

Independent Mental Health Service Inspection Report (Unannounced)

Pinetree Court Independent Hospital

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

Our Purpose

We check the safety and quality of healthcare across Wales.

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 Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

Our Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued, and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.



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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 Pinetree Hospital, on 13,14 and 15 July 2026.

The following hospital wards were reviewed during this inspection:

- Juniper Unit – 12 bed single gender unit providing assessment, treatment and rehabilitation for individuals with learning disabilities and mental health needs
- Larch Unit – 14 bed single gender unit providing assessment, treatment and rehabilitation for individuals with learning disabilities and mental health needs
- Cedar Lodge – 3 Bed specialist unit providing assessment, treatment and rehabilitation in a more independent living environment for individuals with complex needs.

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 invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of eleven questionnaires were completed by patients or their carers and ten were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

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:

We found that patients were treated with dignity and respect and were supported to maintain their independence and make choices about their daily lives. Patients spoke positively about staff interactions and told us they felt comfortable raising concerns and providing feedback. We found a range of opportunities for patients to participate in activities, maintain contact with family and friends, and access information about their care, treatment and available support services.

The hospital promoted patient involvement through regular ward meetings, patient satisfaction surveys and established feedback processes. Patients had access to advocacy services, information about complaints procedures and opportunities to contribute to service development. Welsh language provision was supported, and some information was available in both Welsh and English.

Patients were encouraged to develop and maintain daily living skills through rehabilitation and reablement activities. We also found evidence of health promotion initiatives and opportunities for patients to be involved in decisions about meals and activities.

Patient feedback was generally positive, with respondents describing good care and support, positive relationships with staff, involvement in care and treatment planning, and access to a range of meaningful activities. Bedrooms and outdoor spaces were particularly well regarded, and all respondents reported being offered advocacy support. However, feedback identified concerns regarding aspects of the hospital environment, cleanliness, food quality and patients' feelings of safety. In addition, improvements were needed to ensure information was consistently accessible and readily available to patients, including information about support services, Welsh language provision and mechanisms for raising concerns anonymously.

This is what we recommend the service can improve:

- Ensure patients have access to a clear and effective anonymous complaints process
- Improve the visibility of information relating to support services and self-referral opportunities across the hospital
- Continue to review patient information displays to ensure information is consistently available in both Welsh and English.

This is what the service did well:

- Patients were treated with dignity and respect and spoke positively about their interactions with staff
- The service promoted patient involvement through ward meetings, feedback mechanisms and opportunities to influence service delivery
- Patients were supported to maintain their independence and develop everyday living skills, including making choices about daily activities and participating in tasks that promoted recovery and wellbeing.

Delivery of Safe and Effective Care

Overall summary:

We found patients were receiving safe and clinically effective care. Care plans were detailed, person-centred and reflected patients' individual needs, with clear involvement from the multidisciplinary team. Patients had access to physical healthcare support, and we found evidence of regular monitoring, review and audit processes to support the quality and safety of care. We also found good compliance with the Mental Health Act, with legal documentation completed appropriately and patients supported to understand their rights.

However, we identified several concerns relating to the hospital environment, infection prevention and control, and the timely resolution of known risks. Environmental and maintenance issues were evident across several patient and clinical areas, and the overall standard of cleanliness was below expectations in parts of the hospital during the inspection. While it was positive to note that many of these concerns had already been identified through the hospital's own audit processes, improvements had not always been implemented in a timely manner.

We also identified gaps in assurance relating to the decontamination of medical equipment and found that anti-barricade doors had not been installed in all identified high-risk patient areas despite a previous barricading incident. These issues require action to ensure patients are cared for in an environment that is consistently safe, clean and well maintained.

This is what we recommend the service can improve:

- Ensure environmental, maintenance and cleanliness concerns are addressed promptly and that effective oversight arrangements are in place to monitor completion of actions
- Ensure anti-barricade doors are installed in all identified high-risk patient areas to reduce risks to patient safety
- Strengthen infection prevention and control arrangements, including the decontamination and cleaning assurance processes for medical equipment.

This is what the service did well:

- Care plans were detailed, person-centred and demonstrated strong multidisciplinary involvement in patient care and treatment
- Patients had timely access to physical healthcare support, including regular physical health monitoring and weekly GP clinics within the hospital

- Mental Health Act processes were well managed, with statutory documentation completed appropriately and patients supported to understand their rights.

Quality of Management and Leadership

Overall summary:

We found established governance, leadership and workforce arrangements in place to support the delivery of care and treatment at Pinetree Court Hospital. The hospital had clear governance structures, regular oversight of quality and safety matters, effective monitoring of training, supervision and appraisal compliance, and systems to support incident reporting, risk management and organisational learning. Senior leaders maintained a visible presence within the hospital and staff spoken with during the inspection described positive working relationships and feeling supported within their roles.

However, evidence obtained through the staff survey highlighted a less positive experience amongst a small proportion of the workforce. Staff survey respondents raised concerns regarding staffing levels, workload pressures, communication, leadership engagement, wellbeing and confidence in organisational learning processes. In addition, some respondents reported limited confidence that concerns raised by staff would be addressed effectively and felt insufficiently involved in decisions affecting their work areas. These findings indicate that, whilst governance and workforce arrangements were generally well established, further improvements are required to strengthen staff engagement, communication, organisational learning and assurance that identified issues are addressed in a timely manner.

This is what we recommend the service can improve:

- Ensure actions arising from audits, governance reviews and monitoring activities are implemented and completed in a timely manner
- Strengthen communication arrangements to ensure staff receive consistent and timely updates regarding organisational and operational changes
- Strengthen staff engagement and communication arrangements to ensure staff feel listened to, are appropriately involved in decisions affecting their work, and have confidence that concerns raised will be considered and acted upon where appropriate.

This is what the service did well:

- Demonstrated good mandatory training compliance
- Promoted a positive and supportive working culture, with staff describing good multidisciplinary team working and accessible senior leadership.

3. What we found

Quality of Patient Experience

Patient feedback

HIW received 11 responses from patients, families and carers. All respondents who provided comments agreed that these could be published anonymously within the inspection report.

Overall, feedback was largely positive. Most respondents described receiving good care and support, reported positive relationships with staff, and felt that the service was supporting their recovery. Activities, bedrooms and access to outdoor spaces were particularly well regarded. However, feedback also identified concerns regarding aspects of the care environment, cleanliness, feelings of safety and food quality.

Health promotion, protection and improvement

Patients had access to information to support healthy living and wellbeing. Health promotion information was displayed throughout the wards, including within communal areas and kitchen facilities. Patients confirmed they were provided with advice regarding healthy eating and drinking.

