Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Coed Du Hall Hospital

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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 Coed Du Hall Hospital, on June 30 and July 1, 2 2025.

The following hospital wards were reviewed during this inspection:

- Ash – a seven bedded female ward, which was providing care for five patients
- Beech – a five bedded male ward, which was providing care for four patients
- Cedar – a mixed gender six bedded ward, which was providing care for six patients
- Studio Suites – four mixed gender suites, which were providing care for two patients.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of five questionnaires were completed by patients or their carers and none were completed by staff. However, we spoke to staff 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:
The hospital provides a range of therapeutic activities, with personalised activity planners in place. While there are no on-site fitness facilities, patients can access community-based options with appropriate leave. Staff were consistently observed treating patients with dignity and respect, engaging positively and responding to individual needs. Patients reported feeling safe and supported.

Accommodation varied, with studio suites offering ensuite bathrooms, while ward-based rooms shared communal facilities. Plans are in place to upgrade all rooms to ensuite by 2027. Patients could personalise their rooms, and personal items were risk-assessed individually.

Care planning was person-centred, with patients actively involved in multidisciplinary team (MDT) reviews. Daily risk handover meetings ensured continuity and safety. Equality and diversity were well supported, with accessible facilities and translation services available.

However, there were areas for improvement. Information on healthy lifestyles and the role of Healthcare Inspectorate Wales (HIW) was limited. Staff were not easily identifiable due to the absence of uniforms and visible ID badges. The provider must address these issues to enhance communication and safety.

Overall, the hospital demonstrated a strong commitment to patient care, rights, and engagement.

This is what we recommend the service can improve:

- Improve visible information on healthy eating, hydration, and smoking cessation.
- Improve staff visibility by ensuring all staff wear clearly visible ID badges, or uniforms.

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 has robust systems in place to support safety and governance, including up-to-date fire safety policies, environmental risk assessments, and a business continuity plan. Regular audits and incident reviews, along with daily risk meetings were in place.

However, several environmental issues remain unresolved, including poor cleanliness and organisation in the laundry room, and damaged furniture. Staff shortages of personal safety alarms were noted, with some staff not using them during enhanced observations. Additionally, there is a lack of clear clinical leadership for infection control, with responsibilities falling to housekeeping staff. While medication systems were generally good, we identified missing staff signatures on MAR charts and incomplete temperature logs.

Care plans were detailed and collaborative, and Mental Health Act documentation was fully compliant. However, the dual use of paper and electronic records led to inconsistencies, and care planning templates varied and a standardised approach to documentation is needed.

Communication strategies for non-verbal patients require improvement. Despite these issues, physical health monitoring, discharge planning, and medication management systems were generally effective.

This is what we recommend the service can improve:

- Environmental improvements are needed, including better cleanliness, maintenance, and organisation in key areas such as the laundry room and communal spaces
- Availability and inconsistent use of personal safety alarms by staff, particularly during enhanced observations.
- Ensure consistent and up-to-date record-keeping by providing clear guidance on using paper and electronic systems and regularly auditing both formats.

This is what the service did well:

- Effective care planning and compliance with the requirements of the Mental Health Act
- Physical health monitoring and care planning.

Quality of Management and Leadership

Overall summary:
The hospital had a clear organisational structure with defined lines of accountability. Senior and clinical nurses managed day-to-day ward operations, supported by the multidisciplinary team (MDT). Although a permanent hospital manager was not in post at the time of inspection, an interim manager and newly appointed senior nurse provided leadership. Recruitment of a permanent registered manager is recommended to ensure consistent oversight and leadership.

Staff demonstrated a positive team culture and spoke highly of leadership. Systems were in place to share learning from incidents and complaints, supporting continuous improvement. Incident reporting was well-established, with regular reviews at both local and corporate levels.

Recruitment processes were robust, with appropriate checks in place. Staff induction was structured, and most staff felt supported in their roles. However, night shift arrangements raised concerns, with only one registered nurse on duty, limiting break opportunities. A designated staff break area was also lacking.

Overall mandatory training compliance figures were good, though staff appraisal completion was low. Plans were in place to address this. Staffing levels were generally safe, and staff felt confident raising concerns.

This is what we recommend the service can improve:

- Recruitment of a permanent registered manager should be prioritised to ensure consistent leadership
- Low completion rates of staff appraisals.

This is what the service did well:

- Good system for recording and reviewing incidents and complaints
- Mandatory training compliance figures were good.

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 mainly 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.

