Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Maple Ward, Hafan y Coed Mental Health Unit,

University Hospital Llandough, Cardiff and Vale University Health Board

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Hafan y Coed Mental Health Unit, University Hospital Llandough, Cardiff and Vale University Health Board on 14,15 and 16 April 2025. The following hospital ward was reviewed during this inspection:

- Maple Ward – 13 beds providing low secure forensic services for adult male patients.

Our team for the inspection comprised of three HIW healthcare inspectors, two 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.

No questionnaires were completed by patients or their carers, and two 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:
Throughout our inspection, we witnessed staff treating patients with respect and kindness and supporting them in a dignified manner. The ward's communal areas generally provided a suitable therapeutic environment, and each patient had their own bedroom with ensuite facilities, supporting their privacy and dignity. However, multiple unresolved maintenance issues, including a lack of privacy film on gym windows, compromised patient privacy and the overall quality of the patient experience.

Staff provided timely and effective patient care in accordance with clinical need. Effective processes were in place to support the physical and mental health of patients, ensuring thorough assessments and prompt access to healthcare services. Staff demonstrated a strong understanding of the patients in their care, with regular meetings held to review patient wellbeing and care requirements.

The ward was supported by two dedicated activities coordinators and a team of Occupational Therapy (OT) staff, who delivered a variety of therapeutic activities. We found patients were provided with suitable activities to support their health, wellbeing and rehabilitation.

Suitable arrangements were in place to promote and protect patient rights. A range of relevant information was displayed and provided to help patients and their families understand their care. Individualised intervention plans outlined patient involvement in care decisions, supporting their independence and quality of life. Staff demonstrated a clear commitment to upholding patient rights and respecting individual preferences, with high compliance in mandatory training on Equality, Diversity, and Human Rights.

This is what we recommend the service can improve:

- Install privacy screening within the patient gym to protect patient privacy and dignity.

This is what the service did well:

- Information booklets were in place to support patients and their family/carers in understanding their care

- Welsh speaking staff members wore a ‘Iaith Gwaith’ lanyard to clearly indicate their ability to speak Welsh
- The ward accommodated religious needs by providing a designated multi-purpose room equipped with multifaith information and equipment.

Delivery of Safe and Effective Care

Overall summary:
Policies, processes and procedures were in place to support risk management and safeguard patients, with a suitable governance structure for discussing incidents and concerns, however, timely review of these documents is needed. Staffing levels aligned with core staffing establishments and were proportionate to ensure patient safety. Incidents were recorded and monitored using the Datix system, with regular reports produced to identify trends and share learning. A range of audits, including up-to-date ligature audits, were completed within set timescales to ensure patient safety.

However, we found several improvements needed to maintain the safety of patients, staff and visitors, with some outstanding from our previous inspection. For example, only one patient ensuite bedroom had emergency call points, limiting patients' ability to alert staff in emergencies. Additionally, blind spots in communal corridors remained unaddressed despite previous HIW recommendations for mirror installations. Environmental audits identified fire risks, but the documentation lacked detail on risk descriptions and mitigations. Multiple maintenance issues remained unresolved or were cancelled without resolution.

Infection Prevention and Control (IPC) procedures were in place; however, multiple IPC and environmental issues required attention. For example, excessive clutter, cleaning schedules and shared team cleaning responsibilities, and the use of the Activities of Daily Living kitchen as a laundry room. Additionally, the ward’s disposable curtains were overdue for replacement, despite documentation indicating they had been checked.

We found robust procedures in place for the safe management of medicines, but routine assessments of medication side effects were not documented in patient records.

All patient detentions were compliant with the MHA and Code of Practice and were reviewed within relevant timescales. However, patient records evidenced limited involvement from advocacy services. Additionally, some delays in requesting Second Opinion Appointed Doctors (SOADs) and Statutory Consultees had resulted in an increased reliance on emergency provisions for administering medications.

Patient Care and Treatment Plans were aligned with the domains of the Wales Mental Health Measure, providing a comprehensive overview of patient care and interventions. Records were well-organised, effectively maintained and regularly reviewed. However, specialist risk assessments, such as HCR20 Violence Risk assessments, were overdue due to staffing pressures and the need for additional training.

We found good overall staff training compliance with Strategies and Interventions for Managing Aggression (SIMA) training. Staff demonstrated a strong understanding of the restrictive practices available to them and provided assurance that restrictive interventions were used only as a last resort. Given the nature of patient risks on the ward, the implementation of Positive Behaviour Support (PBS) plans was identified as a valuable approach to further enhancing patient care and risk management.

This is what we recommend the service can improve:

- Implement measures to ensure patients can alert staff in the event of an emergency
- Fully document fire safety risks and the corresponding actions taken
- Eliminate blind spots on the ward
- Ensure IPC and maintenance issues are promptly and effectively documented and resolved
- Ensure advocacy support is routinely offered and documented
- Improve staff communication with SOADs and Statutory Consultees, to ensure timely decision-making and prevent unnecessary delays
- Ensure HCR20 assessments and PBS plans are completed where clinically indicated.

This is what the service did well:

- The ward had adopted the ‘Safewards model’ as a strategy to reduce restrictive practices
- The MHA Administrative team provided an active supportive service to ward staff and patients
- The ward followed Wales Applied Risk Research Network (WARRN) principles
- Individualised intervention plans were in place to closely monitor patients prescribed high-dose antipsychotic medications
- Staff competencies in medication administration were formally assessed

Quality of Management and Leadership

Overall summary:
There was a clear organisational structure in place, providing defined lines of management and accountability. Good teamwork was evident, with staff demonstrating a commitment to delivering high-quality patient care, which was supported by positive staff feedback. However, some staff expressed concerns regarding the limited visibility and involvement of senior management and wider multidisciplinary team (MDT) on the ward. Additionally, poor communication between senior management, the MDT and ward staff was highlighted, with issues or concerns raised by ward staff not always acknowledged.

An appropriate staff skill mix was in place and staffing vacancies were minimal, with a low reliance on temporary staffing. We were informed that staff retention was high, reflecting a supportive working environment.

Robust processes were in place to gather feedback from patients and staff, and staff demonstrated a strong commitment to making improvements based on the feedback received. Regular audits and meetings were conducted to review findings, incidents, and issues related to patient care. Processes were in place to identify, investigate, escalate, and monitor incidents, ensuring preventive measures were taken to reduce recurrence.

We found good compliance with annual staff appraisals, which was supplemented by a structured, formal clinical supervision process. Suitable arrangements were in place for senior staff to monitor compliance with mandatory training, and overall compliance was generally high. However, improvements were needed in timely completion of Fire Safety, Information Governance, and Consent training. Additionally, the health board must implement Duty of Candour training.