Patients had access to a range of opportunities and facilities to support wellbeing, independence and meaningful activity. This included access to indoor and outdoor spaces, activities and recreational resources. We saw evidence that patients were encouraged to engage in activities and make use of available facilities.

The service promoted independence and rehabilitation. Patients were encouraged to participate in activities and make choices about how they spent their time. However, information relating to activities was not always consistently recorded within patient records, reducing assurance that participation and outcomes were fully captured. We also found that patients felt there would be benefit in additional exercise facilities within the hospital.

The registered provider should explore opportunities to increase access to exercise and physical activity facilities, taking account of patient feedback and individual rehabilitation needs.

Dignity and respect

We found staff treated patients with kindness, dignity and respect. During the inspection we observed positive and respectful interactions between staff and patients.

Patients had access to private spaces throughout the hospital, including quiet rooms that supported recovery and wellbeing. Patients were able to meet visitors privately and had access to communal areas that supported social interaction.

Patients had their own bedrooms and were encouraged to personalise them with personal belongings, photographs and artwork. Bedrooms were fitted with locks and patients were able to secure their rooms whilst staff retained emergency access where required.

We found suitable arrangements in place to protect privacy and confidentiality. Patient information was stored electronically and patients confirmed they were treated with dignity and respect.

We identified issues relating to the maintenance of one bedroom door lock and an observation panel. In one bedroom, staff were unable to open the door during a tour of the ward. We also found an observation panel covered internally by a poster and noted a faulty lock, resulting in staff needing to enter the bedroom to undertake observations.

The registered provider should ensure bedroom doors, locks and observation panels are maintained appropriately to support both privacy and patient safety.

Patients were particularly positive about activities, bedrooms and outdoor spaces, with all respondents to the survey expressing satisfaction in these areas. Feedback indicated that access to meaningful activities and appropriate recreational opportunities contributed positively to patient experience and wellbeing.

Feedback relating to the ward and hospital environment was more mixed, with over a third of respondents expressing dissatisfaction.

Comments highlighted concerns regarding cleanliness and environmental standards within the hospital. Specific issues raised included dirty shower facilities, poorly maintained toilets, concerns regarding kitchen cleanliness and general environmental upkeep.

Patient information and consent

Patients had access to a wide range of information about the hospital and available support services. Information was available regarding advocacy services, visiting arrangements, the Mental Health Act, HIW, complaints procedures, legal representatives and the patient guide.

Patients confirmed they were able to access advocacy support when required and received information to help them understand their care and treatment. Written information was displayed throughout the hospital, and information was available to support patients and visitors.

However, while information was available in key areas of the hospital, not all posters displayed in ward and lounge areas had been translated into Welsh.

The registered provider should continue to review information displays to ensure information is consistently accessible in both Welsh and English.

Communicating effectively

We found staff communicated with patients in an appropriate manner. Staff were observed interacting positively with patients and communicating in a way that avoided unnecessary jargon.

We found staff communicated appropriately with patients and adapted their approach to meet individual needs. Patients told us they felt able to speak to staff and raise concerns when required.

Staff demonstrated an awareness of patients' language needs. Welsh language provision was supported by a staff member trained in Welsh language communication and patients were able to communicate in their preferred language where appropriate.

Responses from the survey relating to Welsh language needs were positive. Although most respondents advised they did not speak Welsh, those who expressed language needs felt these were understood and met by the service.

Patients were able to access translation support when required. Information was communicated in a way that supported patients to understand their care and treatment, helping them to participate in decisions affecting their care.

Patients were also supported to maintain contact with family, friends and professionals using personal devices where this had been assessed as appropriate.

Care planning and provision

The service promoted independence and rehabilitation. Patients were encouraged to undertake activities of daily living, make decisions about their daily routines and participate in activities that supported recovery and reablement.

We observed patients being supported with everyday activities, including laundry tasks, helping to maintain practical living skills. Patients were encouraged to make choices regarding activities, clothing and how they wished to be supported.

Most respondents to the survey reported receiving information about their admission and understanding the information provided. All respondents were aware of their Care and Treatment Plan, and almost all felt involved in developing it. Most patients also reported being able to attend meetings and ward rounds where their care was discussed and receiving information in a format they could understand.

The hospital worked collaboratively with other services and agencies to support care planning, treatment and future discharge arrangements. Multidisciplinary meetings and wider service involvement supported the planning and delivery of patient care.

However, whilst staff described available support services and self-referral options to patients, information about these services was not always visible within ward areas.

The registered provider should consider displaying this information more prominently to increase patient awareness.

Equality, diversity and human rights

We found systems were in place to support equality, diversity and human rights.

The hospital had equality and diversity policies and staff completed relevant training. Arrangements were in place to support patients with additional needs, including disability access, lift access, disabled toilet facilities and the availability of easy-read information.

The service demonstrated consideration of individual preferences and identity. Staff described the use of preferred names and pronouns and told us care was tailored to individual needs.

Patients had access to private visiting facilities and were able to make personal telephone calls in private.

Information about advocacy services was available, including details of advocacy visits and contact information displayed on ward noticeboards.

Citizen engagement and feedback

The hospital had several arrangements in place to obtain feedback from patients and demonstrate how feedback informed service development. Patients could raise issues through ward meetings, directly with staff and management, and through feedback forms and complaints processes.

We found evidence that patient feedback, complaints and responses were recorded and reviewed. Outcome reports, complaint records and actions arising from feedback were available, demonstrating attempts to learn from patients' experiences and improve the service.

Patients told us they felt listened to and were satisfied with the opportunities available to provide feedback. Weekly ward meetings provided a regular forum for patients to discuss issues relating to the environment, activities and their experience of care.

However, we found patients did not currently have access to an anonymous complaints system following the removal of a previous reporting mechanism. The service advised that alternative arrangements were being developed.

The registered provider should ensure patients are able to raise concerns anonymously if they wish to do so.

Delivery of Safe and Effective Care

Environment

The hospital provided a range of facilities to support patients' care, treatment and wellbeing, including communal areas, quiet rooms, sensory areas and outdoor spaces. However, we found that the environment was not consistently maintained to the standard expected. During the first evening of the inspection, the overall standard of cleanliness in several areas of the hospital was below expectations and several environmental and maintenance concerns were identified.

Environmental issues included damaged fixtures and fittings, worn furniture, areas requiring more thorough cleaning and concerns relating to the upkeep of some patient and staff areas.

