Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Ty Gwyn Hall

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Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@gov.wales
Website: www.hiw.org.uk

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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 Ty Gwyn Hall on 08, 09 and 10 September 2025.

The inspection primarily focused on the following wards during the inspection:

- Ty Gwyn Hall – 17 bed male rehabilitation ward
- Skirrid View Main – 12 bed female assessment ward

While this inspection report is centred on these two wards, we also considered the experiences and circumstances of patients on the remaining two wards at the hospital, though with a more limited scope of review:

- Skirrid View Annex - 3 bed mixed gender assessment ward
- Pentwyn House - 4 bed mixed gender 'step down' unit.

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 seven questionnaires were completed by patients or their carers and 13 were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Overall, patient feedback about the hospital was largely positive. Most patients rated the care and service as “good” or “very good,” and reported feeling safe and well cared for. Staff had a good understanding of patients’ needs and provided timely treatment. A dedicated physical healthcare nurse and access to outdoor spaces and wellbeing activities supported patients with their health and in managing long-term conditions.

Patients felt respected, with staff also agreeing that dignity and privacy of patients was maintained. However, one patient raised concerns about bank staff entering rooms without knocking, highlighting a need for consistent professional standards across all staff.

Care and Treatment Plans (CTPs) were found to be up-to-date and aligned with legal standards. Patients generally told us that they felt involved in their care planning. The new activity hub was a welcome addition to help patients to participate in therapeutic and recreational activities

The hospital promoted equality and diversity, with policies in place and staff trained in inclusive practices. However, one patient reported racial discrimination, and a staff member urged continued monitoring of equality issues. We asked the service to ensure that any such incidents are investigated with appropriate support provided to patients and staff involved.

Patients had access to advocacy services and were encouraged to provide feedback through various channels. While feedback mechanisms exist, there was limited evidence of how patient input leads to service improvements.

This is what we recommend the service can improve:

- Consider upgrading bedrooms on Ty Gwyn Hall Ward with ensuite facilities and observation panels to improve privacy and allow less disruptive monitoring.

This is what the service did well:

- Bedrooms were clean, tidy, and personalised, contributing to a homely feel
- Staff engaged warmly and respectfully, with aids like braille and bilingual signage supporting accessibility.

Delivery of Safe and Effective Care

Overall summary:
The hospital provided safe and effective care in a clean, well-maintained environment. Staff worked collaboratively across disciplines, guided by clear policies and regular audits, to deliver person-centred care. Patients benefited from personalised Care and Treatment Plans (CTPs), which were regularly reviewed and co-produced with patients to support recovery and independence.

Infection prevention and control measures were robust, with a designated lead, regular audits, and well-trained staff. Nutritional needs of patients were being assessed and met, with support from dietitians and speech therapists. Patients were supported to make healthy choices. Medicines management was safe and efficient, with secure storage, electronic systems, and regular pharmacy oversight.

Safeguarding procedures were clear and well understood by staff. Mental Health Act (MHA) responsibilities were met, with strong documentation and legal safeguards in place. Patients were informed of their rights and involved in care decisions. However, we noted some statutory documentation from previous admissions was incomplete or missing, which could lead to legal ambiguity.

Some areas required improvement. Staff on Ty Gwyn Hall Ward did not have access to personal safety alarms, which raised concerns about a timely emergency response. Minor environmental repairs were needed, and we found an unlocked cupboard during the inspection which stored hazardous items which could potentially place staff and patients at risk. Additionally, care plans lacked clear discharge planning and did not consistently identify unmet needs.

This is what we recommend the service can improve:

- Review and clarify the use of personal alarms and radios to ensure consistent safety practices and safeguard staff and patients
- Introduce regular checks to keep cupboards with hazardous items securely locked
- Strengthen Mental Health Act processes to ensure all patient documentation is complete and accessible
- Ensure all renewal forms clearly state the rationale for continued detention
- Improve care planning by identifying unmet needs and embedding discharge planning more consistently.