Patient comments included:

> *"Support here is great"*
>
> *"I wish I had this help a long time ago. This is the best thing that's happened to me"*
>
> *"The wrong people getting in here bringing people from high secure down here"*

Health promotion, protection and improvement
Coed Du Hall had a range of facilities to support the provision of therapies and activities for patients. While a list of activities was displayed, there were no on-site fitness facilities available. Patients could, however, access community-based facilities, provided they had the appropriate leave in place. It was positive to see individualised personal activity planners in patient records.

A single sheet about food was displayed on the notice board, but it didn't provide enough information. In addition, there was no visible information promoting healthy eating, hydration, or smoking cessation.

Services such as physiotherapy and dietetics were available based on individual patient needs. Patients also had access to GP services, dental care, and other physical health professionals as required.

Our review of patient records confirmed that appropriate physical health assessments and ongoing monitoring were being conducted in line with best practice.

Dignity and respect
We found that all staff, including ward staff, senior managers, and admin staff, treated patients with dignity and respect.

The staff we spoke to were positive about their roles and committed to supporting patients. We observed many staff taking time to talk with patients and respond to their needs or concerns. This showed that staff were caring and responsive in their approach.

During the inspection, we saw staff respecting patients' privacy by knocking before entering their rooms. Patients were not able to lock their rooms, but each was given an electronic wristband that allowed them to access their own room and shared patient areas as appropriate.

The studio suites and Cedar Ward had ensuite bathrooms. However, patients on Ash and Beech, shared communal bathrooms, as these rooms were not ensuite. The registered provider has a long-term plan to renovate these bedrooms, aiming to make them all ensuite by 2027.

Cedar Ward provided mixed gender care which can present challenges around aspects of dignified care. However, staff were knowledgeable and had effective safeguards and processes in place to manage these challenges to ensure that dignified care was maintained.

There were no observation panels on patient bedroom doors in the setting. However, registered provider had carried out a survey with patients, who expressed a preference for the doors to remain as they are. As a result, no changes were made based on the patient preferences.

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.

Patient information and consent
There were patient notice boards, containing information on ‘you said, and we did’.

Patients told us they were informed and aware of their rights and care processes. They also said their solicitors and legal teams helped them understand these matters. However, there was limited information available about the role of Healthcare Inspectorate Wales (HIW) within the setting.

Staff reported that various advocacy services regularly visit the hospital to meet with patients and support them, including by arranging meetings.

During the inspection, we noted there were no pictorial information boards to help patients or visitors identify hospital staff. Staff were not easily identifiable due to the absence of uniforms and visible ID badges. This could make it difficult for patients and visitors to know who is responsible for care or to seek help quickly in urgent situations.

While there is no specific Welsh Government policy mandating uniforms, NHS Wales and HIW emphasise the importance of clear staff identification to support patient safety and effective communication.

The registered provider must display accessible information on the role of HIW.

The registered provider should consider introducing pictorial staff boards and must ensure that staff wear visible ID badges to help patients and visitors easily recognise staff roles and responsibilities.

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 at the hospital, allowing staff to provide the active offer of speaking to patients in Welsh. At the time of the inspection there were patients that spoke 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 patients' agreement, and wherever possible, their families or carers were included in these meetings.

Care planning and provision

Patients had personalised activity planners that included both individual and group sessions, delivered within the hospital and, where authorised, in the community.

During the inspection, we observed staff and patients actively participating in some activities.

We also observed staff respecting patients' privacy and personal space. Staff demonstrated an understanding of when patients preferred time alone and supported this appropriately, while still maintaining necessary levels of observation to ensure safety.

Patients have the opportunity to be involved in their monthly multidisciplinary team (MDT) reviews. Care plans were detailed, person-centred, and structured to support patients in achieving their individual goals. This approach enabled the hospital to deliver comprehensive and tailored care.

A daily risk handover meeting took place each weekday morning, where nursing staff updated the MDT on any incidents, concerns, or developments from the previous day. We attended one of these meetings and found that staff had a strong understanding of the patients in their care. Discussions were focused on individual needs and aimed at ensuring the best outcomes for each patient.

Equality, diversity and human rights

We found effective arrangements in place to promote and protect patient rights. Legal documentation for patients detained under the Mental Health Act was compliant with the legislation. Reasonable adjustments were made to ensure equal access to services for all. The hospital was fully accessible, with ground-level access, wide corridors, and doorways suitable for wheelchair users. Specialist equipment was also available when needed.

Patients were encouraged to take part in their multidisciplinary team (MDT) meetings, and the involvement of family members or advocates was supported where appropriate.