We also identified environmental risks within key patient areas, including a faulty bedroom door lock, a damaged observation panel, an unsecured drawer containing sharps and a cracked window. In addition, the condition of the outdoor smoking area and garden areas required improvement. These issues did not consistently support the provision of a safe, clean and well-maintained environment for patients.

We noted that anti-barricade doors had been installed in some parts of the hospital. However, they had not yet been installed in all identified high-risk patient areas. We were informed of a previous incident involving a patient barricading themselves in the room where an anti-barricade door had not yet been installed.

The registered provider should ensure that identified environmental risks are addressed promptly and that appropriate anti-barricade measures are implemented in all relevant patient areas.

It was positive to note that many of the environmental issues identified during the inspection had already been recognised through the hospital's environmental audit processes. Senior management demonstrated awareness of the concerns identified. However, further work is required to ensure environmental issues are addressed in a timely manner and that effective oversight arrangements are in place to monitor progress and maintain standards.

Managing risk and health and safety

Risk management arrangements were well embedded across the service. Staff understood how to identify, record and escalate risks, and demonstrated confidence in reporting incidents or safeguarding concerns. Observation levels were appropriate and clearly documented, and patients confirmed that they felt safe on the wards.

Morning operational meetings were used to discuss key clinical and operational matters, helping to ensure staff remained informed of current risks and priorities across

the hospital.

Staff had access to personal alarms and were observed wearing them during inspection. Environmental risk assessments, including ligature audits, were conducted regularly, with clear processes in place for addressing hazards. Fire safety measures were understood by staff, with evidence of regular checks and clear evacuation routes. The service demonstrated awareness of ward pressures and responded appropriately by adjusting activities or staffing when required.

Infection prevention and control (IPC) and decontamination

The hospital had arrangements in place to support infection prevention and control. Staff demonstrated a good understanding of IPC principles and were able to describe their responsibilities in relation to maintaining safe standards of hygiene and cleanliness.

However, inspection findings identified concerns regarding environmental cleanliness and decontamination. On the first evening of the inspection, the overall standard of cleanliness in several areas of the hospital was below expectations. Specific concerns included unclean bathroom facilities, unclean fridges and beverage preparation areas, and cleanliness issues within patient care areas. The condition of these areas did not consistently support effective infection prevention and control.

Although most respondents from the patient survey considered the hospital clean, several responses indicated concerns regarding standards of cleanliness. Some patients reported that cleanliness was inconsistent, while one respondent stated that the hospital was not clean. The themes identified through patient feedback were consistent with environmental and cleanliness issues identified elsewhere during the inspection.

The registered provider must ensure that concerns regarding cleanliness raised by patients are promptly reviewed and addressed. The registered provider must also demonstrate how patient feedback is used to inform improvements and provide assurance that cleanliness standards are consistently maintained across the hospital.

We also found that the sluice room was disorganised and was being used for storage rather than its intended purpose. This reduced assurance that clinical areas were being used appropriately to support safe infection prevention and waste management practices.

The registered provider must ensure that the sluice room is organised and used for its intended purpose.

Nutrition

Patients' nutritional needs were assessed on admission and monitored throughout their stay. Records demonstrated that patients underwent nutritional screening and that dietary requirements, preferences and any identified nutritional risks were considered as part of the assessment process. Appropriate referrals were made to other healthcare professionals where required.

Patients were offered a choice of meals and were involved in selecting their food in advance through the hospital's menu planning arrangements. This supported patient choice and enabled individual dietary preferences and requirements to be considered.

Patients had access to food and drinks throughout the day, and staff supported patients to maintain adequate nutrition and hydration. We found arrangements were in place to monitor patients where there were concerns regarding nutritional intake or identified nutritional risks.

Feedback regarding meals was mixed. However, patients told us that there had been some improvement in the quality of the food provided. Satisfaction was less positive regarding food and the ward environment following the results of the patient survey. While most respondents were satisfied with the food provided, some expressed concerns about food quality and stated that previous concerns had not always been resolved.

The registered provider should continue to seek and respond to patient feedback regarding catering arrangements to ensure meals meet patients' needs and preferences.

Medicines management

We found effective arrangements in place to support the safe management of medicines. Medication records reviewed were comprehensive and complete, and there was evidence that patients' medicines were routinely discussed with them. Medication audits were undertaken regularly and demonstrated compliance with the service's medicines management standards.

Most medicines were stored appropriately. We found evidence that regular temperature monitoring of medication fridges and clinic rooms was undertaken to ensure medicines were stored within the manufacturer's recommended temperature ranges. Temperature records were complete and maintained appropriately.

We found some issues relating to the secure storage of medicines and clinical items. On one ward, the key had broken in the medicines trolley lock. Staff told us that, as an interim measure, the trolley had been relocated to the main clinic room to maintain security while a replacement trolley was awaited.

In the main clinic room, a drawer containing various topical preparations was not

secured. Staff informed us that this was a temporary arrangement pending the installation of replacement storage cupboards. We were also advised that new lockable cupboards had been ordered, as some existing cupboards used for storing clinical equipment, including syringes, could not be locked.

While the service had taken steps to mitigate immediate risks and had arrangements in place to address the issues identified, these findings highlight the importance of ensuring that medicines and clinical equipment are stored securely at all times.

The registered provider must ensure that medicines, topical preparations and clinical equipment are stored securely at all times and that maintenance and replacement of storage facilities are completed promptly when defects are identified.

We found that emergency and resuscitation equipment checks were completed routinely. Records demonstrated that equipment was present, within expiry dates and subject to regular monitoring. Oxygen cylinders were also being stored in line with safety requirements.

The service had systems in place to monitor medicines management practice and identify areas requiring improvement. During the inspection, we identified that sharps bins had not been dated or signed appropriately. However, this issue was addressed by the service during the inspection.

Overall, we found appropriate governance arrangements in place to support medicines management, with evidence of regular monitoring and audit activity to promote the safe storage, handling and administration of medicines.

Safeguarding children and safeguarding vulnerable adults

We found appropriate arrangements were in place to support the safeguarding of children and vulnerable adults. The hospital had access to safeguarding policies and procedures, and safeguarding leadership was provided through designated safeguarding leads at both hospital and organisational level. Established working relationships were in place with the local authority to support the management and escalation of safeguarding concerns when required.

During discussions with staff, they demonstrated a good understanding of safeguarding processes and were able to describe how concerns would be recognised, reported and escalated. Staff understood their responsibilities in protecting patients from abuse, neglect and harm.

Information about safeguarding was available to patients through the service user guide. However, we found the guide required updating as it referred to patients making safeguarding referrals but did not contain contact details for the local authority or the Iris safeguarding lead.

