Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Independent Mental Health Service Inspection Report (Unannounced)

## Ward y Ddol, Ty Glyn Ebwy Hospital,

Inspection date: 9, 10 and 11 July 2025
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# Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

## Our purpose

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

## Our values

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

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

## Our goal

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

## Our priorities

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

# Contents

# 1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at Tŷ Glyn Ebwy Hospital, on 9, 10 and 11 June 2025.

The following hospital ward was reviewed during this inspection:

- Ward y Ddol - 15 beds providing services for women aged 18 and over who have a primary diagnosis of an eating disorder.

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 reviewers.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. Only one questionnaire was completed by a patient. We also invited staff to complete a questionnaire to tell us their views on working for the service, only two questionnaires were completed by staff. However, we spoke to staff, patients and carers during our inspection and some of their comments are highlighted 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:
Most patients we spoke with said they felt safe and were able to speak with staff when needed, that they were happy at the hospital, and that staff were kind and helpful. Other data received through hospital internal feedback was also generally positive.

There was a range of activities in place providing therapies to patients, to support and stimulate them as part of their recovery. It was positive to see staff supporting patients to engage in activities, such as arts and crafts, board games and mindfulness activities.

Patients had their own bedrooms, which provided them with privacy, and assisted staff in maintaining the dignity of patients. However, some patients shared concerns about occasions when staff have opened observation blinds without knocking or giving prior notice. This has caused concern, particularly when patients may be in the process of changing clothes.
Overall, we found that patients were provided with timely care, and their needs were promptly assessed upon admission. Staff provided care and assisted patients when required. Staff were knowledgeable of each patient and strove to provide individualised care. We observed kindness, warmth and respect between staff and patients.

Most patients spoke highly of staff and told us that they were treated well and felt safe. During the inspection we noted that when patients approached staff, they were met with polite, caring and responsive attitudes. Throughout the inspection the team observed a very calm, inclusive and professional environment at the hospital.

There is ongoing confusion about the availability of lockable, secure storage in patient bedrooms. While staff confirmed that such storage is provided, patients reported being unaware of it.

This is what we recommend the service can improve:

- Consider the privacy and dignity of patients when using the observation blinds for patient bedrooms
- Ensure that patients are fully informed about the secure storage options available to them and understand how to access and use these facilities.

This is what the service did well:

- Good team working and motivated staff
- Patients spoke highly of staff and told us that they were treated well.

## Delivery of Safe and Effective Care

Overall summary:
The hospital had appropriate systems and governance arrangements in place, supporting the delivery of safe and effective care for patients. A range of up-to-date health and safety policies were in place, and various risk assessments had been completed, including ligature point and fire risk assessments. Clinical audits were being conducted and monitored by clinical leads, reflecting a commitment to continuous improvement.

There was clear evidence that care plans were regularly reviewed and updated by staff to reflect patients' current needs. Risk assessments were actively maintained, and there was a strong focus on planning for long-term placements and discharge. Notably, the psychology team had developed a "Moving On" workbook, which was identified as an area of noteworthy practice. This resource supported patient's progress toward discharge by helping them prepare for the transition and promoting independence.

Safeguarding procedures for vulnerable adults and children were robust, with appropriate referrals made to external agencies when necessary. Ward staff had access to safeguarding protocols, which were aligned with the Wales Safeguarding procedures, ensuring consistency and clarity in practice.

The hospital environment was generally clean, tidy and welcoming. However, we noted a shortage of seating in the dining and lounge areas, which could impact patient and staff comfort and accessibility, particularly during busy periods. While most cleaning equipment was stored safely and waste disposal arrangements were appropriate, we had concerns about the inconsistent securing of COSHH (Control of Substances Hazardous to Health) substances in an area accessible to patients.

We observed medication rounds and noted they were conducted professionally, with staff interacting respectfully and considerately with patients. Improvements in meal provision were also evident, including more suitable portion sizes, better food preparation and presentation, and increased staff engagement with patients during mealtimes. Staff reported that recent training had enhanced their confidence in supporting the patient group effectively.