Staff demonstrated a strong commitment to upholding patient rights and respecting individual preferences. The Care and Treatment Plans (CTPs) we reviewed showed that patients' social, cultural, and spiritual needs were considered. An Equality, Diversity, and Inclusion policy was in place to help ensure that all patients were treated with dignity and respect.

Citizen engagement and feedback

The hospital had systems in place to gather patient feedback, including regular meetings, surveys, and a suggestion box for patients and family carers. Information was also available to guide relatives and carers on how to share their views.

A clear complaints policy and procedure was in place, outlining how all complaints are managed. An independent person was assigned to investigate complaints, and actions were taken in line with the registered provider's policy. We reviewed a

sample of both formal and informal complaints and found they had been handled appropriately and in accordance with the policy.

Delivery of Safe and Effective Care

Safe Care

Environment
The hospital has reception coverage, and reception staff are responsible for booking visitors appointment and ensuring safety of the hospital keys, wrist bands and staff alarms.

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 wards.

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.

Evidence of audits were recorded electronically, and all were up to date and fully complete at the time of the inspection.

As part of the inspection, the team assessed the hospital environment through an initial tour on the first evening and continued observations over the following days. Overall, the hospital appeared clean, and several improvements were noted since the previous inspection. However, some environmental issues remain that require further attention:

- Laundry Room: Cleaning equipment was stored inappropriately, there was evidence of a leak, and the room was cluttered and disorganised and required cleaning. These concerns were also identified during the previous inspection and remain unresolved.

- Bedroom Areas: Some bedrooms required cleaning. While this was addressed during the inspection, it highlights the need for improved oversight.

- Furniture Condition: Damaged furniture was observed in the dining area and visitors' room, which requires replacement.

- Outdoor Areas: Garden patio furniture was unclean and appeared worn, detracting from the overall environment.

The registered provider should carry out a comprehensive review of the hospital environment to address ongoing maintenance and cleanliness issues. This should include ensuring proper storage of cleaning equipment, timely repairs, regular monitoring of bedroom standards, replacement of damaged furniture, and improvements to outdoor areas to support a safe, hygienic, and therapeutic setting for patients and staff.

Managing risk and health and safety

Overall, we found that appropriate systems and governance arrangements were in place which helped ensure the provisions of safe and effective care for patients. There was an electronic system in place for recording, reviewing, and monitoring patient safety incidents. Staff confirmed that de-briefs take place following incidents. The meetings we attended, and the evidence obtained during the inspection confirmed that incidents and the use of physical restraint interventions are monitored and supervised robustly.

There were nurse call points around the hospital and within patient bedrooms and bathrooms so that patients could call for help if needed. There was also a well-equipped laundry room in place for use by patients, under supervision and patients are encouraged to manage their own laundry to promote independence.

A range of up-to-date health and safety policies were in place and various risk assessments had been completed, such as ligature point risk assessments and fire risk assessments.

During the inspection, we observed that staff supporting patients on enhanced observations were not wearing personal safety alarms. Staff reported that there were not enough alarms available, and additional alarms were needed. Some staff also expressed the view that alarms were unnecessary, even while carrying out enhanced observations. This issue was previously identified in an earlier inspection and remains unresolved.

The registered provider should ensure that all staff involved in enhanced observations have access to and consistently use personal safety alarms. This is essential for maintaining staff safety and responding effectively to incidents.

The registered provider should review current alarm availability, reinforce the importance of their use through training, and take immediate steps to address any shortfall in equipment.

Infection prevention and control (IPC) and decontamination

Whilst it is acknowledged that some environmental improvements had been made since the previous inspection, further enhancements are still required, particularly

in relation to the cleanliness and organisation of the laundry room, certain bedroom areas, and the garden.

It was also noted that there appears to be a lack of clear clinical leadership in overseeing Infection Prevention and Control (IPC). Currently, responsibility for IPC appears to fall primarily on housekeeping staff, which is not appropriate for ensuring robust clinical governance. This was also a finding in our previous inspection.

Despite this, hospital staff demonstrated good knowledge of IPC practices, and there was evidence of ongoing audit activity.

The registered provider should ensure that there is a clinical lead responsible for IPC. This role should ensure effective clinical oversight and provide support to the housekeeping team.

Nutrition

We found that patients' nutritional and hydration needs were appropriately assessed and monitored. Assessments were completed on admission, with ongoing weight checks and care plans in place for those with specific dietary needs.