The registered provider should ensure safeguarding information provided to patients contains up-to-date contact details to enable patients to access appropriate support and advice when required.

Most respondents to the patient survey reported feeling safe within the setting. However, almost a third of respondents stated they did not feel safe. Comments suggested that these concerns primarily related to the behaviour of other patients and previous incidents on the ward. Some respondents acknowledged that safeguarding measures had subsequently been implemented to address identified concerns.

Whilst all respondents reported being able to access facilities important to them, the feedback regarding safety indicates that further work may be required to ensure all patients consistently feel safe within the hospital environment.

The registered provider must ensure that all patients consistently feel safe within the hospital environment. This should include reviewing the causes of patients' reported safety concerns, strengthening measures to reduce the impact of behaviours that may affect the safety and wellbeing of others, and regularly seeking feedback from patients to monitor whether improvements have been effective

Overall, the safeguarding arrangements in place provided assurance that staff understood their responsibilities and had access to appropriate guidance and support when safeguarding concerns arose.

Medical devices, equipment and diagnostic systems

We found appropriate arrangements in place for the management and monitoring of medical devices and equipment. Records demonstrated that medical equipment was subject to routine servicing, maintenance and calibration checks to ensure it remained safe and fit for purpose.

We reviewed records relating to emergency and resuscitation equipment and found these checks were completed routinely. Documentation confirmed that equipment was present, available for use and within expiry dates. Oxygen cylinders were also stored in line with safety requirements.

However, while we found evidence that equipment was regularly maintained and calibrated, there was no recorded evidence to demonstrate that medical equipment was cleaned between patient use. We did not see a system, such as 'I am clean' labels or equivalent assurance measures, to indicate that equipment had been decontaminated prior to being used with another patient. This reduced assurance that decontamination processes were being applied consistently and documented appropriately.

The registered provider should strengthen arrangements to ensure the cleaning and decontamination of equipment between patient use is consistently recorded and evidenced.

The registered provider should implement a daily checklist for nursing staff to record the cleaning of medical devices, with records signed and dated to provide assurance that equipment has been appropriately cleaned.

Safe and clinically effective care

Care delivered at Pinetree was safe, clinically appropriate and informed by regular multidisciplinary review. Staff described having sufficient time to meet patients' needs, and the mix of skills across the team supported effective care delivery.

Policies, NICE guidance, and the Code of Practice were accessible and understood by staff, and updates were communicated through governance meetings and supervision. MDT working was strong, with regular ward rounds and reviews documented clearly across the service.

Clinical audits, including those focused on medication, restrictive practices, physical health and record-keeping were used to monitor practice and identify improvements. Staff were confident that the escalation processes for clinical concerns were effective.

The overall approach to care was recovery-focused, with structured opportunities for therapeutic engagement.

Participating in quality improvement activities

We found evidence that the hospital used a range of audit and monitoring processes to review the quality and safety of care provided. It was positive to note that many of the concerns identified during the inspection had already been recognised through the hospital's own audit and governance systems, demonstrating that processes were in place to identify areas requiring improvement.

Learning and improvement opportunities were also supported through established governance arrangements. The hospital had systems in place to review incidents, complaints, safeguarding matters and issues relating to patient care. Information from these processes was discussed through governance structures to support service development and quality improvement.

Whilst quality improvement systems were established, inspection findings demonstrated that some identified issues remained outstanding despite being recognised through internal monitoring processes.

The registered provider should ensure that actions arising from audits and improvement activities are implemented in a timely manner and that progress is effectively monitored to ensure sustained improvements in care quality and the

hospital environment.

Information management and communications technology

Information governance arrangements ensured that patient records and communications were secure. Electronic systems were password-protected, and paper files were stored in locked areas, with access limited to staff who required it for their work.

Staff used secure email systems when sharing information with external agencies, and digital devices used by patients were subject to individual risk assessments.

Policies relating to data protection were in place, up to date and understood by staff. The use of digital tools for patient communication, including translation apps and video calls, supported safe and effective information exchange while maintaining confidentiality.

Records management

Record-keeping was well organised and supported safe, coordinated care. Electronic and paper records were easy to navigate, stored securely and compliant with GDPR requirements. Staff documented care consistently across assessments, MDT reviews, physical health checks, and ward round notes. Audit processes monitored the quality and completeness of documentation.

Mental Health Act monitoring

We reviewed five sets of patient records to assess the application of the Mental Health Act (1983) and Code of Practice for Wales (2016). Overall, we found that legal documentation was well organised, appropriately completed, and stored securely. Statutory forms were completed within required timescales and reflected that patients were lawfully detained.

We found that patients were provided with information about their rights both verbally and in writing. This was delivered in a format appropriate to individual needs, including the use of Easy Read materials where required. Patients were supported to understand their rights on an ongoing basis, and there was clear evidence that Independent Mental Health Advocates (IMHAs) were routinely involved, with referrals made on admission and regular access available.

We saw good evidence that Section 17 leave was appropriately managed. Leave arrangements were risk assessed, clearly documented, and included patient involvement in planning where appropriate. Outcomes of leave were recorded within patient records and reviewed through multidisciplinary team (MDT) discussions.

Capacity assessments were completed where required and recorded within patient records. These reflected the principles of the Mental Capacity Act, with evidence of

decision-specific assessments and consideration of least restrictive options.

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

We reviewed five patient records and found evidence that care planning was completed in accordance with the requirements of the Mental Health (Wales) Measure 2010. Care plans were detailed, individualised and reflected patients' assessed needs across the relevant care and treatment domains.

Records demonstrated involvement from the multidisciplinary team in the planning and delivery of care. We found evidence that care and treatment interventions were clearly documented and that patients' needs were reviewed on an ongoing basis.

It was positive to note that patient records clearly reflected the patient's voice. The records reviewed contained evidence of regular reviews and documented one-to-one sessions between patients and their primary nurses. Care and Treatment Plan (CTP) meeting minutes were comprehensive and demonstrated patient involvement in decisions relating to their care and treatment.

We found that risk assessments were updated when changes occurred in a patient's presentation and were reviewed consistently. The records reviewed also demonstrated evidence of discharge planning arrangements and ongoing monitoring of patients' progress and recovery.

Patients had timely access to physical healthcare support. Weekly GP clinics were provided within the hospital, and we found evidence that physical health monitoring was undertaken regularly and recorded within patient records

However, staff told us there were insufficient handheld devices available to support the recording and review of patient information. This reduced assurance that all staff could consistently access and record contemporaneous information to support the delivery of safe, effective and person-centred care.