This is what the service did well:

- Staff were engaged in audits and initiatives to improve care planning and reduce restrictive practices

- WARRN assessments were thorough, patient-led, and clearly outlined steps to manage risk safely
- The on-site social worker played a key role in safeguarding and liaising with external agencies.

Quality of Management and Leadership

Overall summary:
Staff feedback about the hospital's leadership and management was generally positive, with most respondents satisfied with the quality of care and support provided to patients. Many felt patient care was a priority and that the service worked to keep both staff and patients safe.

Governance arrangements were found to be appropriate, with regular senior management and staff meetings taking place covering key operational and clinical issues. Clinical audits were embedded into routine practice using a digital assurance platform, which helped support continuous improvement. Multidisciplinary working was strong, with effective collaboration evident in patient safety meetings.

Recruitment processes were robust, and staffing levels were generally appropriate. The hospital had low reliance on agency staff, supporting continuity of care. Most staff were aware of occupational support services, and wellbeing initiatives were in place. However, some staff raised concerns about management's responsiveness, wellbeing support, and the handling of incidents. Feedback indicated that staff did not always feel listened to or supported after difficult events. Some policies were found to be out of date, and staff expressed a need for more meaningful supervision and additional training in specialist areas.

This is what we recommend the service can improve:

- Discuss aspects of staff feedback from the HIW questionnaires, especially around debriefs and patient suitability, and provide assurance to HIW
- Update out-of-date policies and share with staff to support safe and effective care
- Strengthen staff feedback processes to ensure concerns are acknowledged and acted upon
- Review the supervision process to make it more meaningful and supportive of staff development.

This is what the service did well:

- Most staff members said they would recommend the hospital as a place to work and were confident in the standard of care provided

- Staff were well-trained, with most confirming they had received appropriate training for their roles
- New staff underwent structured induction and competency assessments.

3. What we found

Quality of Patient Experience

Patient feedback
Responses to the HIW patient questionnaires were generally positive. Five out of the seven patients rated the care and service provided by the hospital as either 'very good' or 'good'. Most patients said that they felt safe at the setting (6/7) and all patients agreed that staff provide them with care and treatment when they need it. Patients also said that they felt staff understood their needs (6/7) and their hopes, dreams and aspirations (5/7).

Health promotion, protection and improvement
We saw evidence that the physical healthcare needs of patients were being assessed and managed in a timely and appropriate manner. A dedicated physical healthcare nurse was employed by the hospital to support patients in improving their health and managing long-term conditions.

Patients had access to the large, well-kept grounds of the hospital, which offered a pleasant environment for patients to relax and spend time outside. Occupational Therapy (OT) staff supported patients to engage in health and wellbeing initiatives such as walking groups, swimming, and visits to a local gym.

Dignity and respect
All staff members who completed a questionnaire felt that patients' privacy and dignity is maintained (13/13). One staff member commented:

> *"Patients are treated as individuals and are cared for with dignity and pride within this setting."*

Six of the seven patients who completed a questionnaire agreed that staff treated them with dignity and respect. However, one patient commented:

> *"Bank staff sometimes just walk into my room without knocking."*

The service should remind all staff, including bank and agency staff, to knock before entering patient bedrooms to uphold patient rights and maintain expected professional standards.

All patients had their own bedrooms, but only the bedrooms on Skirrid View Main Ward had ensuite facilities. We also noted that not all bedroom doors throughout

the hospital had viewing panels. This meant that staff were unable to undertake enhanced observations on patients without frequently opening the door, which meant patients were often disturbed. Whilst we acknowledge the cost involved with renovating a ward environment, it would be beneficial to patients if the bedrooms on Ty Gwyn Hall Ward were adapted to provide ensuite facilities and if all bedrooms had observation panels.

The service must consider adapting bedrooms on Ty Gwyn Hall Ward to include ensuite facilities and installing observation panels on all bedroom doors to support patient privacy and enable less intrusive enhanced observations.