Patients were offered a variety of meals and had access to drinks and snacks throughout the day. Meals appeared appetising and well-prepared. Patients could also purchase and store their own food and had access to the occupational therapy kitchen to prepare meals independently.

Patients told us they were satisfied with meal timings and the dining environment. Menus were available, and patients were given options to choose from. However, we found that patients had limited involvement in reviewing or updating the menu, which was primarily managed by kitchen staff.

The registered provider should increase patient involvement in menu planning and review to ensure meals reflect their preferences and needs.

During lunch, we observed that desserts or fruit were not offered as part of the meal. While the kitchen was clean and food items were in date, several opened items in the dining area, such as cereals were left uncovered and undated, which could pose hygiene concerns.

The registered provider should consider offering a complete meal experience, including desserts or fruit, where appropriate.

The registered provider must ensure that food items in the communal area are properly sealed, labelled and stored in line with food safety standards.

Medicines management

Medication records were comprehensive and well-maintained. Patients were routinely involved in discussions about their medication, and we saw evidence of regular audits that met required medication standards.

It was positive to note that the clinic room was undergoing reorganisation. However, the space would benefit from additional storage and the installation of a more practical door. This would improve staff visibility and control during medication rounds, supporting safer interactions with patients.

The registered provider should review the current storage and consider installation of a more practical door to support safer administration of medications.

Temperature checks of the medication fridge and clinic room were being carried out regularly to ensure medicines were stored in line with manufacturers' guidance. However, it was noted that two dates in June 2025 were missing from the log.

The registered provider must ensure that consistent daily temperature monitoring is undertaken to ensure that medicines are stored within the required temperature range.

We noted that some Medication Administration Record (MAR) charts were missing staff signatures. This could lead to uncertainty about whether medication had been administered as prescribed. It is essential that staff sign MAR charts immediately after administering medication to maintain accurate records and ensure patient safety.

The registered provider must ensure that staff sign MAR charts immediately after administering medication.

Staff we spoke with during the inspection demonstrated a clear understanding of medication management procedures. Robust systems were in place to ensure that any medication errors were properly recorded, investigated, and overseen. We also found that learning from these incidents was shared across the team to support continuous improvement and safe practice.

We also saw evidence of regular checks on resuscitation and emergency equipment. Staff had clearly documented these checks to confirm that equipment was present, in date, and ready for use.

Safeguarding children and safeguarding vulnerable adults

There were established policies and processes in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

Ward staff had access to safeguarding procedures 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.

Through conversations with staff, it was evident that they had built up a close working relationship with the local authority, who often attended the hospital to provide training to staff. This collaborative approach is key to effective safeguarding processes and demonstrated that the hospital placed a strong emphasis on safeguarding their patients.

Medical devices, equipment and diagnostic systems

Regular clinical audits were carried out at the hospital, including consistent checks of resuscitation equipment. Staff had clearly documented these checks to confirm that equipment was in date and ready for use.

During discussions, staff demonstrated awareness of emergency procedures, including the location of ligature cutters. Up-to-date safety audits were in place, and ligature risk assessments had been completed to help manage and reduce potential risks.

Safe and clinically effective care

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

Staff confirmed that de-briefs take place following incidents. Meetings we attended and evidence obtained during the inspection confirmed that incidents and use of physical interventions (such as restraint) are checked, analysed, and supervised.

The inspection team witnessed positive redirection and de-escalation of difficult behaviours on the wards during the inspection, all of which were done respectfully and in a very supportive manner. Any physical intervention that occurred during the previous 24 hours was reported and discussed at the daily meeting and then reviewed through the hospital's clinical governance structure.

Staff training compliance for Physical Intervention was currently at 100%. Each shift continues to maintain adequate coverage with trained staff to manage situations requiring physical intervention.

There was an established electronic system in place for recording, reviewing, and monitoring incidents and there was evidence of robust monitoring and discussions at governance meetings.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and reviewed so that the occurrence of incidents could be reviewed and analysed. 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

During our discussions with the hospital manager, we were given examples of ongoing efforts to review and enhance service provision across the hospital.

At the time of inspection, several improvement projects were underway, including upgrades to the garden and outdoor spaces. A long-term project was also in place to convert all bedrooms to ensuite facilities by 2027. Since our previous inspections, some positive changes had been made to the hospital environment. It was reassuring to see that the hospital manager was aware of areas still needing development and was actively working towards further improvements.

We also noted a positive initiative led by the occupational therapy team, aimed at encouraging patients to take part in cleaning their own rooms. This project was thoughtfully designed to consider each patient's individual abilities and limitations, promoting independence and personal responsibility.