The registered provider should review the availability of handheld devices to ensure staff have timely access to patient information when required.

Regular audits of patient records were undertaken by the service, which supported oversight of care planning standards and helped ensure care documentation remained current, comprehensive and reflective of patients' individual needs.

Quality of Management and Leadership

Staff Feedback

HIW received 10 staff survey responses as part of the inspection of Pinetree Court Hospital. Whilst the survey provides useful insight into staff experiences, it represents the views of a relatively small proportion of the workforce and may not reflect the experiences of all staff working within the hospital. Survey findings have therefore been considered alongside other inspection evidence.

Governance and accountability framework

We found established governance and accountability arrangements in place to support the delivery of care and treatment. The hospital had a clear management structure, with defined responsibilities for operational oversight, safeguarding, clinical governance, incident management and risk management.

Regular governance meetings were held at both hospital and organisational level to monitor service quality, patient safety and operational performance. We found evidence that patient feedback, advocacy updates, incidents, safeguarding matters, staffing, maintenance issues and clinical outcomes were discussed through these forums. Clinical audits were undertaken regularly, and findings were used to identify areas of good practice and areas requiring improvement.

Senior managers maintained a visible presence within the hospital and regularly engaged with staff. Staff told us they felt supported by senior leaders and described a positive culture within the hospital. Policies and procedures were available to staff and were subject to regular review. Staff confirmed that changes to policies and guidance were communicated through email updates, supervision, handovers and team meetings.

Although not a finding on the inspection, staff survey responses identified concerns regarding leadership visibility, management support and staff involvement in decision-making. Whilst most respondents felt senior managers were visible and committed to patient care, many respondents reported that communication between senior management and staff was ineffective.

Feedback regarding immediate management was less positive. Most respondents reported that managers did not seek their views before making decisions affecting their work, did not provide clear feedback, and could not always be relied upon for support with difficult tasks. Responses also indicated low levels of confidence in organisational support and problem-solving arrangements.

The findings suggest that further work is required to strengthen relationships between staff and managers and ensure staff feel listened to, supported and involved in decisions affecting their work.

The registered provider must ensure that managers at all levels provide effective support, communication and engagement with staff. This should include creating opportunities for staff to contribute to decision-making and ensuring staff receive regular feedback, support and opportunities to raise concerns.

Whilst governance systems were well established, inspection findings demonstrated that some issues identified through audits and monitoring processes remained unresolved.

The registered provider should ensure that actions arising from governance processes are implemented and monitored in a timely manner to support sustained improvement.

Dealing with concerns and managing incidents

The hospital had clear processes in place for managing complaints, concerns and incidents. Information about how to raise a complaint was available through the patient guide, information displays and discussions with staff. Patients were able to raise concerns through a range of routes, including directly with staff, managers, advocacy services and through formal complaints procedures.

Complaints were investigated and outcome letters provided to patients and families where appropriate. We found evidence that complaints were reviewed to identify themes, trends and learning opportunities. Learning from complaints was shared with staff through handovers, supervision and governance meetings.

The service demonstrated appropriate arrangements for reporting and managing incidents. Incidents were recorded, reviewed and escalated through organisational reporting systems. Serious incidents were reviewed through governance processes and trends were monitored to help prevent recurrence. We found evidence that debriefs were completed following incidents and that learning was shared with staff.

The hospital also had arrangements in place to support staff involved in incidents, including access to debriefs, welfare support and management oversight. These arrangements helped promote learning and supported a culture of openness and continuous improvement.

Within the survey results some staff felt that identified issues were not always addressed quickly and that more support was needed to help them raise and resolve concerns. Most respondents reported that they were not involved in decisions affecting their work area and felt communication between senior management and frontline staff was not effective. Staff also reported uncertainty regarding how patient feedback was used to inform service improvements, and many felt that learning following incidents was insufficient.

The registered provider must ensure governance arrangements effectively support staff engagement, organisational learning and continuous improvement. This

should include improving communication with staff, demonstrating how concerns and patient feedback are used to inform service development, and strengthening confidence in incident management and organisational learning processes.

Workforce recruitment and employment practices

We found appropriate recruitment and employment processes were in place. Recruitment activity was ongoing and managers told us vacancies were reviewed regularly to ensure staffing levels remained appropriate to meet patients' needs. At the time of inspection, we were told there were no nursing vacancies and the hospital had recently recruited additional nursing staff.

The service had systems in place to ensure appropriate pre-employment checks were completed. Workforce governance arrangements included oversight of professional registration, Disclosure and Barring Service (DBS) checks and mandatory employment requirements.

Staff told us they felt supported within their roles and described positive working relationships with colleagues and managers. Staff also reported that they felt able to approach managers for support and guidance when required. We found evidence of arrangements to support staff wellbeing, including access to supervision, appraisals, debriefs and welfare support following incidents. However, a minority of respondents from the staff survey were confident that concerns raised by staff would be addressed appropriately. These findings suggest opportunities to strengthen governance arrangements, communication processes and mechanisms that demonstrate learning and service improvement.

Workforce planning, training and organisational development

We found appropriate workforce planning arrangements in place to support the delivery of care and treatment. Staff told us staffing levels generally enabled them to complete care planning, risk assessments and therapeutic work with patients. Whilst staff described occasional pressures associated with enhanced observation levels and patient acuity, additional staffing support was available when required.

The hospital had effective systems in place to monitor staff training, supervision and appraisal compliance. At the time of inspection, overall mandatory training compliance was reported as 93% within Juniper Unit and 95% in Larch. Compliance with prevention and management of violence and aggression training was reported as 100%. However, compliance with Basic Life Support and Intermediate Life Support training was lower than other mandatory subjects and would benefit from continued monitoring.

The registered provider must ensure that Basic Life Support and Intermediate Life Support training compliance figures are improved.

We found evidence that staff received regular supervision and appraisal.

Staff reported positive multidisciplinary team working and told us their views were respected. Regular team meetings, handovers, supervision sessions and governance meetings provided opportunities to share learning, discuss service developments and communicate changes to policies and procedures.

Staff survey findings highlighted significant workforce pressures. All respondents reported that there were insufficient staff to undertake their role effectively, and comments referred to chronic understaffing, reliance on agency staff and the impact this had on staff wellbeing and service delivery.

While appraisal arrangements were largely positive and staff generally viewed training provision favourably, respondents identified the need for additional support through supervision, management development and specialist training opportunities.