Patients could personalise their bedrooms with photos and pictures. We viewed some of the bedrooms on each ward, and it was positive to see they were generally clean and tidy and provided a homely feel.

Patient information and consent
We saw a wide range of accessible information available which supported informed decision-making and helped patients to understand their rights. Patients were also provided with an information leaflet on admission to provide useful information on the hospital environment, daily routines, available services, and how to raise concerns or give feedback.

Most patients who completed a questionnaire said that they were given information about their stay at the hospital (6/7) and that they understood everything that was given to them (5/7).

Communicating effectively
We observed staff engaging warmly and respectfully with patients. It was evident that staff had a good understanding of individual patients' needs and preferences, helping patients feel valued and understood. Five out of the seven patients who completed a questionnaire felt that staff listened to them. One patient commented in their questionnaire:

"Staff are really good at building relationships with patients."

Various aids were used throughout the hospital to support individuals with additional needs, including large clocks, braille documents, and pictorial signage. We saw that some of the information displayed throughout the hospital was bilingual and available in alternative languages. Staff informed us that translation services are available for patients who need to communicate in Welsh.

Care planning and provision
During the inspection we reviewed the care and treatment plans of six patients at the hospital. All patients had up-to-date, individualised Care and Treatment Plans (CTPs) that clearly reflected their assessed needs and prioritised their safety. The plans were comprehensive, person-centred, and aligned with the criteria set out in the Mental Health (Wales) Measure 2010.

Each patient had an identified Care Coordinator, and the plans were outcome-focused and included a broad range of interventions, covering both therapeutic and social activities, with clear identification of staff responsible for delivery. This approach supported a holistic and collaborative model of care. All staff who completed a questionnaire felt that patients were kept informed and were involved in decisions about their care.

Most patients who completed a questionnaire said that they were aware of a care and treatment plan (CTP) in place for them (5/7) and felt they were involved when the CTP was created (4/7). Almost all respondents said they were able to attend meetings, or ward rounds where their CTP is discussed (6/7).

Since our last inspection, a new activity hub had been built on-site. This bright and engaging space enabled patients to participate in therapeutic and recreational activities, and we considered it a valuable addition to the service. However, three of the seven patients who completed a questionnaire expressed dissatisfaction with the activities available. The service may wish to explore this feedback further with patients.

Patients were supported to take positive risks, such as unescorted leave within the local community, where appropriate. This approach promoted independence and recovery, while ensuring safety through robust risk assessments and ongoing staff oversight.

Equality, diversity and human rights
The hospital had suitable policies in place to help ensure that patients' equality and diversity were respected. This included a policy to support the care and management of transgender patients which we noted as good practice. We saw evidence that staff had completed mandatory Diversity, Equity and Inclusion training as part of their role.

Most patients felt they could access the right healthcare at the right time (regardless of any protected characteristics) (5/7). However, one patient reported experiencing racial discrimination when accessing or using the service. Additionally, one staff member provided the following comment in their questionnaire:

"I encourage the organisation to continue monitoring and addressing issues related to equality, diversity, and inclusion, including racial discrimination, to ensure all staff and patients feel respected and treated fairly."

This feedback suggests that while the overall experience is positive for most, there may be underlying issues that require further attention.

The service must monitor and address all issues related to Equality, Diversity and Inclusion, ensuring that any incidents are investigated promptly and that appropriate support is provided to patients and staff involved.

We were told that all patients have access to a mental health advocate who visits the hospital once a week to provide information and support to patients with any issues they may have regarding their care. All seven patients who completed a questionnaire confirmed that they had been offered the support of an advocate.

Citizen engagement and feedback

Patients are actively encouraged to provide feedback through various channels, including suggestion boxes, patient representative meetings, and community meetings. Information about how to give feedback, including the complaints procedure and advocacy support, is clearly displayed and easily accessible throughout each ward. While patient satisfaction surveys are reportedly conducted, some patients did not recall participating in them but confirmed that their views are regularly sought and acted upon.