In addition, the hospital had established strong multi-agency relationships with the local police and safeguarding teams. These agencies made regular visits to the hospital to engage with and educate patients, as well as to support staff training. Their involvement contributed to both patient safety and stronger community integration.

Information management and communications technology

The hospital had effective electronic systems in place to support incident reporting, clinical and governance audits, human resources, and other operational functions. These systems contributed positively to the overall management and running of the hospital.

We reviewed the arrangements for maintaining patient confidentiality and compliance with Information Governance and the General Data Protection

Regulation (GDPR) 2018. Staff accessed hospital systems via personal logins with password protection, ensuring secure access to the intranet, policies, procedures, and the incident reporting system.

Staff demonstrated a clear understanding of their responsibilities regarding accurate record keeping and the protection of personal and sensitive information. Training compliance for information governance was confirmed, and staff were able to describe their roles in maintaining confidentiality and data security.

Records management
The hospital used both paper and electronic record systems, with the electronic system protected by password access. However, we noted that the use of both formats sometimes led to inconsistencies. Paper records did not always contain the most up-to-date information, making it difficult to determine which records were current. This can be particularly challenging for agency staff or new team members who rely on clear, accurate documentation.

If the dual system continues to be used, clear guidance should be provided to all staff on where the most current information is recorded. In addition, regular audits should be carried out to ensure that both paper and electronic records are consistently updated and aligned.

The registered provider must evaluate the use of both paper-based and electronic systems, ensuring robust oversight so that the most current information is consistently maintained and readily accessible to all staff.

Mental Health Act monitoring
We reviewed the statutory detention documents for five patients and found them to be fully compliant with the Mental Health Act 1983 (revised Code of Practice for Wales, 2016). All documentation confirmed that patients were legally detained, and there was clear evidence that patients had been informed of their rights, with signed acknowledgements included in the records.

Paper records were stored securely and were well-organised, easy to navigate, and contained detailed, relevant information. It was positive to note that improvements had been made in MHA documentation and administration since the last inspection, particularly in the completion of Section 17 leave forms.

The Mental Health Act Administrator operated an efficient and effective system to support the implementation, monitoring, and review of legal requirements under the Act.

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

We reviewed four sets of patient records. Care plans were detailed, personalised, and demonstrated input from a wide range of professionals within the multidisciplinary team (MDT). There was clear evidence of patient involvement and collaboration in the planning process.

However, we noted inconsistencies in the use of care planning templates. In one patient record, four different templates were used, which may lead to confusion. A standardised approach to care planning documentation is needed to ensure consistency, clarity, and ease of use, particularly for new or agency staff.

The registered provider should implement a standardised care planning template across all wards to ensure consistency and clarity.

Risk assessments and management plans, including the Historical Clinical Risk Management 20 (HCR-20) and Positive Behaviour Support (PBS) plans, were completed to a high standard. These were regularly reviewed and tailored to meet individual patient needs.

It was positive to see the use of easy-read documents for some patients, supporting accessibility and understanding. However, while efforts are being made to improve communication resources for non-verbal patients, a more structured and proactive approach is required. We recommend that the service reviews current communication aids, identifies any gaps in provision, and ensures that all communication strategies are clearly documented in each patient's care plan. Although a 12-week assessment period is in place for a new patient, their communication needs should be addressed in a timelier manner.

The registered provider should undertake a structured review of communication aids for non-verbal patients, with clear documentation of strategies in care plans.

For patients on enhanced observations, while records were complete, it would be beneficial to include care plans that clearly outline the rationale for observations and the specific interventions required. This would help staff better understand and meet the patient's needs.

The registered provider should ensure that enhanced observation care plans should be developed to include the rationale and specific interventions to support staff understanding and patient care.

Physical health monitoring was appropriately recorded in patient notes, and we found that discharge planning systems were in place and functioning effectively.

Mental Capacity Act and Deprivation of Liberty Safeguards

We reviewed one Deprivation of Liberty Safeguards (DoLS) record and found that the correct procedures had been followed. The documentation showed that the process was applied appropriately, with relevant recommendations made by the local authority. Mental capacity assessments were carried out as required when DoLS referrals were submitted, in line with legal requirements.

Quality of Management and Leadership

Governance and accountability framework
There was a clear organisational structure in place, providing clear lines of management and accountability. Staff defined these arrangements during the day, and with senior management and on-call systems in place for the night and out of hours.

The day-to-day management of the wards was the responsibility of the senior and clinical nurses who were supported by hospital manager and MDT.

