p> <p>Following the inspection, a review of care planning and audit processes is being undertaken to strengthen consistency in the application of these standards across the service. The Nourish audit tool has been reviewed and revised to provide greater oversight of care plan quality, completion, review dates, identified needs, interventions, outcomes, and progression planning. This includes monitoring compliance with the domains and principles set out within the Mental Health (Wales) Measure 2010.</p> <p>Clear expectations have been reinforced with clinical staff regarding the minimum documentation requirements for care and treatment plans, including the recording of identified needs, unmet needs, planned interventions, recovery goals, review arrangements, and evidence of patient involvement. Care plans are reviewed through multidisciplinary team meetings, ward rounds, and clinical review processes to ensure</p>		
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			<p>they remain current and reflective of patients' needs.</p> <p>Audit findings are reviewed through ward-level, clinical, and governance meetings, with action plans developed where areas for improvement are identified.</p> <p>Compliance is monitored through ongoing audit, supervision, and management oversight to ensure that care planning standards are consistently applied and that audit processes drive sustained improvements in documentation quality, patient care, and treatment planning.</p>			
26.	<p>A backlog in DoLS authorisations meant some patients were without a legal framework.</p>	<p>The registered manager must ensure there is robust and consistent oversight of patients who may be subject to a DoLS without a current legal framework, including considering alternative actions where standard escalation has not been effective. This should include proactive engagement with the local authority and clear documentation of how risks are assessed, monitored and reviewed.</p>	<p>Mental Capacity Act and Deprivation of Liberty Safeguards</p>	<p>Assurance was provided during the inspection regarding the actions being taken to manage the national and local backlog in Deprivation of Liberty Safeguards (DoLS) authorisations. Whilst authorisation delays are outside of the hospital's direct control, robust processes are in place to ensure patients' rights, safety, and legal status are actively monitored.</p> <p>A monthly review of all patients awaiting DoLS authorisation is undertaken, and evidence of ongoing communication and escalation with local authorities was</p>	<p>Senior Management Team</p>	<p>Completed</p>

			<p>provided to inspectors during the inspection. This ensures clear oversight of applications, submission dates, escalation activity, and current legal status.</p> <p>For patients awaiting authorisation, capacity assessments, best interest's decisions, and individual risk assessments are regularly reviewed and documented to ensure risks are identified and managed appropriately. Oversight is maintained through multidisciplinary team reviews, governance processes, and management meetings, ensuring patients awaiting authorisation remain subject to ongoing review, risk management, and escalation until a legal framework is in place.</p>		
27.	<p>We identified that one policy relating to reducing restrictive practices was out of date at the time of the inspection.</p>	<p>The registered manager must ensure that all policies and procedures are kept up to date and reviewed in line with organisational requirements, including those relating to reducing restrictive practices.</p>	<p>Governance and accountability framework</p>	<p>The matter was escalated to the Operations Director on the day of the inspection to expedite the review and approval. This has since been reviewed and the new version is available on staffnet.</p>	<p>Operational lead for Hospitals</p> <p>Completed</p>

28.	<p>Appraisal compliance was relatively low, with only 59% of staff having received an appraisal in the last 12 months.</p>	<p>The registered manager should ensure that appraisal processes are consistently completed for all staff, in line with organisational requirements, to support ongoing professional development and effective performance management.</p>	<p>Workforce planning, training and organisational development</p>	<p>At the time of inspection, it was explained that the annual appraisal cycle had only recently commenced, with the current appraisal window remaining open until July. As such, a number of appraisals were scheduled and in progress in line with the organisational appraisal process and timescales.</p> <p>Assurance was provided during the inspection that compliance with staff supervision requirements was being maintained across all units. Regular supervision continues to be prioritised to ensure staff receive appropriate support, performance oversight, and opportunities for professional development. Progress against appraisal completion rates will continue to be monitored by management to ensure full compliance within the designated appraisal period.</p>	<p>Hospital director, Clinical lead and Practice lead.</p>	<p>July 2026</p>
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The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

**Service representative:**

**Name (print): Amy-Louise Dymond**

**Job role: Hospital Director**

**Date: 19 June 2026**