It was evident that the health board was continuously evaluating the service provision to drive quality improvement. Staff also highlighted initiatives, such as team-building days, additional training, and professional development opportunities. Established governance arrangements provided oversight of clinical and operational issues. However, several health board policies and procedures were overdue for review.

This is what we recommend the service can improve:

- Review the staff feedback on senior management and MDT visibility, communication, and engagement, and implement improvements to strengthen collaboration in patient care
- Ensure timely completion of all mandatory training
- Implement Duty of Candour training for staff
- Ensure policies are reviewed in a timely manner.

This is what the service did well:

- Good ward staff teamwork
- Positive leadership of the ward manager
- Good compliance with staff supervisions and annual appraisals
- Effective processes in place to routinely capture staff, patient and family/carer feedback.

3. What we found

Quality of Patient Experience

Person-centred

Health promotion
There were effective processes in place to help promote and maintain the physical and mental health needs of patients. We reviewed three patient records and found that patients received appropriate physical assessments on admission, with regular review of their care plans and progress. Long term health conditions were appropriately monitored, and staff demonstrated a good understanding of the needs of the patients in their care.

Each patient had an individual ensuite bedroom and access to the communal areas of the ward throughout the day. The ward's secure garden areas provided patients with access to fresh air and green spaces. A wide range of self-directed activities was available, including games, puzzles, books, a pool table, and a gymnasium.

The ward was supported by two dedicated activities coordinators and a team of Occupational Therapy (OT) staff who delivered a variety of therapeutic activities. During the inspection, we observed staff actively engaging with patients and providing a suitable programme of activities to support their health, wellbeing, and rehabilitation.

Dignified and respectful care
Throughout our inspection we observed staff engaging with patients appropriately and treating them with dignity and respect. We witnessed positive interactions, which demonstrated their attentiveness to individual patient needs. We saw an appropriate mix of staff working on the ward to meet the needs of the patient group.

Each patient had their own bedroom with ensuite shower facilities, supporting their privacy and dignity. All bedroom doors were fitted with observation panels, allowing staff to undertake therapeutic observations without disturbing patients. Patients were provided with individual wrist bands to access their rooms and could lock their rooms as needed, with staff able to override the locks when necessary. During the inspection, we observed staff respecting patient privacy by knocking before entering their rooms.

The ward generally provided a suitable therapeutic environment for patient needs. However, we noted multiple unresolved maintenance issues, including a longstanding requirement for frosted film for the gym windows. This meant that patients could potentially be seen from outside the unit while using the gym, compromising their privacy and dignity.

The health board must undertake measures to install suitable privacy screening within the gym, to ensure patients' privacy and dignity are protected.

Individualised care

We saw evidence that patients had individualised, person-centred Care and Treatment Plans (CTPs) and intervention plans, which outlined areas where they were involved in making decisions regarding their care. More findings on patient care plans can be found in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

We found that patients were supported to make their own decisions about how to care for themselves wherever possible, promoting their independence and quality of life. This was supported by a range of appropriate health promotion information on display.

Patients were able to store possessions and personalise their bedrooms where appropriate. The ward had suitable visiting rooms where patients could see their families in private. Additionally, rooms were available for patients to spend time away from other patients according to their needs and wishes. The staff members who completed a questionnaire and whom we spoke with during the inspection felt that patients were informed and involved in decisions about their care.

Timely

Timely care

Established meeting processes were in place to support the timely care of patients, including twice daily handover meetings to discuss bed occupancy, patient needs, and staffing levels. We attended a handover meeting and saw that staff demonstrated a strong understanding of the individuals in their care, with discussions focused on patient well-being and care requirements.

Staff attended regular multidisciplinary team (MDT) meetings, where information was shared to ensure timely care. We were informed that concerns and incidents were routinely discussed during clinical governance meetings, enabling the identification of trends and opportunities for wider organisational learning. We found that staff provided timely and effective care in accordance with clinical need.

Equitable

Communication and language

The ward used electronic patient record keeping to document and communicate patient care in a timely manner. Staff could also participate in online meetings, conduct audit processes and share other information electronically.

A range of suitable and relevant information was displayed and provided to help patients and their families understand their care. This included details about advocacy services and how to raise a concern or complaint. The ward displayed a helpful information board to identify staff members for patient and visitor awareness. Additionally, comprehensive information booklets had been developed to support patients and their family/carers, which we identified as an example of good practice.

A communal laptop was available for patient use, and ward telephones allowed patients to maintain contact with family and carers. We were informed that some patients had access to their personal electronic devices while off the ward, subject to individual risk assessments. Measures were in place to ensure the safe use of digital devices, including a structured sign in/out process.

Staff demonstrated an understanding of the importance of speaking with patients in their preferred language. We were informed that Welsh language training was available to staff, and translation services were utilised to support patients when needed. We observed that Welsh-speaking staff members wore a 'Iaith Gwaith' lanyard to clearly indicate their ability to speak Welsh.

Rights and equality

We reviewed the records of three patients who were detained under the Mental Health Act. The documentation was compliant with relevant legislation and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code). We were told that patients had access to a mental health advocate who provided information and support for patients regarding any issues they may have regarding their care. However, the involvement of advocacy services was not clearly evidenced within the patient records. Further information on our findings is detailed in the Mental Health Act Monitoring section of this report.

We generally found appropriate arrangements in place to promote and protect patient rights, with staff demonstrating high compliance with mandatory training in Equality, Diversity, and Human Rights. The ward accommodated religious needs by providing a designated multi-purpose room equipped with multi-faith information and resources for prayer, which we identified as an example of good practice. Policies were in place to ensure equitable access to the same

opportunities and fair treatment; however, the Equality, Inclusion, and Human Rights Policy was overdue for review.

During our staff discussions, they demonstrated a clear commitment to upholding patient rights and individual preferences. Regular meetings were held to review practices and minimise restrictions based on individual risks, ensuring care was consistently delivered in accordance with patient needs. Reasonable adjustments were in place to ensure equitable access to services. The ward was accessible to wheelchair users, and additional specialist equipment was available to support individual patient requirements.