Although feedback mechanisms are in place, there was no visible evidence of how the service demonstrates that feedback is used to inform improvements. The service may wish to consider how it can provide assurance to patients, families, and carers that their feedback is acknowledged and acted upon.

Delivery of Safe and Effective Care

Safe Care

Environment
The hospital environment was generally clean, tidy and well-maintained. We found that Skirrid View Main Ward was more accessible to patients with mobility impairments. We were told that patients with more acute physical healthcare needs on Ty Gwyn Hall Ward would be accommodated in the Annex.

Each ward provided a comfortable environment with appropriate fixtures and fittings for the patient group. We saw that regular risk assessments and audits were being carried out to identify any issues with the environment. However, we did note a few areas in need of minor repair:

- The button surround casing was cracked on one of the communal toilets on Ty Gwyn Hall Ward
- Bedroom 1 on Ty Gwyn Hall needed skirting replaced in the bathroom and the curtains were not fixed securely to the rail in places.

The service should ensure any damage to the fixtures and fittings is repaired in a timely manner.

Managing risk and health and safety
Staff on Skirrid View Main Ward had access to personal safety alarms and radios. However, personal alarms were not available for staff on Ty Gwyn Hall Ward; staff relied on radios and nurse call points located throughout the ward. On the first night of the inspection, a staff member in the Annex was observed alone with a patient without wearing a personal alarm, raising concerns about staff and patient safety and the ability to respond promptly in emergencies such as physical aggression, medical incidents, or safeguarding concerns.

The service must review current safety arrangements and implement a clear policy on the use of personal alarms and radios. This should define when and where alarms must be used to ensure consistent practice and safeguard both staff and patients.

There were up-to-date ligature point risk assessments in place and several ligature cutters located throughout each ward for use in the event of a self-harm emergency. Suitable fire safety measures and precautions were being taken to protect patients and staff in the event of a fire.

During our tour of Ty Gwyn Hall Ward, we found a cupboard unlocked which contained gardening equipment such as scissors and shovels. Further information on how this issue was resolved is provided in Appendix A.

The service must implement a regular check system to ensure all cupboards containing potentially hazardous items are kept locked when not in use to safeguard both patients and staff.

Infection prevention and control (IPC) and decontamination
We found effective IPC measures in place throughout the hospital. A current IPC policy was available, outlining procedures designed to protect both staff and patients. The ward areas were visibly clean and well maintained.

A designated IPC lead had been appointed and there appeared to be a collective approach towards implementing IPC procedures among nursing, housekeeping, and maintenance staff. Regular audits, such as hand hygiene audits, had been completed to check compliance with IPC procedures.

Most staff members who completed a questionnaire agreed that there were effective infection prevention and control practice measures in place (10/13). Staff had completed relevant IPC training and the staff we spoke with during the inspection demonstrated a clear understanding of their responsibilities.

Nutrition
The service had effective systems in place to assess and meet the individual nutritional and hydration needs of patients. On admission, patients' dietary needs were assessed, and care plans were developed with input from dietitians. Fluid and food intake charts were used to monitor patients' consumption, and we were informed that specific dietary requirements—such as diabetic or vegetarian diets—were accommodated without issue.

The service had access to both Dietetic and Speech and Language Therapy (SALT) services. Where swallowing difficulties were identified, modified diets and fluids were provided. Patients were also able to prepare and eat meals in the activity hub, promoting independence and choice.

A Malnutrition Universal Screening Tool (MUST) was in use to identify patients at risk of malnutrition. Patients benefited from a four-week rolling menu with daily meal choices. Where appropriate, patients were supported with weight management medication or high-calorie nutritional supplements to improve physical health.

There were suitable facilities available for patients to have hot and cold drinks. Fruit was available outside mealtimes, and patients were being supported to make healthy choices. We observed mealtimes and the food appeared appetising.

Medicines management
The arrangements for medicines management were found to be safe, effective, and demonstrated good practice across all key areas. Policies relating to medicines management, controlled drugs, and rapid tranquilisation were up to date and easily accessible to staff.