This is what we recommend the service can improve:

- Some hazardous substances and equipment were not consistently secured
- Insufficient seating in dining and lounge areas affected comfort during busy times.

This is what the service did well:

- Strong systems were in place, including up-to-date health and safety policies, regular clinical audits, and active risk assessments
- Care plans were regularly reviewed and updated, with active discharge planning supported by the psychology team's “Moving On” workbook highlighted as noteworthy practice
- Improvements in meal provision and staff training.

## Quality of Management and Leadership

Overall summary:
We found a positive culture at the hospital, with staff expressing confidence in raising concerns and accessing additional training. Staff described leadership as dedicated and supportive, with clear governance structures and strong teamwork observed across the service.

Complaints and incidents were managed effectively through a structured policy, with independent investigations and lessons shared promptly to support patient safety and continuous improvement. Recruitment processes were robust, including appropriate checks and structured inductions. Most policies were up to date; however, the restrictive intervention and restraint policies lacked specific guidance for eating disorder services.

Training compliance was high at 95.2%, with additional clinical training available. Staff supervision and appraisals were in place, and staffing levels were sufficient, with minimal reliance on agency staff. Staff also reported feeling supported and confident in the hospital whistleblowing procedures.

Morning meetings were well-structured; however, we noted there was insufficient staff meetings and low attendance at these.

This is what we recommend the service can improve:

- The restrictive intervention and restraint policies must be updated to specifically address the needs of patients with eating disorders
- Regular staff meetings must be established and attendance improved.

This is what the service did well:

- Good compliance with staff supervision and appraisals regularly taking place

- Strong leadership and a positive, supportive team culture were evident throughout the hospital.

# 3. What we found

# Quality of Patient Experience

**Patient feedback**
We considered the hospitals internal patient feedback, any complaints, and patient discussion data, to help us gain an understanding of the overall patient experience. Feedback was positive. Most patients we spoke with said they felt safe and were able to speak with staff when needed, that they were happy at the hospital, and that staff were kind and helpful.

**Health promotion, protection and improvement**
Throughout the inspection, patients were observed to be actively engaging in a wide range of therapeutic and recreational activities designed to support patient well-being and recovery. These included arts and crafts, gardening, cooking, mindfulness and guided meditation, as well as access to a zen room for relaxation. Additional activities such as games, expressive arts, textile workshops were also available.

Patients also told us that weekend wellness activity meetings take place to discuss activities that will be taking place on the weekend. Patients also have access to an enclosed garden with a sheltered seating area.

Services were also provided by other professionals, such as physiotherapy, dietetics, in line with individual patient needs. Patients can also access a GP service, dental service and other physical health professionals where required. Our review of patient records confirmed that appropriate physical health assessments and ongoing monitoring are being carried out.

Several health promotion leaflets and details of support organisations were available in the hospital for patients.

Overall, the hospital environment was well-maintained, and presented as clean, tidy, and welcoming.

**Dignity and respect**
We found that staff at all levels engaged with patients appropriately and treated them with dignity and respect.

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

and address any needs or concerns they had. This suggested that staff had responsive and caring attitudes towards patients.

All patient rooms were ensuite. Communal bathrooms were also available, and we saw staff respecting the privacy of patients by knocking on bedroom and bathroom doors before entering.

All patient rooms have observation panels that can be open or closed from the outside, to enable staff to monitor a person when necessary. Patients can lock their bedroom doors; however, staff could override this when necessary.

Some patients shared concerns about occasions when staff have opened observation blinds without knocking or giving prior notice. This has caused concern, particularly when patients may be in the process of changing clothes.

**The registered provider must ensure that staff consider the privacy and dignity of patients when using the observation blinds for patient bedrooms.**

There were nurse call points around the hospital, and within patient bedrooms and bathrooms so that patients could call for help if needed.

Patients were able to personalise their rooms and store their own possessions. Personal items are risk assessed on an individualised basis, to help maintain the safety of each patient. This included the use of personal mobile phones and other electronic devices. A telephone was also available for patients to use to contact friends or family if needed, and there were electronic devices available on the units for patients to use.