Delivery of Safe and Effective Care

Safe

Risk management
There were established policies, processes and audits in place to support the management of risk, enabling staff to provide safe and clinically effective care. We reviewed the processes in place to manage risks and maintain the health and safety of patients, staff and visitors, and found the following suitable measures in place:

- The ward entrances were secured throughout the inspection to prevent unauthorised access or egress
- The ward was accessible to all, including those with mobility difficulties
- Clear information was displayed and provided regarding restricted and prohibited items, with environmental checks supporting the enforcement of these restrictions
- Personal safety alarms were available for all staff to use in an emergency situation, and we observed staff carrying them throughout the inspection
- We saw examples of various hospital audits and processes completed within set timescales to support patient safety, including date up-to-date ligature audits
- Ligature cutters were available for use in the event of a self-harm emergency and staff knew where to find them
- Regular audits were conducted to ensure emergency resuscitation equipment was present and in date.

However, our inspection of the patient and clinical areas of the ward identified several environmental, infection control, and health and safety risks that required attention to maintain the safety of patients, staff, and visitors.

During our tour of the ward, we observed that while nurse call points were available in some communal areas, only one patient bedroom and toilet were equipped with emergency call points. We identified that this arrangement posed a potential risk to patient safety, as patients would be unable to alert staff from their bedrooms in the event of an emergency. We were informed that patients could request a personal alarm to call for assistance if needed; however, staff confirmed that there were not enough alarms for all patients on the ward. Notably, this issue was also identified during our previous inspection of Maple Ward in 2020.

The health board must ensure that all patients are provided with appropriate means to alert staff in the event of an emergency.

Staff conducted twice-daily comprehensive environment and security audits, during which instances of fire risks within patient bedrooms were identified and addressed. However, no additional information was included to fully describe the nature of the risk, the follow-up actions taken, or any escalation procedures. We identified that this lack of detail could prevent staff from identifying and monitoring themes and trends to prevent recurrence.

The health board must ensure that all identified fire safety risks and the actions taken to address them are fully documented, to support effective governance oversight and prevent recurrence.

During our previous inspection of the ward in 2020, we identified potential blind spots in the communal corridors that hindered effective patient observations. At that time, we recommended the installation of mirrors to address this issue. However, during this inspection we found that our recommendation had not been implemented, and the associated risk to staff, patient and visitor safety remained unaddressed.

The health board must take action to eliminate blind spots on the ward to ensure staff, patient and visitor safety.

The hospital had an electronic process to log estates and maintenance issues. However, our review of the estates log identified multiple longstanding maintenance requests that remained pending or had been cancelled by the estates department without resolution. Staff expressed concerns about several outstanding maintenance issues on the ward, explaining that all cancelled requests had to be resubmitted. We were informed of several repeated submissions for unresolved issues that remained unaddressed. Therefore, we were not assured there was an effective process in place to ensure that all outstanding estates issues were being appropriately addressed and signed off as complete.

The health board must ensure that the ward's outstanding maintenance issues are promptly and effectively resolved, with a clear process in place to prevent cancellations and duplicate submissions.

The ward's restricted items included plastic bags, and the environment/security checks evidenced occasions when staff had found and removed plastic bags from patient bedrooms to support their safety. However, bins in the communal corridors were lined with plastic bags, posing a potential safety risk for any patients liable to self-harm. We engaged with staff and advised that the health board must review

the use of plastic bags within the ward communal areas. This issue was resolved during the inspection, in that a suitable risk assessment was completed.

Infection, prevention and control and decontamination
Some suitable Infection Prevention and Control (IPC) policies, procedures, staff training and governance arrangements were in place to maintain the safety of staff, patients and visitors. Staff compliance with mandatory level 1 and 2 IPC training was 96% and 100% respectively. The ward had an appointed IPC lead, and individual staff members whom we spoke with during the inspection, demonstrated an understanding of their role and responsibility in upholding IPC standards.

Personal protective equipment (PPE) was readily available to support infection control measures. Appropriate hand hygiene facilities were in place throughout the ward to encourage good hygiene among staff and patients. Shared equipment and reusable medical devices were suitably decontaminated, with sharps safely used and disposed of.

However, our review of the ward environment and clinical areas highlighted areas of unnecessary clutter, including patient belongings stored in communal corridors. Additionally, we identified multiple IPC and environmental issues that required attention or posed potential risks to the safety of staff, patients, and visitors. These included:

- Water damage to ceilings within the communal corridor and bathroom flooring in some bedrooms, causing the flooring to lift
- A bedroom lacking hot water, impacting patient comfort and hygiene
- A rusted, leaking, and odorous toilet cistern in bedroom 7, with a swollen cupboard door restricting access
- Walls in the patient telephone room requiring plastering and painting
- Ripped sofas in the low stimulation room and staff room, preventing effective IPC
- The dining area window and laundry cupboard required cleaning
- The Activities of Daily Living (ADL) kitchen was untidy and cluttered, and the fridge, oven and microwave required cleaning. This was addressed during the inspection
- The ADL kitchen was being used as a laundry room, posing a risk of cross-contamination
- The communal patient servery area and fridge required cleaning. This was addressed during the inspection
- The communal patient servery hot water dispenser was heavily coated with limescale. This was addressed during the inspection

- The dining room servery fridge and cupboards contained open, unlabelled patient foods
- The treatment room floor was covered in tape, potentially harbouring microorganisms and preventing effective cleaning
- The daily environmental/security checks were consistently signed by the Nurse in Charge, but the documentation did not accurately reflect the ward conditions observed during the inspection. For example, many disposable curtains were overdue for replacement, but the checklist was signed to indicate that they had been checked. The curtains were replaced during the inspection; however, our staff discussions highlighted confusion regarding responsibility and governance oversight of this task. Therefore, we were not assured of the validity of the checks being undertaken
- Housekeeping audits were appropriately completed; however, we identified a lack of understanding regarding the cleaning responsibilities shared between ward staff and housekeeping teams. The nursing staff checklists lacked comprehensive coverage of their tasks, including areas that required attention during the inspection.

The health board must:

- **Promptly and effectively resolve the ward's outstanding IPC issues to ensure the safety of staff, patients, and visitors**
- **Review the ward's laundry arrangements to ensure they support effective IPC**
- **Strengthen leadership and governance systems to ensure all ward areas are effectively cleaned, monitored, and that completed audits accurately reflect ward conditions**
- **Enhance existing IPC audit processes and provide clear guidance for nursing and housekeeping staff to ensure full understanding of their IPC responsibilities.**

Safeguarding of children and adults
Appropriate safeguarding measures were in place to protect vulnerable adults, with staff able to access the health board's safeguarding policy and Wales safeguarding procedures via the intranet.

Staff demonstrated high compliance with mandatory training for safeguarding adults and children. Our discussions with staff highlighted a strong knowledge and understanding of safeguarding procedures and reporting arrangements.