Wellbeing was identified as a concern, with over half of respondents reporting that their role negatively affected their health. Many respondents also reported that the organisation was not taking sufficient action to support staff wellbeing.

The registered provider must ensure staffing levels and workforce arrangements are sufficient to support the safe delivery of care and reduce the impact of workload pressures on staff wellbeing and patient care.

The registered provider must ensure staff have access to appropriate supervision, training, development opportunities and wellbeing support, and that action is taken to address workforce concerns identified through staff feedback.

The hospital used information from audits, incidents, complaints and governance reviews to inform organisational learning and service development. Staff described a supportive culture, although some staff reported that changes were not always communicated consistently across the service.

The registered provider should continue to review communication arrangements to ensure staff receive timely updates regarding operational and organisational changes.

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
Lock on Larch Clinic door was broken	The clinic room contained medicines and clinical equipment. A broken lock presented a risk of unauthorised access, which could compromise patient safety and the secure storage of clinical items.	The concern was raised immediately with the ward manager and hospital management team during the inspection.	The lock was replaced during the inspection, and inspectors received assurance that the clinic room could be securely locked.
Fire exit door on the Larch corridor was not operating correctly	A defective fire door could compromise fire compartmentation and evacuation arrangements, increasing risks to patients, staff and visitors in the event of a fire.	The issue was escalated immediately to the ward manager and senior management team.	Arrangements were made for the fire door to be repaired, and the service provided assurance that it was functioning correctly and maintaining fire safety requirements.

Appendix B – Immediate improvement plan

Service: Pinetree Court Hospital

Date of inspection: 13 – 15 July 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.

Findings		No immediate non- compliance issues	
Improvement needed		Standard / Regulation	
1.			
Service Action:		Responsible officer	Timescale

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

Service representative:

Name (print):

Job role: **Date:**

Appendix C – Improvement plan

Service: Pinetree Court Hospital

Date of inspection: 13 – 15 June 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
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	Patients felt there would be benefit in additional exercise facilities within the hospital.	The registered provider should explore opportunities to increase access to exercise and physical activity facilities, taking account of patient feedback and individual rehabilitation needs.	We recognise the feedback from patients regarding the potential benefit of additional exercise facilities and understand the importance of ensuring patients have access to meaningful physical activity options that meet their individual needs and preferences. While patients currently have access to a wide range of physical activity opportunities, including the local leisure centre, Pedal Power cycling, individualised exercise plans developed by the ICG Physical Trainer, local walking groups, and use of the adjoining park, we acknowledge that patients may not	Practice Lead/Occupational Therapy Team	
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				always be fully aware of the range of activities available to them. To address this feedback, we will review how information about exercise and wellbeing opportunities is communicated to patients, including during admission, care planning and community meetings. We will also seek patient feedback on the types of physical activities and exercise facilities they would like to access and, where feasible, work with patients and partner organisations to further develop or expand the range of opportunities available. This will help ensure that our provision remains		
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				responsive to patient needs, supports recovery, and promotes physical wellbeing.		
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1.	The overall standard of cleanliness in several areas was below expectations. Flooring across areas of the hospital required more thorough cleaning.	The registered provider must ensure that all areas of the hospital are maintained to an appropriate standard of cleanliness. Cleaning schedules and checks must be effective in identifying, recording and addressing areas requiring additional cleaning.	Environment	We have implemented detailed cleaning schedules across all hospital areas with assigned responsibilities. Daily housekeeping audits, daily environmental walkarounds and three times weekly validation audits introduced. Weekly meetings between General Manager and Housekeeping Manager established to monitor standards and compliance. Enhanced auditing processes implemented to strengthen oversight and accountability.	General Manager / Housekeeping Manager	Immediate action completed. Ongoing monitoring weekly. Deep cleans have been completed and will continue.
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2.	Damaged and worn furniture was identified throughout the hospital, including ripped chairs and sofas.	The registered provider must ensure that furniture in patient areas is maintained in good repair, replaced where necessary, and subject to effective routine checks to reduce risks to patients and support effective cleaning.	Environment	Comprehensive environmental review completed to identify damaged furniture. Replacement programme established and furniture requiring immediate replacement prioritised through maintenance and procurement processes. Included within weekly environmental audits and validation walkarounds.	General Manager / Maintenance Officer	Immediate risks addressed and all furniture identified at time of inspection has been removed and reupholstered. Full review and ongoing replacement programme implemented.
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3.	A patient bedroom lock in Larch Unit did not work or was faulty lock was identified.	The registered provider must ensure that bedroom door locks are maintained in working order and that any faults affecting patient privacy, security or safety are identified and repaired promptly.	Environment	Fault reported and added to maintenance log. Works to replace identified lock completed. Daily maintenance oversight introduced with all urgent repairs prioritised. Completion monitored through maintenance governance arrangements and validation checks.	General Manager / Maintenance Officer	Completed.
4.	A damaged observation panel/window was identified in Larch Unit, with a poster blocking the window.	The registered provider must ensure that observation panels and windows are maintained in good repair and are not obstructed, unless this is clearly risk assessed and supported by appropriate safeguards.	Environment	Damage identified, logged and escalated through maintenance processes. Repair works commissioned and monitored through daily and weekly maintenance reviews. Environmental checks amended to ensure observation panels remain unobstructed.	General Manager / Maintenance Officer	Poster has been removed and new panel/window has been ordered. Works to be completed within 8 weeks.

5.	Bedroom in Larch (details provided to Registered provider) required improvement. The bathroom was unclean, the sink and toilet were dirty, the radiator cover appeared rusty, and a chair in the bedroom was ripped.	The registered provider must ensure that the identified room in Larch Unit is cleaned, repaired and maintained to a safe and acceptable standard, with effective oversight to ensure any recurring issues are identified and addressed promptly	Environment	Room deep cleaned immediately. Maintenance issues logged and included within planned maintenance works. Additional housekeeping and environmental audits introduced to ensure standards are maintained and recurring issues identified promptly.	General Manager / Housekeeping Manager / Maintenance Officer	Immediate cleaning completed. Remaining repairs (new radiator) within 4 weeks.
6.	The sluice room was disorganised and being used for storage rather than its intended purpose, with items including black bags, blankets, air-conditioning equipment and cleaning equipment present.	The registered provider must ensure that sluice rooms are used appropriately, kept organised and free from inappropriate storage, so that infection prevention and control standards can be maintained.	Environment	Sluice room reviewed, inappropriate items removed and room reorganised for intended use. Weekly environmental audits introduced to ensure ongoing compliance with infection prevention and control standards.	General Manager / Clinical Lead	Completed.