There remains ongoing confusion following the previous inspection regarding patient access to lockable, secure storage in their bedrooms. Patients we spoke with reported that such storage was not available. However, discussions with staff confirmed that secure storage is provided. The issue appears to stem from a lack of patient awareness and understanding about how to use the lockable storage and how to access the keys. It is essential that this information is communicated clearly and consistently to all patients to ensure they can use the storage safely and effectively.

**The registered provider must ensure that patients are fully informed about the secure storage options available to them and understand how to access and use these facilities.**

Staff were allocated personal alarms and radios, and alarms are allocated to visitors when required. We were told that the radio system worked well in the environment and no concerns had been raised by staff around alarms and radios.

There was also a well-equipped laundry room in place for use by patients, under supervision.

Patients appeared familiar with staff members, and a pictorial information board displaying staff photographs and roles was positioned outside the ward.

**Patient information and consent**
Patient boards displayed in the hospital contained relevant information to help patients and their families understand their care. This included information such as the weekly activity timetable and advocacy services.

Registration certificates from HIW and information on how to raise a complaint were on display in the reception. This information can also be accessed in Welsh.

**Communicating effectively**
All patients we spoke with said they felt safe and were able to speak with staff when needed. They also said they were happy at the hospital, and that staff were kind and helpful. There was a clear mutual respect and strong relational security between staff, patients and family/carers.

Throughout the inspection, we observed staff engaging and communicating in a positive and sensitive way with patients, taking time to help them understand their care, and using appropriate language or communication styles.

We were told that some bilingual (Welsh and English) staff are available, this allowed staff to provide the active offer of speaking to patients in Welsh. We were told that translation services can also be accessed should patients need to communicate in other languages other than English or Welsh.

Where applicable, patients can receive support from external bodies, such as solicitors or patient advocacy services during patient specific meetings. With patient agreement, and wherever possible, their families or carers were included in these meetings.

Patient notice boards displayed relevant information to help patients and their families understand their care. This included information, such as the weekly activity timetable and advocacy services.

**Care planning and provision**
Patients had their own individual weekly activity planner including individual and group sessions based within the hospital and the community (when the required authorisation was in place). During the inspection we observed staff and patients engaging in activities in the hospital and in the community.

We observed staff respecting patient privacy, for example, by understanding when patients preferred their own space and facilitating this whilst maintaining appropriate levels of observation.

Patients were fully involved in monthly multidisciplinary reviews. We saw evidence that care plans were person centred with support provided in a structured way to enable patients to achieve individual goals. Care plans were very detailed and personalised, this helped support the hospital in being able to deliver comprehensive care to the patients.

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

**Equality, diversity and human rights**
We found good arrangements in place to promote and protect patient rights. Legal documentation relating to detained patients under the Mental Health Act was compliant with the legislation.

All patients have access to advocacy services, and we were told that advocates visit the hospital when required. Staff told us that patients are invited to be part of their multidisciplinary team (MDT) meeting and that the involvement of family members or advocates was encouraged where possible.

During our discussions with staff, they demonstrated suitable regard for upholding patient rights and individual patient preferences. The Care and Treatment Plans (CTPs) we reviewed evidenced that the social, cultural, and spiritual needs of patients had been considered. We saw that the hospital had an appropriate Equality, Diversity, and Inclusion policy available to help ensure that patients' equality and diversity were respected.

**Citizen engagement and feedback**
A patient suggestion box is in the lounge area to facilitate ongoing feedback. Fortnightly community meetings are held with patients, and minutes are recorded to ensure transparency and accountability. A designated patient representative is

invited to participate in governance meetings, providing an opportunity to share relevant feedback directly with staff. Additionally, two structured surveys are conducted annually, one with patients and one with families and carers. This helps the hospital to gather comprehensive insights and inform service improvements.

There was a complaints policy and procedure in place. The policy provided a structure for dealing with all complaints within the hospital. It was evident that an independent person is assigned to investigate complaints and actions were taken in line with the registered provider's complaints policy to ensure that complaints are dealt with appropriately. We reviewed a sample of formal and informal complaints and confirmed that they had been actioned in line with the organisational complaints policy.