Safeguarding incidents and concerns were recorded on the Datix electronic incident reporting system and monitored by the senior management team. Staff

confirmed that safeguarding concerns were regularly reviewed to identify themes and lessons learned.

Management of medical devices and equipment
We found appropriate resuscitation equipment in place on the ward, with regular checks conducted to ensure that the items were present and in date. All emergency equipment was accounted for and correctly sealed. Daily and weekly emergency drug checks were clearly documented in the clinic records. Oxygen cylinders were suitably stored and routinely checked in accordance with emergency drug provisions.

Medicines management
We reviewed the ward's clinic arrangements and found robust procedures in place for the safe management of medicines. Relevant policies were in place and were accessible to staff, such as medicines management and rapid tranquilisation.

All prescribed medications and controlled drugs were securely stored in medication fridges and locked cabinets. Regular temperature checks of the medication fridges were conducted to ensure that medication was being stored at the correct temperature. The records evidenced that medication stock was accounted for when administered, and that stock checks were being undertaken as required. We found appropriate internal auditing systems in place to support the safe administration of medication, with good pharmacy involvement.

We reviewed patient Medication Administration Records (MAR charts) and found that they were maintained to a good standard. The charts were consistently signed and dated when medication was prescribed and administered, and a reason was recorded when medication was not administered. Patient consent to treatment certificates were appropriately completed and stored alongside their MAR charts. The current MHA legal status for patients was clearly recorded in the MAR charts we reviewed.

We observed safe and appropriate prescribing of medications in accordance with patient needs, with regular reviews completed to ensure they remained appropriate. Individualised intervention plans were in place to closely monitor patients prescribed high-dose antipsychotic medications, which we identified as good practice. However, routine assessments of medication side effects were not recorded in patient records. We advised staff that the use of an evidence-based side effect rating scale, such as the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS), would help to assess the presence and severity of side effects associated with antipsychotic medications.

The health board should consider adopting the LUNSERS scale to measure the side-effects of antipsychotic medications.

We were told that patients or their family/carers were involved in decisions about their medications wherever possible. Patient medications were routinely discussed during biweekly ward round meetings, during which any updates or changes to their medication were recorded.

Staff whom we spoke with during the inspection demonstrated appropriate knowledge and understanding of medication management procedures. It was positive to note that staff competencies in medication administration were being formally assessed, with all registered staff having a completed competency assessment on file. We found good systems in place to ensure medication errors were appropriately recorded, investigated and addressed, and that any learning opportunities were shared with all staff.

Effective

Effective care

During the inspection we found that staff numbers met core staffing establishments and were proportionate to ensure patient safety. Reliance on temporary staff was reportedly low, and when additional support was required, the ward actively sought to book bank staff who were familiar with the hospital and patient group wherever possible.

The MDT was well established, and we were assured that clinical decisions relating to patient care were determined through a multidisciplinary approach. The ward had recently benefited from the appointment of a new psychologist and a therapeutic trauma-informed nurse, both of whom supported patients across the community forensic provision. Additionally, dedicated activities coordinators and community OT staff supported ward staff to deliver effective patient care. However, some staff felt that more could be done to involve ward staff in MDT meetings, and to enhance the presence of senior MDT staff members on the ward. Further information on our findings is detailed in the Governance and Leadership section of this report.

Staff used the Datix system to record, manage and monitor incidents. A structured incident sign-off hierarchy was in place, with regular incident reports produced to establish themes and trends. Senior staff confirmed that relevant learning was shared with the team both verbally and electronically.

Staff received training on the observation policy and our staff discussions confirmed a strong understanding of their role in conducting therapeutic patient

observations. Individual patient observation levels were regularly reviewed to ensure they remained appropriate and safeguarded patient safety. We observed staff conducting safe and supportive observations and were informed that patients were observed more frequently when their behaviour required closer monitoring. This was consistent with our review of patient observation records, which were completed contemporaneously as appropriate.

Training compliance figures indicated that overall staff compliance with Strategies and Interventions for Managing Aggression (SIMA) training was 88%. Staff demonstrated a good understanding of the restrictive practices available to them, including preventative measures designed to reduce the need for restrictive responses to challenging behaviour. The ward had high-care and low-stimulus rooms that were used proactively and reactively to support patient care. Additionally, patients with physical health issues had specific intervention plans to support the use of SIMA when necessary.

We reviewed a sample of restraint incidents and found that they were suitably recorded, investigated and monitored. We saw evidence of restrictive practices being used as a last resort, with thorough assessments of therapeutic effect and risk. Diversionary tactics were consistently implemented as a method of de-escalation.

It was positive to note that the ward had adopted the Safewards model as a strategy to reduce restrictive practices. This approach included the use of 'Getting to Know You' boards and Mutual Help Meetings, which encouraged patient feedback and involvement in their care. Blanket restrictions were appropriately applied to maintain the necessary level of physical and procedural security required within the low-secure environment.

Nutrition and hydration
Our review of patient records found that patients were supported to meet their individual dietary needs and provided with diets in accordance with their medical needs.

There were suitable facilities available for patients to access hot and cold drinks throughout the day. Patients were supported to use the ward’s ADL Kitchen and could also store personal food on the ward.

Patients could choose from set menus provided on the ward; however, some expressed a desire for more variety in the options available. The health board may wish to engage further with patients to explore potential improvements to menu choices.

Patient records
Clinical records were maintained electronically and in paper format. Paper records were stored securely, and the electronic system was password protected to prevent unauthorised access. Clinical details were recorded contemporaneously and comprehensively, providing a detailed overview of the patients and their care.

Further information on our findings regarding patient records and care plans is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Mental Health Act monitoring
We reviewed the statutory detention documents of three patients and discussed the monitoring and audit arrangements with staff. All three patients were subject to the Ministry of Justice (MOJ) jurisdiction, and their detentions were found to be compliant with the Mental Health Act (MHA), MOJ requirements and the Code of Practice.

At the time of our inspection, MHA records were maintained in both paper and electronic formats, with the audit process transitioning to a new digital system. While the records were generally well-organised and contained detailed and relevant information, the mix of formats presented navigation challenges, and some data remained insufficient, making themes and trends difficult to identify. Staff advised that all records would soon be fully transferred to the new digital system, which would improve accessibility, improve data quality and ease analysis.

It was positive to note that the MHA Administrative team were members of the MHA Administrators All Wales Forum, where MHA legislation, good practice and areas for improvement are discussed, standardised, and shared across Wales. The team provided an active supportive service to ward staff and patients, with robust audit systems in place to ensure compliance and efficiency.