7.	Kitchen, fridge and beverage preparation areas required cleaning. This included unclean fridges, a dirty therapy kitchen counter, and a stained bin.	The registered provider must ensure that all kitchen, fridge and beverage preparation areas are cleaned and monitored effectively, with clear action taken where standards fall below expectations.	Environment	Deep clean undertaken and cleaning schedules reviewed. Daily housekeeping checks and weekly validation audits implemented to monitor standards and ensure prompt action where issues are identified.	Housekeeping Manager / General Manager	Completed immediately. Ongoing daily monitoring. Fridges (wards) cleaned on a weekly basis and on weekly schedule. Ward staff have been asked to check that food is within date and is now included on daily reporting and daily audit logs. During the fridge clean – any out-of-date food is disposed of. Fridges in staff
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						room to be cleaned by night staff – included on daily logs .
8.	An unlocked drawer in the occupational therapy kitchen contained sharps that should have been secured.	The registered provider must ensure that all sharps and potentially hazardous items are stored securely and that environmental checks reliably identify and address any unsecured items in patient accessible areas.	Managing risk, health & Safety	Sharps immediately secured and environmental risk assessment undertaken. Lock on drawer has been replaced. Environmental checks reviewed and strengthened to ensure hazardous items are appropriately secured in all patient accessible areas.	Occupational Therapist Lead / General Manager	Completed immediately. Ongoing daily checks.