# Delivery of Safe and Effective Care

## Safe Care

**Environment**
Visitors were required to enter the hospital through a designated reception area, where they were asked to register upon arrival. The hospital is arranged over two floors, with level access provided to the main entrance and ground floor. A lift is available to facilitate access to the first floor. These access arrangements support safe and convenient entry to the ward for all patients and visitors, including those with mobility challenges.

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

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

The hospital had a business continuity plan in place to follow in the event of a major incident occurring at the hospital. These included events such as fire, loss of water and electricity supply and severe weather conditions. Fire safety policies were all up to date and fire risk assessments had all been completed. Audits were recorded electronically, and all were up to date and complete at the time of the inspection.

The hospital environment was generally well-maintained, presenting as clean, tidy, and welcoming. However, there was insufficient seating available in both the dining area and the lounge, which limited comfort and accessibility for patients and staff. This shortfall may impact the overall patient experience, particularly during peak times.

The registered provider should review the current seating capacity in communal areas and consider increasing the number of chairs and tables in both the dining and lounge areas to better accommodate patient and staff needs.

**Managing risk and health and safety**
There was an electronic system in place for recording, reviewing, and monitoring patient safety incidents. A sample of incident forms reviewed on the inspection demonstrated that staff completed detailed forms.

Staff confirmed that debriefs take place following incidents. The meetings we attended, and the evidence obtained during the inspection indicated that incidents

and the use of physical restraint interventions were monitored and supervised robustly. The data we reviewed evidenced that the use of physical restraint at the hospital is rare. When restraints were applied, it was usually part of a pre-planned approach for nasogastric feeding, with all instances being documented in patient records.

These were informed by risk assessments which included age, frailty, health issues, trauma history and religious and cultural needs.

Staff confirmed that debriefs take place after any physical intervention incident and both patients and staff engage and consider their psychological and physical health and wellbeing. Our review of a sample of patient records also confirmed this.

The current Restrictive Intervention Policy only referred to a general local policy and was not specifically tailored and bespoke to the patient group. Having a focused policy would help staff respond more consistently and confidently in situations that are unique to this patient group. This was also a finding in our previous inspection and remains an important area for improvement, as it ensures that staff have clear, relevant guidance to follow, which helps them respond safely, consistently and confidently in challenging situations. A bespoke policy also supports best practice, reduces the risk of inappropriate interventions, and promotes the wellbeing and dignity of patients.

The registered provider must ensure that a restrictive intervention policy is created and specifically designed for the needs of the patient group.

A range of up-to-date health and safety policies were in place.

**Infection prevention and control (IPC) and decontamination**
We found suitable Infection Prevention and Control (IPC) arrangements in place which were supported by a range of up-to-date policies to maintain patient and staff safety. Regular hospital audits had been completed to review the cleanliness of the environment and check compliance with hospital procedures. All were appropriate and compliance was checked by senior ward staff. Staff compliance with mandatory IPC training was currently at 97.40%.

We saw evidence to confirm that staff had conducted the necessary risk assessments and relevant policies and procedures were updated accordingly. Staff also explained their responsibilities in line with infection prevention and control.

We found that staff had access to and were appropriately using Personal Protective Equipment (PPE). Staff told us that PPE was always readily available, and we saw that sufficient hand washing and drying, and sanitisation facilities were available.

Most cleaning equipment was stored safely and organised appropriately and there were suitable arrangements in place for the disposal of domestic and clinical waste. However, it was identified that COSHH (Control of Substances Hazardous to Health) equipment and substances were not consistently secured in an area accessible to patients. This presents a potential safety risk, as patients should not have access to hazardous materials. This was immediately resolved during the inspection. See appendix A for details.

**Nutrition**
During the previous inspection, patients raised concerns about meal provision, specifically regarding portion sizes and the way food was prepared and served. Additionally, it was noted that staff engagement with patients before and after meals was limited, and both staff and patients highlighted the need for more specialist training in eating disorders.

During this inspection, we observed notable improvements in meal provision, including more appropriate portion sizes, better food preparation and presentation, and increased staff engagement with patients around mealtimes. Staff also told us they felt the training they had received helped them feel more confident in supporting patient group.