Suitable processes were generally in place to uphold patient rights. Patient detentions were found to be compliant with relevant timescales, and any patients wishing to formally appeal their section received active support from the MHA team and the MDT. We saw evidence of comprehensive reports completed for Mental Health Review Tribunals (MHRTs) and Hospital Managers' Review panels. We were informed that advocacy services were available; however, the records we reviewed indicated limited involvement from these services.

The health board must ensure that:

- **Patients' entitlement to an advocate is routinely offered, and they are actively supported in making a referral if they choose to accept advocacy services**
- **This process is clearly documented within patient records, to ensure transparency and accessibility.**

During the inspection, we reviewed recent health board-wide Mental Health Legislation and Governance meeting minutes that highlighted delays in the Responsible Clinician (RC) requesting a Second Opinion Appointed Doctor (SOAD), and challenges faced by SOADs in contacting Statutory Consultees. These delays had resulted in an increased reliance on emergency provisions for administering patient medication under Section 62 of the MHA. To address this issue, the MHA team had implemented a system to send reminders to RCs three weeks ahead of three-month deadlines.

While these issues were not specific to Maple Ward, where there had been no instances of Section 62 use in the previous 12 months, we advised staff during our feedback meeting that a more efficient process should be developed to improve communication between RCs, SOADs and Statutory Consultees. This would ensure timely decision making, prevent unnecessary delays, and reduce reliance on emergency provisions for administering patient medication.

The health board must consider implementing a process to improve communication between Responsible Clinicians, Second Opinion Appointed Doctors and Statutory Consultees, to ensure timely decision-making, prevent unnecessary delays and reduce the reliance on emergency provisions for administering patient medication.

Suitable arrangements were in place to ensure Section 17 leave was appropriately documented. Patient leave was subject to appropriate risk assessments and the forms clearly determined the conditions and outcomes for each patient. Following a series of incidents related to Section 17 patient leave at Hafan y Coed prior to our inspection, additional training had been provided to enhance staff understanding of their roles and responsibilities, reinforcing patient safety and procedural compliance.

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

Alongside our review of statutory detention documents, we considered the application of the Mental Health (Wales) Measure 2010. During the inspection, we reviewed three patient records and found a good standard of clinical record keeping. The Care and Treatment Plans (CTPs) were aligned with the domains of the Wales Mental Health Measure, providing a comprehensive account of the

patients' presentation and the interventions being offered. The records were regularly reviewed, well organised and easy to navigate.

Appropriate arrangements were in place to meet both the physical and mental health needs of patients. Physical health was assessed upon admission and regularly monitored throughout their stay. Patients also benefited from strong support provided by wider physical health services available on-site, particularly the Patient at Risk Team (PART) at University Hospital Llandough.

All patients had an individualised and person-centred CTP that reflected their needs and risks. The CTPs were supplemented by individualised Intervention Plans covering areas such as physical health care, levels of observation, and SIMA. To support patient care plans, an extensive range of assessments was in place to identify and monitor care provision, along with risk assessments that set out the identified risks and how to mitigate and manage them. The ward followed Wales Applied Risk Research Network (WARRN) principles, and we saw evidence of comprehensive assessments aligned with patient needs.

However, we found that some specialist risk assessments were clinically indicated but had not been completed, including HCR-20 Violence Risk assessments. At the time of our inspection, only one of the 13 patients had a completed HCR-20, with delays attributed to staffing pressures and the need for additional staff training to complete the assessments. Given the nature of the patient risks on the ward, we also identified that the implementation of Positive Behaviour Support (PBS) plans would be beneficial in enhancing patient care and risk management.

The health board must ensure that HCR-20 assessments and Positive Behaviour Support plans are completed where clinically indicated, and provide staff with the necessary support, training, and resources to effectively undertake these tasks.

Biweekly MDT reviews were being undertaken to conduct a more formal review of patient care, which included the involvement of family and carers, external agencies, and community professionals as appropriate. We saw that patients, family, and carers had been involved in the development of their CTPs wherever possible. We found strong evidence of discharge and aftercare planning within the patient records, with discussions being held regarding appropriate future placements.

Quality of Management and Leadership

Staff feedback

We engaged with staff throughout the inspection and received two responses to our staff questionnaire. Therefore, the response rate was too small to draw robust conclusions about themes or trends within the ward.

The two responses to the questionnaire were generally negative. Both respondents agreed they were satisfied with the quality of care they gave to patients; however, only one agreed that patient care was the health board's top priority. Neither recommended the hospital as a place to work and both stated they would not be happy with the standard of care provided to their friends or family. Additionally, both were not content with the health board's efforts to keep staff and patients safe.

Both staff members agreed that their current working pattern allowed for a good work-life balance, but one felt that their job was detrimental to their health. While both confirmed being aware of the Occupational Health support available to them, they disagreed that the health board took positive action on staff health and wellbeing.

The health board must reflect on these aspects of staff feedback about patient care and staff wellbeing and consider what improvements can be made.

Leadership

Governance and leadership

We observed strong teamwork on the ward and found that staff were dedicated to delivering a high standard of patient care. There was a clear organisational structure in place, providing clear lines of management and accountability. Staff whom we spoke with during the inspection and who completed our questionnaire shared positive feedback about their colleagues and immediate managers, expressing that they felt supported in their roles.

Many staff spoke highly of the ward's leadership, particularly the positive changes implemented by the ward manager, which had strengthened staff culture and morale. All staff we spoke with confirmed that the ward team worked collaboratively; however, some staff expressed concerns about the poor visibility and involvement of senior management and MDT staff members on the ward. Additionally, they reported poor communication between senior management, the

MDT and ward staff, with issues or concerns raised by ward staff not always being acknowledged.

Staff suggested that these issues could be addressed through more frequent ward visits from senior managers and MDT staff members, and by involving ward staff in decision-making and MDT meeting processes. They explained this would enhance communication and support a more collaborative approach to patient care.

The health board must consider the feedback regarding senior management and MDT visibility, communication and staff engagement. Necessary improvements should be implemented to foster a more collaborative approach to patient care.

Workforce

Skilled and enabled workforce
There appeared to be sufficient appropriately trained staff to meet the assessed needs of patients throughout our inspection. Most staff reported feeling able to deliver safe and effective patient care. Staffing vacancies on the ward were minimal, with a low reliance on temporary staff to cover shifts. We were told that staff retention was high, reflecting a supportive work environment.

Suitable processes were in place for senior staff to monitor compliance with mandatory training. While overall compliance rates were generally high among ward staff, improvements were required in some mandatory training, including:

- Fire safety – 76%
- Information governance - 69%
- Consent - 69%

The health board must implement measures to ensure all outstanding mandatory training is completed, regularly monitored, and that staff receive appropriate support to complete the training in a timely manner.