At the time of the inspection, the service did not have a permanent hospital manager in post. An interim manager was in place to provide oversight, and a new senior nurse had recently been appointed to a leadership role.

It is recommended that the service prioritise the recruitment of a permanent registered manager to provide consistent leadership and ensure robust oversight of care delivery. Establishing a stable leadership presence will support staff confidence and help embed good consistent practice across the service.

We observed a positive staff culture with good relationships between staff who worked well together as a team. Most staff spoke positively about the leadership at the hospital. During conversations with staff, they shared that morale had improved and that the current manager is visible and approachable. Staff also mentioned there are limited spaces in the hospital available for taking breaks.

Staff had very positive things to say about the doctor, noting how well he builds relationships with both colleagues and patients. During the inspection, we saw patients approach him, and he was seen chatting and engaging with them in a friendly and focused way.

Effective systems were in place to ensure that information and lessons learned from complaints and incidents were promptly shared with staff across the hospital and the wider organisation. This supported ongoing service improvement and helped maintain a strong focus on patient safety.

Dealing with concerns and managing incidents

The hospital had a well-established electronic system for recording, reviewing, and monitoring incidents. Regular incident reports were generated and reviewed both locally and at the corporate level to help identify trends and patterns in behaviour.

Individual incidents were discussed with members of the multidisciplinary team (MDT) and senior staff during daily risk review meetings and bimonthly clinical governance meetings. We observed that incidents, complaints, and safeguarding concerns were consistently included as standing agenda items in daily morning meetings, with any learning outcomes shared across the staff team to support continuous improvement and safe practice.

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 generally able to access and provide most of the requested documentation promptly.

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

Newly appointed staff undertook a period of induction under the supervision of the experienced ward staff. Staff showed us documentary evidence and talked us through the systems of induction in place.

We were provided with a range of policies, all of which were up to date.

During our inspection, most staff reported that they were able to meet the demands of their roles and that staffing levels were generally sufficient to ensure safe patient care. However, we observed that during night shifts, only one registered nurse was on duty, supported by a team of healthcare support workers. This arrangement meant the nurse was unable to take a break without leaving the hospital without registered nursing cover.

We raised this concern with the hospital manager, who explained that breaks were typically taken during the early hours of the shift, and that staff could use the visitors' room for this purpose. We also noted that there was no dedicated staff area available for breaks.

The registered provider must review night shift staffing arrangements. Additionally, a designated staff area should be provided to allow staff to take their breaks in a safe, appropriate, and comfortable environment.

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 86%.

While supervision is conducted regularly, the completion rate of staff appraisals has been low. Management has acknowledged this and indicated that the annual appraisal cycle is approaching, with plans to complete outstanding reviews soon.

The registered provider must ensure that staff appraisals are carried out in accordance with the required schedule and completed annually to support staff development and maintain service quality.

Staffing levels were appropriate to maintain patient safety within the wards at the time of our inspection. We were told that agency staff are used, however when there are shortfalls the hospital will try to use regular agency staff who are familiar with working at the hospital and the patient group.

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

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
Clinical Fridge unlocked during evening visit.	Medication could be compromised and breaches policy and guidance.	Immediately brought to the attention of the nurse in charge	Clinical fridge remained locked throughout the inspection and registered provider will ensure ongoing compliance.
Bedroom area extremely cluttered and untidy	Poses a health and safety and potential fire safety risk	Immediately brought to the attention of the hospital manager	Housekeeping and patient tidied the bedroom area and removed clutter.

Appendix B - Immediate improvement plan

Service: Coed Du Hall

Date of inspection: 30 June, 1 & 2 July 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.	There was no immediate non-compliance issues identified.					
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: Coed Du Hall

Date of inspection: 30 June, 1 & 2 July 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.	There was limited information available about the role of Healthcare Inspectorate Wales (HIW) within the setting.	The registered provider must display accessible information on the role of HIW.	Patient information and consent.	Post information and contact details about the role of HIW in communal areas (for staff, patients and visitors)	Gerald Taylor (IM)	03/07/2025 Completed
2.	No pictorial information boards to help patients or visitors identify hospital staff. Staff were not easily identifiable due to the	The registered provider should consider introducing pictorial staff boards and must ensure that staff wear visible ID badges to help patients and visitors easily recognise staff roles and responsibilities.	Patient information and consent.	Pictorial information boards to be posted at the entrance to the hospital. All staff to receive ID Badges.	Hannah Low (Admin)	31/07/2025 Completed & Ongoing