The dining areas were observed to be clean, tidy, and provided a suitable environment for patients to enjoy their meals. However, as previously noted in this report, there is a need for additional tables and chairs to ensure all patients can be comfortably accommodated during mealtimes.

**Medicines management**
We found suitable arrangements in place for the management of medicines including safe and secure storage. We also saw evidence of regular temperature checks of medication fridges to maintain safe storage.

Staff made sure that patients had personalised medication management plans, involving patients in the planning and discussions.

We observed several medication rounds, and saw staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately.

We reviewed a sample of five Medication Administration Records (MAR Charts) and confirmed they were fully completed by staff. This included the completion of all

patient details on the front and subsequent pages and their Mental Health Act legal status.

**Safeguarding children and safeguarding vulnerable adults**
Appropriate processes were in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

Hospital staff had access to the health board safeguarding processes, which were supported by the Wales Safeguarding procedures, accessible via the intranet. Senior ward staff confirmed they were confident that staff were aware of the correct procedure to follow should they have a safeguarding concern. During discussions with staff, they were able to show knowledge of the process of making a safeguarding referral.

The hospital employed a dedicated social worker who maintained positive relationships with multi-agency partners and collaborated with the staffing team to enhance awareness and understanding of safeguarding issues.

**Medical devices, equipment and diagnostic systems**
We confirmed there were regular clinical audits undertaken at the hospital. We also saw evidence of regular checking of resuscitation equipment. Staff had documented when this had occurred to ensure that the equipment was ready for use and in date.

From our discussions with staff, it was evident that they were aware of the locations of ligature cutters in case of an emergency.

Storage of oxygen complied with regulations and guidance; risk assessments are completed for the clinical areas including the storage of oxygen.

**Safe and clinically effective care**
Overall, we found appropriate governance arrangements in place which helped ensure that staff provided safe and clinically effective care for patients.

Staff confirmed that debriefs take place following incidents. Meetings we attended and evidence obtained during the inspection demonstrated that incidents, safeguarding referrals, and use of physical interventions are monitored and reviewed.

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation.

**Participating in quality improvement activities**
The hospital continues to make meaningful progress in enhancing the quality of care provided. As part of this, the deputy hospital director is actively engaging with other eating disorder services to identify best practices and explore opportunities for local improvement.

There is a clear commitment to staff development, with ongoing investment in training to deepen understanding of eating disorders. Refresher sessions are being planned to support staff in managing challenging behaviours in a compassionate and effective way. Additional training focused on meal support is also being introduced to build staff confidence and ensure consistency during mealtimes.

To strengthen communication, the hospital director has introduced open forums, giving staff a regular opportunity to engage directly with the leadership team and raise questions or concerns.

Support for families is also a priority, with a monthly carers' group now in place. This is facilitated by the family therapist and social worker and provides a valuable space for carers to receive guidance and connect with others.

Overall, the hospital team demonstrates a forward-thinking and proactive approach. Their strong focus on training and continuous learning is clearly translating into improved practice and better outcomes for patients.

**Information management and communications technology**
The computerised patient record systems were well developed and provided high quality information on individual patient care. The system was comprehensive, and easy to navigate.

There were good electronic systems in place for incident recording, clinical and governance audits, human resources, and other hospital systems, which assisted the management and running of the hospital. Staff indicated that the electronic system was working well.

**Records management**
Patient records were kept electronically. The electronic system was password protected to prevent unauthorised access and any breaches in confidentiality.

Overall, we found robust systems in place to ensure that personal information relating to patients and staff were kept securely. There was a formal information governance framework in place and staff were aware of their responsibilities in respect of accurate record keeping and maintenance of confidentiality.

**Mental Health Act monitoring**
We reviewed the statutory detention documents of four patients and found them to be fully compliant with the Mental Health Act (MHA) and the Code of Practice for Wales (1983, revised 2016).

Electronic and paper records were securely stored, well-organised, and easy to navigate. The documentation was detailed, relevant, and demonstrated a high standard of record-keeping.