9.	Concerns were identified in the Blue Room, including a cracked window, a dirty weighted blanket and items such as a pen/cellophane/tissue being present or concealed.	The registered provider must ensure that the Blue Room is maintained in a safe, clean and secure condition, and that regular environmental checks identify and remove any potential risks to patients.	Managing risk, health & safety.	Identified issues logged and addressed immediately. Environmental safety checks strengthened and incorporated into routine daily walkarounds. Maintenance works commissioned where required.	General Manager / Maintenance Officer	Immediate actions completed. Remaining works within 8 weeks. Glass has been measured – installation date arranged for 21.08.26.
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10.	The condition of some outdoor areas, including the smoking area and garden areas, required improvement.	The registered provider must ensure that outdoor areas used by patients are safe, clean, well maintained and suitable for patient use.	Environment	Garden and smoking areas reviewed and incorporated into housekeeping and maintenance schedules. Ongoing environmental inspections introduced to ensure outdoor areas remain safe, clean and suitable for patient use.	General Manager / Maintenance Officer	Initial improvements within 6 weeks. Ongoing monitoring. Walkaround with maintenance every day, ashtrays are being replaced due to being damaged. Request for area to be cleaned on a daily basis by maintenance.
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11.	Anti-barricade doors had not been installed in all identified patient areas, despite a recorded incident involving a patient barricading themselves.	The registered provider must ensure that risks of patients barricading themselves are assessed and mitigated in all relevant patient areas. This must include completing planned anti-barricade door works, or recording suitable alternative risk controls where required, with clear oversight until completed.	Managing risk, health & safety.	Review of all outstanding anti-barricade works undertaken. Outstanding works to be prioritised through Estates programme with interim risk assessments maintained until completion. Progress monitored through weekly estates review meetings. Doors measured and awaiting delivery. Asked V3 for a delivery date – waiting for an update	Director of Estates / Estates Manager / Hospital Director	Programme review completed immediately. Completion subject to Estates schedule, target 12 weeks.
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12.	Although many environmental issues had been recognised through the hospital environmental audit processes, the inspection identified that actions had not always been completed in a timely way.	The registered provider must ensure there are robust systems to identify, record, prioritise, complete and monitor environmental and maintenance actions within appropriate timescales, with clear senior oversight.	Governance & accountability	Daily maintenance walkarounds introduced. Comprehensive maintenance log established with clear oversight of actions, owners and completion dates. Weekly monitoring meetings and validation audits implemented. Escalation process strengthened through Hospital Director oversight and escalation to Responsible Individual and ICG Executive Board for support if not completed within timeframe.	General Manager / Hospital Director	Completed immediately. Ongoing governance arrangements.
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13.	There were some issues relating to the secure storage of medicines and clinical items. On one ward, the key had broken in the medicines trolley lock. Staff told us that, as an interim measure, the trolley had been relocated to the main clinic room to maintain security while a replacement trolley was awaited. In the main clinic room, a drawer containing various topical preparations was not secured. Staff informed us that this was a temporary arrangement pending the installation of replacement storage cupboards. We were also advised that new lockable cupboards had been	The registered provider must ensure that medicines, topical preparations and clinical equipment are stored securely at all times and that maintenance and replacement of storage facilities are completed promptly when defects are identified.		Medication trolley was fixed immediately; however new one was ordered and has arrived. New cupboard space within the clinic room which was installed on 14th August 2026. Overstock medication is kept within locked cupboards within the clinic room. All items including items that were stored on top of cupboards have now been appropriately stored. All clinic rooms within the hospital have a weekly audit to oversee environmental expectations that have been allocated to the medication nurses and oversight from Clinical	Clinical Lead / General Manager	Medication trolley was fixed immediately; however new one was ordered and has arrived.
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	ordered, as some existing cupboards used for storing clinical equipment, including syringes, could not be locked.			Lead and Practice Lead. This is then reported within the Clinical Lead's report at monthly Governance meetings.		
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14.	There was no recorded evidence that shared or reusable medical equipment was being cleaned between patient use.	The registered provider should strengthen arrangements to ensure the cleaning and decontamination of equipment between patient use is consistently recorded and evidenced. The registered provider should implement a daily checklist for nursing staff to record the cleaning of medical devices, with records signed and dated to provide assurance that equipment has been appropriately cleaned.	Infection prevention & control	Daily cleaning checklist to be introduced for shared and reusable medical equipment, requiring staff sign-off and audit oversight. Compliance to be monitored through clinical governance arrangements. I Am Clean' stickers have been ordered for use on medical devices throughout the hospital to provide clear visual assurance that equipment has been cleaned and is ready for use. In addition, a standardised process has been developed for the nursing team outlining the required actions before and	Clinical Lead / Practice Lead	Within 4 weeks
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				after the use of medical devices. This guidance will be shared and reviewed with staff at the upcoming nursing team meeting. A practical demonstration will also be provided to support implementation and ensure staff understanding of the new process at this meeting.		
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15.	The service user guide referred to patients making safeguarding referrals but did not include relevant contact details for the local authority or the IRIS safeguarding lead.	The registered provider must ensure that the patient guide/service user guide is accurate, accessible and kept under review, and includes clear safeguarding contact details so patients know how to raise safeguarding concerns independently if they choose to do so.	Safeguarding	Service User Guide reviewed and updated to include safeguarding contact information including Local Authority and IRIS contacts. Process introduced for regular review of patient information documentation. Safeguarding posters are also in reception areas for ease of reference for individuals.	Hospital Director / Practice Lead	Completed
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16.	Most respondents to the patient survey reported feeling safe within the setting. However, almost a third of respondents stated they did not feel safe. Comments suggested that these concerns primarily related to the behaviour of other patients and previous incidents on the ward. Some respondents acknowledged that safeguarding measures had subsequently been implemented to address identified concerns.	The registered provider must ensure that all patients consistently feel safe within the hospital environment. This should include reviewing the causes of patients' reported safety concerns, strengthening measures to reduce the impact of behaviours that may affect the safety and wellbeing of others, and regularly seeking feedback from patients to monitor whether improvements have been effective	Safeguarding	Patient feedback reviewed alongside incident and safeguarding information. Existing safeguarding controls and risk management arrangements reinforced. Patient forums and feedback mechanisms to monitor improvements in perceived safety enhanced. Review completed within 4 weeks. Weekly client meetings completed Patient voice meetings have commenced monthly that are being facilitated by Clinical Lead and Practice Lead. This gives the opportunity for positive discussions	Hospital Director / Clinical Lead	Review completed within 4 weeks with ongoing actions implemented for embedding.
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				and what is going well and what may not be going well on the unit. There are then specific unit base client meetings that take place on the ward. Both notice boards on the unit now have 'You Said We Did' posters following Governance and highlight requests clients have made for Governance and then provide them with feedback in an easy read format.		
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17.	There was no facility for patients to make anonymous complaints	The registered provider must ensure that patients, and where appropriate families or carers, have clear and accessible information about how to make complaints or provide feedback anonymously, including arrangements accessible to patients who may not be able to use online systems independently.	Concerns & Incidents	Anonymous feedback and complaints process to be implemented. Information to be made available on wards and within patient information materials. Accessibility options to be reviewed to support all patients. This is complete – the box is allocated on reception with a poster above and on both wards explaining how to use this for the patients. These posters are also on the ward notice boards.	Hospital Director / General Manager	Completed
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18.	Staff survey responses identified concerns regarding leadership visibility, management support and staff involvement in decision-making. Whilst most respondents felt senior managers were visible and committed to patient care, many respondents reported that communication between senior management and staff was ineffective. Feedback regarding immediate management was less positive. Most respondents reported that managers did not seek their views before making decisions affecting their work, did not provide clear feedback, and could not always be relied upon for support with difficult	The registered provider must ensure that managers at all levels provide effective support, communication and engagement with staff. This should include creating opportunities for staff to contribute to decision-making and ensuring staff receive regular feedback, support and opportunities to raise concerns.		Leadership restructure implemented with creation of General Manager role. Weekly primary team meetings ongoing. Clinical Lead and Practice Lead provide dedicated attendance and support. Monthly attendance from General Manager and Hospital Director established. Monthly staff drop-in sessions and engagement forums introduced. Additional Actions following review: A suggestion box is going to be placed in the staff room. Hospital Director completing a monthly staff newsletter.	Hospital Director / General Manager / Clinical Lead	Implemented immediately. Ongoing
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	tasks. Responses also indicated low levels of confidence in organisational support and problem-solving arrangements			Notice board for staff's achievements have been implemented on reception. Monthly drop-in meetings have commenced with Practice Lead and Clinical Lead.		
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19.	Most respondents reported that they were not involved in decisions affecting their work area and felt communication between senior management and frontline staff was not effective. Staff also reported uncertainty regarding how patient feedback was used to inform service improvements, and many felt that learning following incidents was insufficient.	The registered provider must ensure governance arrangements effectively support staff engagement, organisational learning and continuous improvement. This should include improving communication with staff, demonstrating how concerns and patient feedback are used to inform service development, and strengthening confidence in incident management and organisational learning processes.		Staff engagement arrangements strengthened through team meetings, drop-in sessions and planned multidisciplinary forums. Learning from incidents and feedback to be routinely communicated through team meetings and governance structures. Clinical Lead and Practice Lead have introduced a monthly staff forum 'drop in meeting', this gives opportunity for staff to discuss any concerns. The Primary Team Meeting (PTM) agenda has been altered which allows Clinical Lead and Practice	Hospital Director / Clinical Lead / Practice Lead	Immediate and ongoing.
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				Lead space to attend the PTM so that staff are giving another opportunity of a reflective space. Support workers are allocated to attend MDT meeting for the clients on a weekly basis. Nurses are also invited to attend Governance Meetings.		
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20.	Respondents to the survey identified the need for additional support through supervision, management development and specialist training opportunities. Wellbeing was identified as a concern, with over half of respondents reporting that their role negatively affected their health. Many respondents also reported that the organisation was not taking sufficient action to support staff wellbeing.	The registered provider must ensure staffing levels and workforce arrangements are sufficient to support the safe delivery of care and reduce the impact of workload pressures on staff wellbeing and patient care. The registered provider must ensure staff have access to appropriate supervision, training, development opportunities and wellbeing support, and that action is taken to address workforce concerns identified through staff feedback.		Recruitment to vacancies completed, including all Senior Support Worker vacancies. Ongoing recruitment to Support Worker vacancies. Increased visibility and support from Clinical Lead and Practice Lead. Staff wellbeing initiatives, recognition awards and monthly engagement forums introduced. Weekly audit introduced for supervision compliance - quality and quantity to ensure staff support available regularly	Hospital Director / Clinical Lead / Practice Lead	Immediate and ongoing review quarterly.
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21.	Mandatory training compliance was generally good, but Basic Life Support and Immediate Life Support required improvement. The registered provider also needs to capture the BOC oxygen cylinder training completion rates.	The registered provider must ensure staff complete all required emergency response and oxygen cylinder training relevant to their role, including Basic Life Support, Immediate Life Support and BOC oxygen cylinder training where applicable. Compliance should be monitored and gaps acted upon promptly.	Workforce	Training compliance review undertaken. Staff requiring training identified and booked onto sessions for BLS and ILS. All outstanding nurses who are in work have attended BOC training. Compliance monitoring strengthened through workforce governance reporting and escalation of outstanding training requirements. Bloods and ECG training sessions implemented.	Clinical Lead / Learning & Development Lead	Within 8 weeks for compliance recovery. Ongoing monitoring monthly.
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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): Kim Davies

Job role: Hospital Director

Date: 20/08/2026