Clinic rooms were clean, tidy, and well organised. We noted a particularly helpful visual aid - a photo of the clinical room treatment cupboard's contents displayed on the outside of the door. This supported quick identification, improved efficiency during stock checks, and reduced unnecessary handling of cupboard doors and contents.

Medication, including controlled drugs, was securely stored in locked cupboards, fridges, and trolleys, with keys held appropriately. Fridge temperatures were monitored consistently. Controlled drugs were recorded, administered, and stock-checked daily. Patients were involved in decisions about their medication through monthly reviews and discussions with key workers.

The service operated a comprehensive electronic medicines management system, supported by weekly audits and pharmacy input. Medication charts were well maintained, with clear documentation of legal status, patient ID, and reasons for non-administration.

Medication errors were escalated to MDTs and governance structures, with learning shared at ward level. Emergency medication was sourced via a local chemist, ensuring timely access when needed.

Safeguarding children and safeguarding vulnerable adults
We found suitable measures in place to safeguard vulnerable adults. An up-to-date safeguarding policy was available, clearly outlining procedures for staff to follow in the event of a concern. Staff we spoke with were confident in identifying and escalating safeguarding issues and understood their responsibilities. Regular training was provided and monitored, ensuring staff remained informed and competent.

A social worker was based on-site, who provided valuable support in managing safeguarding matters and liaising with external agencies. Safeguarding leads and champions were present throughout the hospital, and visual aids such as flowcharts and contact lists supported staff awareness.

Patients were informed about safeguarding through posters and advocacy arrangements and reported feeling safe.

We saw evidence of appropriate referrals and oversight at management level, with issues discussed at clinical governance meetings. Although no patients were subject to Deprivation of Liberty Safeguards (DoLS) at the time of inspection, staff understood the process and confirmed that MDT assessments would be used to consider less restrictive options.

Medical devices, equipment and diagnostic systems
We saw evidence of weekly checks being undertaken on resuscitation and emergency equipment held on each ward. Staff had documented when these had occurred to ensure that the equipment was present, in date and safe to use in the event of an emergency such as patient collapse. Staff received annual Immediate Life Support (ILS) training and were confident in using emergency equipment.

Safe and clinically effective care
Staff were supported by clear policies and a collaborative multidisciplinary approach to deliver safe and clinically effective care while minimising restrictive interventions. Staff reported having sufficient time to complete monthly Care and Treatment Plan (CTP) reviews, hold one-to-one meetings, and update clinical records.

Daily MDT meetings and structured handovers supported continuity of care, and governance meeting minutes were shared with staff. Safety bulletins were communicated via email and supervision.

Preventative measures were in place to reduce the need for restrictive practices. Although the Safewards model was not formally used, mutual expectations were displayed, and the Wales Applied Risk Research Network (WARRN) tool was used to support risk assessment and management. The WARRN assessments we reviewed were comprehensive, completed collaboratively with patients, and clearly outlined actions, responsibilities, and timelines to manage risk and support safe care delivery.

Positive Behaviour Support training had been completed by staff, and psychology facilitated reflective practice sessions and debriefs following incidents. CTPs included strategies for managing challenging behaviour, and restrictive practices appeared to be used only as a last resort, with the last restraint occurring several months ago.

Participating in quality improvement activities
We were told that various quality improvement initiatives were taking place, including support for nurses to improve care planning with patient involvement. Drop-in sessions were offered for night staff, with senior management support. Clinical audits were conducted using Tendable, and findings informed practice. A recent audit led to a service-wide effort to enhance the individualisation of care plans.

Records management
Patient records were maintained electronically using a secure, password-protected system to prevent unauthorised access and uphold confidentiality. Records were stored securely, easy to locate, and clearly organised, with relevant sections easily identifiable. All members of the multidisciplinary team documented within a single, unified patient record, supporting continuity and consistency in care.

Mental Health Act monitoring
We reviewed the statutory detention documents of five patients at the clinic and were assured that the service is meeting its responsibilities under the Mental Health Act (the Act). We saw evidence of good clinical practice, legal safeguards, and strong documentation standards during current detention episodes.