We noted that Section 17 leave forms currently do not include a space for patient signatures. While not a legal requirement, incorporating this feature would support best practice by promoting patient involvement and reinforcing a collaborative approach to care planning.

**The registered provider should consider incorporating a space for patients to sign on section 17 leave forms.**

All statutory documents reviewed confirmed that patients were legally detained. The medical scrutiny process was thorough, with evidence of comprehensive evaluation and oversight.

The admission letter issued by the MHA Administrator conveyed a warm and welcoming tone and included detailed, helpful information that supports patients and their families during the admission process.

Overall, the MHA Administrator operates an efficient and effective system that supports the implementation, monitoring, and review of the legal requirements of the Mental Health Act.

**Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision**
We reviewed the Care and Treatment Plans (CTPs) of five patients. The records evidenced a fully completed and current overall physical health assessment and standardised monitoring documentation, such as NEWS and MUST. In addition, there were standardised assessments based on the individual patient needs.

It was positive to see that the clinical records clearly showed patient and family involvement in care discussions, which were patient focussed.

There was evidence that care plans are reviewed regularly by staff and updated to reflect current needs and risks. Physical health monitoring is consistently recorded

in patient records. Risk management plans were good with detailed risk assessments and risk management strategy plans. Physical health monitoring is consistently recorded in patient records. Full physical checks take place on a frequent basis. It was positive to see to see that food and fluid charts are reviewed daily by the dietitian, demonstrating a high standard of nutritional oversight.

In addition, there was evidence of active planning and discharge planning for long term placements. The Moving On workbook developed by the psychology team was a valuable resource that looked to supported progress of patients on discharge and identified as an area of noteworthy practice.

# Quality of Management and Leadership

**Staff Feedback**
We invited staff to complete HIW questionnaires following the inspection to obtain their views on the service provided at the hospital. In total, we received two response from staff at the setting. We also spoke to staff during the inspection.

Staff told us that the culture at the hospital was positive, and that they would feel confident in raising a concern and knew the process of how to do so.

Staff informed us that they had opportunities for additional training to enhance their skills.

**Governance and accountability framework**
There was a clear organisational structure in place which provided clear lines of management and accountability. They defined these arrangements during the day, with senior management and on-call systems in place for the night shift.

It was positive to see that senior staff attended when notified of the inspection team's arrival and were on hand to provide additional support.

There was clear, dedicated and passionate leadership from hospital staff, who are supported by committed multidisciplinary teams and the hospital manager. Staff were able to describe their roles and appeared knowledgeable about the care needs of most patients they were responsible for.

During our time at the hospital, we observed a positive culture with good relationships between staff who we observed working well together as a team. Most staff spoke positively about the leadership at the hospital. Most staff also spoke favourably about the support from colleagues working within the hospital and reported a good team-working ethos at the hospital.

Arrangements were in place to quickly share information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helped to maintain patient safety and continuous improvement of the service provided.

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

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

Arrangements were in place to quickly share information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helps to promote patient safety and continuous improvement of the service provided.

**Workforce recruitment and employment practices**
Staff we interviewed spoke passionately about their roles, and throughout the inspection we observed a strong and cohesive team working together.

Staff were able to access and produce most documentation we requested in a prompt and timely manner, therefore demonstrating good governance processes.

There were appropriate systems in place to ensure that recruitment followed an open and fair process. Prior to employment, staff references are sought, Disclosure and Barring Service (DBS) checks are undertaken, and professional qualifications are checked.

Newly appointed staff undertook a period of induction under the supervision of the experienced ward staff. Staff also showed us evidence of this and described the induction process to us.

We were provided with a range of policies, the majority of which were in in date; however, as previously highlighted the hospital should have a restrictive intervention policy in place specific to eating disorders.

**Workforce planning, training and organisational development**
The inspection team considered staff training compliance and provided with a list of staff mandatory training compliance. Training figures provided to us on the inspection indicated that overall compliance figures were 95.2%. In addition to mandatory training some staff had been trained in nasogastric tube feeding and phlebotomy training.

We saw evidence of staff annual appraisals and supervision in staff files and staff told us that supervision takes place on a regular basis.