Staff whom we spoke with felt they had received appropriate training to undertake their roles. We were told that development opportunities were available to staff and were provided with examples where additional training was provided to staff to support them in their roles. Staff who completed our questionnaire were asked what other training they would find useful and suggested:

> *"Bloods training, Multi-Agency Public Protection Arrangements (MAPPA) and wellbeing."*

The health board should reflect on the staff feedback regarding suggestions for additional training and consider whether this can be facilitated.

We found a high percentage of staff had received an annual appraisal. We were told that a regular, formal clinical supervision process was in place for all staff, including qualified nurses and healthcare support workers.

During the inspection, we were provided with a range of policies and procedures and noted that several were overdue for review:

- Duty of Candour – Review date 2021
- Hand Hygiene Infection Control Procedure – Review date December 2024
- Violence and Aggression (Personal Safety) Procedure – Review date December 2023
- Incident, Hazard and Near Miss Reporting Procedure – Review date September 2024
- Infection Control Procedure for Needlestick and Similar Sharps Injuries – Review date September 2022
- Infection Control Procedure for Infectious Incidents and Outbreaks in University Health Board Hospitals – Review date November 2024
- Procedure for NHS Staff to Raise Concerns – Review date - 2017
- Observation and Enhanced Engagement Procedure – Review date January 2025
- Equality, Inclusion, and Human Rights Policy – Review date January 2024
- Search of Patients' Person and Belongings Policy and Procedure – Review date March 2016
- Personal Protective Equipment Procedure – Review date December 2023
- Violence and Aggression (Personal Safety Procedure) – Review date December 2023.

The health board must ensure policies and procedures are reviewed in a timely manner to provide clear and up-to-date guidance for staff.

Culture

People engagement, feedback and learning

An established process was in place for young people or their family/carers to escalate concerns through the NHS Wales 'Putting Things Right' (PTR) process. Senior staff confirmed that formal complaints were recorded on the Datix system and were monitored by senior managers throughout the investigation. We were told that no complaints had been made during the six months prior to our inspection.

Our staff discussions evidenced that informal and formal complaints were appropriately recorded and investigated, and any learning outcomes were shared with all staff to support continuous improvement. Staff confirmed that they felt supported to raise concerns about patient care or other issues at the hospital. However, our staff engagement identified a limited understanding of the Duty of Candour (DoC) requirements, and we were told that staff had not received any DoC training to support them in their roles.

The health board must implement Duty of Candour training to support staff in their roles.

We found effective processes in place to routinely capture patient and family/carer feedback. Daily mutual help patient meetings provided a platform for patients to offer feedback and suggest improvements, and monthly communal patient meetings allowed them to raise concerns and discuss issues. We saw evidence of actions taken as a result of patient feedback highlighted on the 'You Asked and You Got' board.

We were told that learning from incidents was regularly discussed with staff, with various organisational support systems in place to support them. The ward had two well-being champions, and one staff member had taken on the role of a trade union representative to provide further support and guidance.

A dedicated monthly staff meeting process was in place to encourage regular staff engagement and feedback. Senior staff told us that staff well-being was a priority, contributing to a positive workplace culture. We were told that staff morale was further strengthened through team-building exercises and social activities, supporting good staff working relationships.

Information

Information governance and digital technology

We considered the arrangements for maintaining patient confidentiality and adherence to information governance and the General Data Protection Regulation 2018 (GDPR) within the ward.

Paper records and data were securely stored in locked areas, ensuring confidentiality and protection. All information recorded on the hospital's electronic health record system was password-protected, with access restricted to relevant staff. Established processes were in place to ensure safe and secure information sharing with partner agencies.

While staff demonstrated a clear understanding of their role and responsibilities in managing personal and sensitive information, compliance with mandatory information governance training was just 69%, as highlighted earlier in this report.

Learning, improvement and research

Quality improvement activities
It was evident through our staff discussions that the health board was continuously reviewing the provision of patient care to drive quality improvement. Good processes were in place to seek feedback from patients and staff, and staff demonstrated a strong commitment to making improvements based on the feedback provided.

The existing governance arrangements supported continuous improvement and shared learning from incidents. Our staff discussions confirmed that regular audit activities and meetings were conducted to review findings, incidents and issues related to patient care. Processes were in place to identify, investigate, escalate and monitor incidents, ensuring preventive measures were taken to reduce recurrence.

In addition to regular staff meetings and individualised supervision processes, structured team-building days were scheduled to encourage staff discussions on strengths and areas requiring further support. Supervisory staff demonstrated a strong commitment to staff development and upskilling, with team members receiving additional training to enhance their roles, including Compassion-Focused Therapy and venepuncture. At the time of our inspection, staff were due to complete PBS training and Training in Psychological Skills (TIPS).

Staff spoke positively about ongoing efforts to improve the quality of ward-based documentation and patient records. We were told that work was being undertaken to enhance staff one-to-one interactions with patients, with a template in development to ensure clear guidance and consistency. Additionally, a ward security initiative was being developed to strengthen patient safety and overall security, with a designated nurse appointed to ensure continuity and provide support to staff.

Throughout the inspection, staff were receptive and responsive to our findings and recommendations. Some improvements we identified were rectified during the inspection; however, further action is required from the health board to address the recommendations highlighted in this report, and to sustain the improvements made.

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
Bins in the communal corridors were lined with plastic bags, which were restricted items due to the risk posed to patient safety.	This posed a potential safety risk for any patients liable to self-harm.	We engaged with staff and advised that the health board must review the use of plastic bags within the ward communal areas.	A suitable risk assessment was completed.
We identified multiple IPC and environmental issues that required attention or posed potential safety risks: • The ADL kitchen was untidy and cluttered, and the fridge, oven and microwave required cleaning	These issues posed a potential IPC safety risk for patients, staff and visitors.	We engaged with staff regarding these issues throughout the inspection.	These areas were suitably cleaned, and all expired disposable curtains were replaced.

• The communal patient servery area and fridge required cleaning • The communal patient hot water dispenser was heavily coated with limescale • The dining room servery fridge and cupboards contained open, unlabelled patient foods • Many disposable curtains were overdue for replacement.			

Appendix B – Immediate improvement plan

Service: Hafan y Coed, Maple Ward

Date of inspection: 14, 15 and 16 April 2025

The table below includes any immediate 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.	No immediate assurance issues were identified during the inspection.					