Capacity assessments were consistently completed in line with the Mental Capacity Act, with Responsible Clinicians (RCs) clearly documenting decisions. Treatment certificates were appropriately issued and stored, and weekly audits supported compliance where patients lacked capacity.

Section 3 detention paperwork was largely accurate and submitted within required timescales. Medical recommendations confirmed mental disorder and justified detention. Approved Mental Health Professional (AMHP) assessments were thorough and reflected detention criteria. However, one AMHP form lacked a 'date seen' entry. The form was historical, relating to a previous placement for the patient. Nonetheless, the service should ensure all statutory forms relevant to the patient are reviewed on admission to confirm they have been completed appropriately and to avoid future legal ambiguity. We also noted that one AMHP form for another patient, also from a previous placement, could not be located. Efforts were made to retrieve it from the previous placement during the inspection.

The service must strengthen its processes to ensure all statutory documentation relating to each patient is accurate, retained, and accessible.

Section 17 leave was well managed, with clear risk assessments and patient involvement. Conditions and outcomes were documented, and the electronic

system helped reduce confusion by displaying only active leave. Leave was appropriately restricted in some cases due to relapse or Ministry of Justice conditions.

We saw evidence that patients were informed of their rights both verbally and in writing and were supported to appeal. Renewal procedures were followed, with RCs consulting MDT members and submitting statutory reports. However, one renewal form lacked a rationale for continued detention; this was escalated during the inspection.

The service must ensure that all renewal forms include a clearly documented rationale for continued detention to support transparency and ensure decisions are clinically justified and auditable.

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

Alongside our review of statutory detention documents, we considered the application of the Mental Health (Wales) Measure 2010. We examined a sample of six patient records from the hospital and found that documentation was well organised, easy to navigate, and reflected the domains of the Welsh Measure.

Each patient had current and detailed risk assessments, supported by appropriate use of evidence-based tools. Care and Treatment Plans (CTPs) were individualised, person-centred, and included achievable goals with planned review dates. A Care Coordinator had been identified in each case, supporting continuity and accountability.

There was strong evidence of patient involvement in co-producing their CTPs, with use of personal language, quotes, and aspirations. Nearest relatives and carers were identified and involved where appropriate, and advocacy services were offered or used. Capacity assessments were completed, and patients had agreed to, signed, and received copies of their plans.

Planning around patient leave was particularly strong, with clear procedures for managing vulnerability and incidents, giving staff confidence in managing risk. The plans also considered patients' social, cultural, and spiritual needs, and drew on individual strengths to support recovery, rehabilitation, and independence. However, unmet needs had not been identified in the care plans we reviewed. Additionally, care plans tended to focus on short-term goals, with limited visibility of future discharge planning. While we recognise that discharge planning can be complex, particularly for some patients, we would expect discharge goals to be more clearly embedded throughout care planning.

The service must:

- **Ensure care planning includes active identification and escalation of unmet needs**
- **Ensure that discharge planning has a clearer and more consistent focus throughout care planning, even where timelines are uncertain, to support recovery and continuity of care.**

Quality of Management and Leadership

Staff Feedback
Responses to the HIW staff questionnaires were mixed. The questionnaire results were generally positive, however, some staff members provided less positive feedback in their comments, which are included throughout this report.

All staff who completed a questionnaire were satisfied with the quality of care and support given to patients. Most respondents felt that patient care was the service's top priority (11/13) and were content with the efforts of the service to keep them and patients safe (10/13).

The majority of respondents also agreed that they would recommend the service as a place to work (9/13) and agreed they would be happy with the standard of care provided by the service for themselves, friends or family (10/13).

Governance and accountability framework
We found appropriate governance and oversight arrangements in place to support safe and effective patient care. Senior management meetings were held regularly and covered a wide range of operational and clinical issues. Monthly staff meetings followed structured agendas, including updates on hospital developments, training, referrals, discharges, and new admissions.