	absence of uniforms and visible ID badges					
3.	Laundry Room: Cleaning equipment was stored inappropriately, there was evidence of a leak, and the room was cluttered and disorganised and required cleaning. These concerns were also identified during the previous inspection and remain unresolved	The registered provider should take immediate action to address the issues identified in the laundry room. This includes: Ensuring all cleaning equipment is stored safely and appropriately. Investigating and repairing the source of the leak. Decluttering and organising the space to promote a safe and efficient working environment. Implementing a regular cleaning and maintenance schedule.	Environment	Deep clean of the laundry room and schedule of cleaning to incorporate daily cleaning to be delivered. Ensure all cleaning equipment is stored safely and appropriately. Leak to be repaired. De clutter of the laundry room to be delivered.	Lynne Oldfield (Housekeeping)	07/07/2025 Completed & Ongoing
4.	Some bedrooms required cleaning. While this was addressed during the	The registered provider must strengthen its housekeeping oversight procedures to ensure that	Environment	Daily overview of all bedrooms to be delivered.	Lynne Oldfield (Housekeeping)	07/07/2025 Completed & Ongoing

	inspection, it highlights the need for improved oversight	all bedrooms are consistently clean and tidy.		Deep cleaning schedule of bedrooms to be implemented.		
5.	Damaged furniture was observed in the dining area and visitors' room, which requires replacement.	The registered provider must ensure that the damaged furniture in dining area and visitors room is fixed or replaced.	Environment	All dining room seating to be replaced. Inventory of furnishings required throughout the hospital to ensure replacements and repairs are delivered promptly.	Steve/Frank (Maintenance)	31/07/2025 Dining Room furniture in situ. Awaiting delivery date for Visitors room furniture.
6.	Garden patio furniture was unclean and appeared worn.	The registered provider must ensure that the garden furniture is clean.	Environment	Garden furniture to be deep cleaned and repaired/replaced where required.	Steve/Frank (Maintenance)	07/07/2025 Completed
7.	During the inspection, we observed that staff supporting patients on enhanced observations were not wearing personal safety alarms. Staff reported	The registered provider should review current alarm availability, reinforce the importance of their use through training, and take immediate steps to address any shortfall in equipment.	Managing risk and health and safety	Review of procedures and policy. Address through agenda at staff meetings. Ensure all patients who demonstrate a	Gerald Taylor (IM)	14/07/2025 Completed

	that there were not enough alarms available, and additional alarms were needed. Some staff also expressed the view that alarms were unnecessary, even while carrying out enhanced observations.			risk requiring staff to hold a personal alarm are identified and care plans/risk assessments direct the use of personal alarms. Ensure sufficient alarms within the hospital to meet identified need.		
8.	There appears to be a lack of clear clinical leadership in overseeing Infection Prevention and Control (IPC) Currently. Responsibility for IPC appears to fall primarily on housekeeping staff, which is not appropriate for ensuring robust clinical governance.	The registered provider should ensure that there is a clinical lead responsible for IPC. This role should ensure effective clinical oversight and provided support to the housekeeping team.	Infection prevention and control (IPC) and decontamination	Identify clinical lead for IPC to complement and support the current arrangements.	Gerald Taylor (IM)	07/07/2025 Completed staff identified JR (Clinical Lead), SH (Senior Nurse)

9.	Patients had limited involvement in reviewing or updating the menu, which was primarily managed by kitchen staff.	The registered provider should increase patient involvement in menu planning and review to ensure meals reflect their preferences and needs.	Citizen engagement and feedback.	Patients to be involved in menu planning through patient's forum, suggestion box and patients' surveys.	Steph Steel (Catering) Andrew Bishop (OT)	14/07/2025 Completed & Ongoing
10.	During lunch, we observed that desserts or fruit were not offered as part of the meal.	The registered provider should consider offering a complete meal experience, including desserts or fruit, where appropriate.	Nutrition	Deliver a 'fruit bowl' for patients to exercise choice include dessert options.	Steph Steel (Catering)	07/07/2025 Completed
11.	While the kitchen was clean and food items were in date, several opened items in the dining area, such as cereals were left uncovered and undated.	The registered provider must ensure that food items in the communal area are properly sealed, labelled and stored in line with food safety standards.	Nutrition	Catering team to ensure all food items in the communal area are properly sealed, labelled and stored in line with food safety standards.	Steph Steel (Catering)	07/07/2025 Completed
12.	The clinic room would benefit from additional storage and the installation of a more practical door. This would improve staff visibility and control during	The registered provider should review the current storage and consider installation of a more practical door to support safer administration of medications.	Safe and clinically effective care	Review access, egress and safe interactions with patients during medication rounds. Review and deliver adequate storage for the clinic.	Mark Holmes & Maintenance	28/07/2025 Completed & Ongoing