Staffing levels were appropriate to maintain patient safety within the wards at the time of our inspection. We were told that agency staff are rarely used, and any

staff shortfalls are covered by hospital staff. Processes were also in place to ensure that staff were not working excessive hours via overtime.

Staff also told us that they would feel secure raising concerns about patient care or other issues at the hospital and felt confident that the hospital manager would address their concerns. A whistleblowing policy was in place to provide guidance on how staff can raise concerns.

Morning meetings were well-structured and consistently addressed key areas such as patient safety, incidents, safeguarding, and care planning. However, the absence of regular staff meetings and the low attendance at existing ones requires improvement. Regular staff meetings are vital for maintaining open communication, sharing important updates, and fostering a cohesive team environment.

**The registered provider must ensure that regular staff meetings take place and take steps to encourage consistent attendance.**

# 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 |
|---|---|---|---|
| It was identified that COSHH (Control of Substances Hazardous to Health) equipment and substances were not consistently secured in an area accessible to patients. | This presents a potential safety risk, as patients should not have access to hazardous materials | Escalated to ward manager and deputy hospital manager | Items immediately removed and area locked. |
| | | | |

# Appendix B - Immediate improvement plan

## Service: Hospital

## Date of inspection: 9 - 11 June 2025

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

| | Risk/finding/issue | Improvement needed | Standard / Regulation | Service action | Responsible officer | Timescale |
|---|---|---|---|---|---|---|
| 1. | No Immediate non compliance issues | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |

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: Ty Glyn Ebwy Hospital

## Date of inspection: 9 - 11 June 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. | Some patients shared concerns about occasions when staff have opened observation blinds without knocking or giving prior notice. | The registered provider must ensure that staff consider the privacy and dignity of patients when using the observation blinds for patient bedrooms. | Dignified Care | Communication has been sent to the ward-based teams through email and face to face engagement such as supervisions and team meetings. | Laura Jakilaitis, Deputy Hospital director. | 29/08/2025 |
| 2. | There remains ongoing confusion following the previous inspection regarding patients' access to lockable, secure storage in their bedrooms | The registered provider must ensure that patients are fully informed about the secure storage options available to them and understand how to access and use these facilities. | Dignified Care | The system will be made clear and communicated in the patient community meeting. The arrangements for secure storage will | Dean Harries. Hospital Director | 29/08/2025 |

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|---|---|---|---|---|---|---|
| | | | | also be added to the patient guide. | | |
| **3.** | There is insufficient seating available in both the dining area and the lounge, which limits comfort and accessibility for patients and staff. | The registered provider must ensure that there is sufficient seating in the lounge area for patients and staff. | Dignified Care | Seating has been ordered for the lounge and the service is awaiting delivery. | Dean Harries. Hospital Director | 26/09/2025 |
| **4.** | The current Restrictive Intervention Policy only referred to a general local policy, but there doesn't appear to be anything specifically tailored and bespoke to the patient group | The registered provider must ensure that a restrictive intervention policy is created and specifically designed for the needs of the patient group. | Managing risk and promoting health and safety | This has been escalated through the Elysium RRI group. Feedback from the HIW has been passed to this team in order to develop appropriate policies. | Dean Harries. Hospital Director | 28/11/2025 |
| **5.** | Section 17 leave forms currently do not include a space for patient signatures. | The registered provider should consider incorporating a space for patients to sign on section 17 leave forms. | Mental Health Act monitoring | This has been presented to Elysium Regional governance to consider the amendment of the form for patient signatures. | Dean Harries. Hospital Director | 26/09/2025 |

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|---|---|---|---|---|---|---|
| **6.** | Absence of regular staff meetings and the low attendance at existing ones. | The registered provider must ensure that regular staff meetings take place and take steps to encourage consistent attendance. | Workforce recruitment and employment practices | The service has added attendance and engagement as a focus topic under its governance process to explore ways of increased engagement in team meetings.<br><br>The dates of the meetings have been set for the rolling year and advertised across the service. | Laura Jakilaitis, Deputy Hospital director. | 31/10/2025 |
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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): Dean Harries**

**Job role: Hospital Director**

**Date: 28/07/2025**