Good multidisciplinary working was evident throughout the inspection, with strong input from occupational therapy and the wider MDT. The patient safety meeting we attended during the inspection demonstrated effective collaboration and decision-making focused on individual needs and best interests.

Most staff who completed a questionnaire felt that their manager could be counted on to help with difficult tasks at work and provides clear feedback on their work (11/13). Most respondents felt senior managers were committed to patient care (12/13), and many felt senior managers were visible (8/13). However, some staff raised the following concerns:

> *"Managers need to focus less on money and looking good for other organisations and focus more on listening to their staff."*

> *"Patients are all treated differently. Some patients would be better treated in other establishments, E.g., eating disorders. Staff don't get debriefed after incidents. A lot of unsuitable patients coming through the ward and staff are told to just put up with it."*

The service must reflect and discuss this feedback with staff and provide assurance to HIW on the issues raised, particularly in relation to staff debriefs following incidents and the suitability of patient admissions.

During the inspection we found two policies that were out-of-date according to their review dates. These were the Health, Safety and Environmental Policy Statement and the Recruitment Policy.

The service must review any out-of-date policies and procedures to help staff provide safe and effective care and share with staff once ratified.

Dealing with concerns and managing incidents
There was an established electronic system in place to ensure incidents were reported, investigated and managed appropriately. All staff members who completed a questionnaire said that they knew and understand their role in meeting the Duty of Candour Standards.

Most staff members who completed a questionnaire agreed that the service encourages them to report errors, near misses or incidents (12/13). Most respondents also agreed that when errors, near misses or incidents are reported, the service takes action to ensure that they do not happen again (12/13). However, one staff member commented:

> *"Staff concerns are not acted upon; you feel a burden for bringing anything up."*

While this may reflect a minority view, the service should explore this further with staff to determine whether it indicates a wider issue of staff not feeling heard or supported.

Workforce recruitment and employment practices
Staffing levels appeared appropriate to maintain patient safety across the hospital at the time of our inspection. However, staff noted that when patient needs and acuity increased, such as during enhanced observations, it often placed additional pressure on their workload and affected their ability to work effectively. Staffing and recruitment were standing agenda items at senior management and staff forum meetings, and the service should continue to monitor staffing to ensure patients have consistent access to therapeutic activities and individual support. It was positive to note that reliance on agency staff was minimal, supporting continuity of care.

Recruitment processes were found to be robust and transparent. Pre-employment checks, including references, Disclosure and Barring Service (DBS) clearance, and

verification of professional qualifications, were consistently applied. Newly appointed permanent staff receive a period of induction where they are required to complete an induction programme. Senior managers are responsible for assessing whether newly appointed staff have demonstrated the required levels of competency to pass their probation and work at the hospital.

Almost all staff who completed a questionnaire confirmed they were aware of the occupational support services available to them (12/13). One staff member said:

> *"A variety of wellbeing initiatives are offered throughout the year by our local Wellbeing Champions, helping to foster a positive and supportive working environment."*

However, feedback from other respondents suggested inconsistencies in staff wellbeing support:

> *"Management don't really care for staff's wellbeing. They don't check in with staff."*

> *"The setting generally provides good patient care and staff support. However, there are occasions where patients can be verbally abusive to staff, and the organisation should continue supporting staff to manage these situations and maintain their wellbeing."*

The service must reflect on this feedback with staff to strengthen its wellbeing support to ensure staff feel valued and supported, particularly following incidents of abuse from patients.

Workforce planning, training and organisational development
We saw that suitable processes were in place for senior staff to monitor compliance with mandatory training. It was positive to see that overall compliance among staff with such training was high. Staff members who completed a questionnaire told us that they have had appropriate training to undertake their role (12/13). We asked staff what other training they would find useful, and one staff member said:

> *"Additional training in advanced mental health awareness, leadership, and care coordination would be useful for my continued development."*

We were told that staff receive regular supervision and annual appraisals. Of those who could remember, eight out of eleven staff who completed a questionnaire confirmed that they have had an appraisal, annual review or development review of their work in the last 12 months. However, one staff member said:

“Supervisions don't get reviewed or read so are quite pointless to complete.”