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: Hafan y Coed, Maple Ward

Date of inspection: 14, 15 and 15 April 2025

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.	We noted multiple unresolved maintenance issues, including a longstanding requirement for frosted film for the gym windows.	The health board must undertake measures to install suitable privacy screening within the gym, to ensure patients' privacy and dignity are protected.	Dignified and respectful care	Maintenance requests have been submitted. To be escalated by Service Manager.	Submitted by Service Manager awaiting Operations Manager Estates	31 August 2025
2.	Only one patient bedroom and toilet were equipped with emergency call points. We were informed that patients could request a personal alarm to call for	The health board must ensure that all patients are provided with appropriate means to alert staff in the event of an emergency.	Risk management	A centralised pool of individual call bells exists for Adult Mental Health Directorate. The Clinical Board has an individual alarm bell protocol, this is in line with health		

	assistance if needed; however, staff confirmed that there were not enough alarms for all patients on the ward.			organisations across Wales. The individual call bells can be allocated to patients who require support and assistance with complex physical health issues, mobility issues or if risks have been identified where a patient call device would be required for safety purposes. If the patient is on an enhanced level of observations such as close or specialling these devices would not be required, but can be used if it would assist with the safe reduction of observations relating to a physical health or mobility issue.		

				There are no incidents of patients requiring individual call bells and there not being one available. However, levels of usage are being monitored by the Senior Nurse for Physical Health based in Hafan y Coed, to support a review of stock and availability. This review will be reported to the Adult Mental health Quality and Safety meeting for discussion.	Senior Nurse for Physical Health	31 July 2025
3.	Staff conducted twice-daily comprehensive environment and security audits, during which instances of fire risks within patient bedrooms were identified and addressed. However, no additional	The health board must ensure that all identified fire safety risks and the actions taken to address them are fully documented, to support effective governance oversight and prevent recurrence.	Risk management	The ward manager has undertaken a review of fire risk documentation and has identified that there was an isolated incident of poor documentation. This is being addresses by provision of targeted	Ward Manager	Complete

	information was included to fully describe the nature of the risk, the follow-up actions taken, or any escalation procedures			advice. However, all staff have been reminded by the Ward Manager to ensure that fire risks (such as build-up of paper, magazines etc) should be described clearly on the environment check documentation. Environment check documentation has been reworded to ensure risk is described more clearly. This is a service-wide change.	Service Manager for Inpatients Service Manager for Inpatients	Complete Complete
4.	We identified potential blind spots in the communal corridors that hindered effective patient observations. This issue had not been addressed since our previous inspection.	The health board must take action to eliminate blind spots on the ward, to ensure staff, patient and visitor safety.	Risk management	Mirrors will be installed to reduce the risk posed by existing blind spots.	Service Manager for Inpatients and Estates Operational Manager	31 August 2025

5.	Our review of the estates log identified multiple longstanding maintenance requests that remained pending or had been cancelled by the estates department without resolution.	The health board must ensure that the ward's outstanding maintenance issues are promptly and effectively resolved, with a clear process in place to prevent cancellations and duplicate submissions.	Risk management	Estates requests are cancelled in the event that they are duplicate requests or gave been requested with the wrong department. Notes are always attached to all cancellations to advise of the reason for cancellation or further actions required. There are currently 28 outstanding maintenance requests, and all work is planned to be undertaken within the next two months.	Estates Manager	. 31 July 2025
6.	We identified multiple IPC and environmental issues that required attention or posed potential risks to the safety of staff, patients, and visitors.	The health board must: • Promptly and effectively resolve the ward's outstanding IPC issues to ensure the safety	Infection, prevention and control and decontamination	The ADL kitchen has been designed to mirror a domestic kitchen and laundry environment allowing patients to cook and undertake their own	Service Manager and Ward Manager and Housekeeping	30 June 2025

		of staff, patients, and visitors • Review the ward's laundry arrangements to ensure they support effective IPC • Strengthen leadership and governance systems to ensure all ward areas are effectively cleaned, monitored, and that completed audits accurately reflect ward conditions • Enhance existing IPC audit processes and provide clear guidance for nursing and housekeeping staff to ensure full understanding of their IPC responsibilities.		laundry. A protocol for the cleanliness of the ADL kitchen will be developed jointly between the Ward Manager and the IP&C team and the necessary IP&C checks will be facilitated through Tendable. The standard of the daily environmental / security checks will be discussed at the monthly Ward Managers Forum to reinforce the importance of these checks and the assurance that they provide. Intermittent ward Senior and Lead nurse spot check audits will be undertaken using the Tendable System.	Service Manager Service Manager	31 July 2025 31 July 2025

7.	Routine assessments of medication side effects were not recorded in patient records.	The health board should consider adopting the LUNSERS scale to measure the side-effects of antipsychotic medications.	Medicines management	LUNSERS copyright now agreed. LUNSERS score now added to Ward Round template.	Ward Manager	Complete
8.	We were informed that advocacy services were available; however, the records we reviewed indicated limited involvement from these services.	The health board must ensure that: • Patients' entitlement to an advocate is routinely offered, and they are actively supported in making a referral if they choose to accept advocacy services • This process is clearly documented within patient records, to ensure transparency and accessibility.	Mental Health Act monitoring	The Ward Advocate has a physical presence on the ward and actively approaches patients to offer advocacy. Posters and leaflets to promote the offer of advocacy are displayed. Staff will be reminded to document the offer of advocacy regardless of the outcome and this will be monitored.	Ward Manager	30 June 2025 with ongoing monitoring.
9.	We reviewed staff meeting minutes that highlighted delays in the Responsible Clinician (RC) requesting a Second	The health board must consider implementing a process to improve communication between Responsible Clinicians, Second Opinion Appointed	Mental Health Act monitoring	Delays in SOAD availability and any significant delays impacting quality of care and breach of the Act are to be	Mental Health Act Team Manager	Complete with ongoing monitoring

	Opinion Appointed Doctor (SOAD), as well as challenges faced by SOADs in contacting Statutory Consultees.	Doctors and Statutory Consultees, to ensure timely decision-making, prevent unnecessary delays and reduce the reliance on emergency provisions for administering patient medication.		escalated to the Mental Health Mental Capacity Acts Legislation Committee and recorded via DATIX. A Quality Improvement project will be implemented to review and improve the communication between the RC, SOAD and Statutory consultees.	Mental Health Act Team Manager	31st August 2025
10.	Some specialist risk assessments were clinically indicated but had not been completed, including HCR-20 Violence Risk assessments. Given the nature of the patient risks on the ward, we also identified that the implementation of	The health board must ensure that HCR-20 assessments and Positive Behaviour Support plans are completed where clinically indicated, and provide staff with the necessary support, training, and resources to effectively undertake these tasks.	Monitoring the Mental Health (Wales) Measure 2010: care planning and provision	Training has been delivered by Clinical Psychologist to use HCR 20. This training is also being delivered to the community and wider MDT. A rolling improvement and audit programme will follow this to ensure HCR 20 documentation is completed.	Senior Nurse for Forensic Services	Completed with ongoing monitoring