	medication rounds, supporting safer interactions with patients.					
13.	Temperature checks of the medication fridge and clinic room were being carried out regularly to ensure medicines were stored in line with manufacturers' guidance. However, it was noted that two dates in June 2025 were missing from the log.	The registered provider must ensure that consistent daily temperature monitoring is undertaken to ensure that medicines are stored within the required temperature range.	Safe and clinically effective care	Deliver a schedule for recording consistent daily temperature monitoring to ensure that medicines are stored within the required temperature range.	Jodie Rogers (Clinical Lead) Sheila Humphries (Senior Nurse)	07/07/2025 Completed Monitoring ongoing.
14	We noted that some Medication Administration Record (MAR) charts were missing staff signatures.	The registered provider must ensure that staff sign MAR charts immediately after administering medication.	Safe and clinically effective care	To ensure that all staff sign MAR charts immediately after administering medication. Agenda for nurses meeting, deliver robust and	Jodie Rogers (Clinical Lead) Sheila Humphries (Senior Nurse)	14/07/2025 Completed & monitoring ongoing.

				comprehensive monitoring process.		
15	The hospital used both paper and electronic record systems. However, we noted that the use of both formats sometimes led to inconsistencies. Paper records did not always contain the most up-to-date information, making it difficult to determine which records were current.	The registered provider must evaluate the use of both paper-based and electronic systems, ensuring robust oversight so that the most current information is consistently maintained and readily accessible to all staff.	Record Keeping	Review and evaluate recording systems. Deliver process that is consistent, comprehensive and accessible.	Jodie Rogers (Clinical Lead)	31/07/2025 Completed & Ongoing.
16	We noted inconsistencies in the use of care planning templates. In one patient record, four different templates were used, which may lead to confusion.	The registered provider should implement a standardised care planning template across all wards to ensure consistency and clarity.	Record Keeping	Develop and deliver a standardised care planning template across the hospital	Jodie Rogers (Clinical Lead)	14/07/2025 Completed
17	While efforts are being made to	The registered provider should undertake a		Develop and deliver communication aids	Jodie Rogers (Clinical Lead)	14/07/2025 Ongoing

	improve communication resources for non-verbal patients, a more structured and proactive approach is required.	structured review of communication aids for non-verbal patients, with clear documentation of strategies in care plans.		for non-verbal patients, with clear documentation of strategies in care plans.		
18	It would be beneficial to include care plans that clearly outline the rationale for observations and the specific interventions required. This would help staff better understand and meet the patient's needs.	The registered provider should ensure that enhanced observation care plans should be developed to include the rationale and specific interventions to support staff understanding and patient care.	Record Keeping	Deliver enhanced observation care plans and risk assessments to include the rationale and specific interventions prescribed.	Jodie Rogers (Clinical Lead) Sheila Humphries (Senior Nurse)	14/07/2025 Completed & Ongoing.
19	At the time of the inspection, the service did not have a permanent hospital manager in post.	It is recommended that the service prioritise the recruitment of a permanent registered manager to provide consistent leadership and ensure robust oversight of care delivery.	Workplace planning training and organisational development.	Continue with the recruitment of a permanent registered manager to provide consistent leadership and ensure robust oversight of care delivery.	Gerald Taylor (IM)	30/09/2025 Ongoing
20	During night shifts, only one registered	The registered provider must review night shift	Workplace planning training and	The hospital manager to review the night	Gerald Taylor (IM)	14/07/2025 Completed

	nurse was on duty, supported by a team of healthcare support workers. This arrangement meant the nurse was unable to take a break. We also noted that there was no dedicated staff area available for breaks.	staffing arrangements. Additionally, a designated staff area should be provided to allow staff to take their breaks in a safe, appropriate, and comfortable environment.	organisational development.	shift staffing arrangements. Provide a designated staff area to allow staff to take their breaks in a safe, appropriate, and comfortable environment.		
21	The completion rate of staff appraisals has been low.	The registered provider must ensure that staff appraisals are carried out.	Workplace planning training and organisational development.	Deliver staff appraisals for all employees.	Gerald Taylor (IM)	07/07/2025 Increased compliance & Ongoing.

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.

Name (print): **Gerald Taylor**

Job role: **Interim Manager (Director of Operations)**

Date: **18 August 2025**