	Positive Behaviour Support (PBS) plans would be beneficial in enhancing patient care and risk management.			PBS plans are not standard practice at present and in order to implement, training is required. PBS training has been requested from HEIW.	Senior Nurse for Quality, Safety, Education and Patient Experience.	31 August 2025
11.	The two staff responses to the questionnaire were generally negative. only one agreed that patient care was the health board's top priority. Neither recommended the hospital as a place to work and both stated they would not be happy with the standard of care provided to their friends or family. Additionally, both were not content with the health board's	The health board must reflect on these aspects of staff feedback about patient care and staff wellbeing and consider what improvements can be made.	Staff feedback	The Clinical Board has a rolling programme of visits to all inpatient and community areas where all staff have the ability to discuss and raise any concerns with the Clinical Board Team. The Patient Safety Leadership Walkround process is currently being reviewed. 209 walkrounds were scheduled in the 12 months up until October 2024 and the revised process will	Director of Operations Executive Director of Nursing	Ongoing 31 July 2025

	efforts to keep staff and patients safe.			seek to increase this number. The walkrounds are an opportunity for colleagues to speak openly to board members about their experiences at work. The Maple Team have managerial supervision every 4-6 weeks with all staff members which is documented. The purpose of supervision is to discuss areas of concern and to provide support. The UHB conducts a wider staff survey which is shared with all staff. Maple Ward will ensure, along with other areas that this is circulated to all staff.	Ward Manager	Complete and Ongoing

				The UHB Speaking up safely sharepoint page encourages colleagues to speak up and raise concerns safely and provides advice on how to do so. The Sharepoint page also provides access to the WorkInConfidence site that allows a confidential and anonymous method of raising a concern.	Corporate Governance	Complete and Ongoing
12.	Some staff expressed concerns about the poor visibility and involvement of senior management and MDT staff members on the ward. Additionally, they reported poor communication between senior management, the MDT and ward staff, with issues or concerns	The health board must consider the feedback regarding senior management and MDT visibility, communication and staff engagement. Necessary improvements should be implemented to foster a more collaborative approach to patient care.	Governance and leadership	The Clinical Board has a rolling programme of visits to all inpatient and community areas where all staff have access to discuss and raise any concerns with the Clinical Board Team. Recent long-term leave reduced the availability of some	Director of Operations Ward Manager	Ongoing Complete and Ongoing

	raised by ward staff not always being acknowledged.			members of the MDT, however, this position is now improved which has increased the availability of the wider MDT. The Ward has a monthly communal meeting chaired by the patients which includes all MDT members and management. A full yearly schedule has been arranged and communicated.		
13.	Improvements were required in some mandatory training, including: • Fire safety – 76% • Information governance - 69% • Consent - 69%	The health board must implement measures to ensure all outstanding mandatory training is completed, regularly monitored, and that staff receive appropriate support to complete the training in a timely manner.	Skilled and enabled workforce	Recent review of training compliance: • Fire Safety – 88% • Information Governance – 77% • Consent – 92%	Ward manager	Ongoing review and monitoring

				A review of mandatory training compliance has been undertaken, and non-compliant staff members have been identified. These staff members will be given dedicated time to undertake their mandatory training.	Ward Manager	30 June 2025
14.	Staff who completed our questionnaire were asked what other training they would find useful and suggested: "Bloods training, Multi-Agency Public Protection Arrangements (MAPPA) and wellbeing."	The health board should reflect on the staff feedback regarding suggestions for additional training and consider whether this can be facilitated.	Skilled and enabled workforce	Specific training requests are considered as part of the annual staff VBA's. MAPPA training forms part of the Clinical Board training needs analysis and awareness sessions are booked for staff members to attend in July 2025. Bloods training is not an essential requirement and is delivered as required	Ward Management Team Ward Management Team Ward Management Team	Ongoing July 2025 Complete

				to specific staff members but cannot be offered to all staff although the VBA process seeks to identify areas of development for all staff equitably. Two staff members are trained in wellbeing and deliver training to ward staff.	 Ward Management Team	 Complete
15.	We were provided with a range of policies and procedures and noted that several were overdue for review.	The health board must ensure policies and procedures are reviewed in a timely manner to provide clear and up-to-date guidance for staff.	Skilled and enabled workforce	Hand Hygiene – Currently under review by the IP&C team Incident hazard and near Miss Reporting procedure- Under review Violence and Aggression (personal Safety) procedure – Under review	IP&C team Head of Patient Safety Health and Safety	Ratification in December 2025 Ratification August 2025 Ratification September 2025

				Incident Control Procedure for needlestick and Similar Sharps Injuries. Under review by IP&C Team	Infection prevention and Control	Ratification December 2025
				Infection Control Procedure for Infectious Incidents and Outbreaks. Under review	Infection prevention and Control	Ratification December 2025
				Procedure for NHS Staff to Raise Concerns. This is an All Wales Procedure and is not in the gift of the UHB to update, however the UHB Speaking up safely staff guide supports staff to raise concerns.		
				Observation and Enhanced Engagement		

				Procedure is under review Equality Inclusion and Human Rights. This was ratified and published in February 2025, however the outdated policy remains online. The UHB website will be updated to ensure the correct document is accessible. Personal Protective Equipment Procedure. Under review.	Mental Health Clinical Board Peoples Services / Corporate Governance Health and Safety	Ratification 30 December 2025 30June 2025 Ratification September 2025
16.	Our staff engagement identified a limited understanding of the Duty of Candour (DoC) requirements, and we were told that staff had not received any DoC training to	The health board must implement Duty of Candour training to support staff in their roles.	Skilled and enabled workforce	Cardiff and Vale UHB has a Duty of Candour SharePoint page with information available to all staff members. Duty of Candour E-Learning is also available to all staff	Ward Management Team	Immediate and ongoing

	support them in their roles.			on ESR. This will be promoted by the ward manager. The Clinical Board oversee all patient safety incidents that are reported as causing moderate harm and meet the Duty of Candour with dedicated roles contacting patients and ensuring the process is followed.		

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): **Dan Crossland**

Job role: **Director of Operations, Mental Health Clinical Board**

Date: **6/6/25**