The service must work with staff to review the supervision process to ensure it is purposeful to support staff growth and service improvement.

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
During our tour of Ty Gwyn Hall Ward, we found a cupboard unlocked which contained gardening equipment such as scissors and shovels	Unauthorised access to these items presents a safety risk, as they could be used to cause harm, either intentionally or accidentally.	We reported this immediately to the nurse in charge of the ward.	The cupboard was immediately locked, and staff were reminded of their responsibility to keep the store cupboard locked when not in use.

Appendix B – Immediate improvement plan

Service: Ty Gwyn Hall

Date of inspection: 08, 09 and 10 September 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 assurance issues were identified on this inspection.					

Appendix C - Improvement plan

Service: Ty Gwyn Hall

Date of inspection: 08, 09 and 10 September 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.	Only the bedrooms on Skirrid View Main Ward had ensuite facilities. We also noted that not all bedroom doors throughout the hospital had viewing panels.	The service must consider adapting bedrooms on Ty Gwyn Hall Ward to include ensuite facilities and installing observation panels on all bedroom doors to support patient privacy and enable less intrusive enhanced observations.	Dignity and respect	The Hospital Director will meet with the Regional Estates Manager and review the practicalities of adapting bedrooms to allow for ensuites in all rooms. Review and upgrade current en-suite facilities in Ty Gwyn in line with 2025-26 Capital Expenditure Plan.	Hospital Director Hospital Director	January 2026 April 2026

				Audit Ty Gwyn bedrooms to confirm any that would benefit from an observation panel. The assessment must account for the shape of the room and bed position. This will ensure patient observation and signs of life could effectively monitored from outside of the room.	Ward Manager	December 2025
				Audit Service User feedback regarding the use of observation panels and impact on dignity and privacy.	Ward Manager	December 2025
				Discuss within the Elysium governance framework the supportive observation policy and whether this can be amended to allow for less	Hospital Director	January 2026

				frequent supportive observation checks for those assessed as low risk and on Level 1 observations.		
2.	Patient and staff feedback suggested that while the overall experience is positive for most, there may be underlying issues in relation to discrimination that require further attention.	The service must monitor and address all issues related to Equality, Diversity and Inclusion, ensuring that any incidents are investigated promptly and that appropriate support is provided to patients and staff involved.	Rights and equality	All incidents to be reviewed within the weekly senior team meeting. Whenever issues relating to Equality, Diversity or Inclusion (DEI) are identified a full review takes place and actions allocated to ensure both service users and staff are supported. Themes and trends remain a topic for review under the Hospitals Governance arrangements. This includes incidents relating to DEI and post incident action planning.	Hospital Director Hospital Director	November 2025 November 2025

				Continue with quarterly relationship meetings with Gwent Police where referrals via safeguarding and direct complaints relating to DEI are reviewed and actions agreed. All patient related DEI incidents escalated through our safeguarding processes to ensure actions are agreed and implemented.	Hospital Director Safeguarding Lead	November 2025 November 2025
3.	There were a few areas in need of minor repair on Ty Gwyn Hall Ward.	The service should ensure any damage to the fixtures and fittings is repaired in a timely manner.	Environment	The button surround casing in the communal bathroom has been replaced. The skirting in Bedroom 1 has been replaced, and the curtains have been reinstated securely onto the curtain pole.	Support Services Manager	November 2025

				The Support Services Manager completes a weekly environment checklist, and this has been updated to include a check of curtains, light and toilet fittings.	Support Services Manager	November 2025
4.	Personal alarms were not available for staff on Ty Gwyn Hall Ward, and we observed a staff member alone on with a patient on the Annex without wearing a personal alarm.	The service must review current safety arrangements and implement a clear policy on the use of personal alarms and radios. This should define when and where alarms must be used to ensure consistent practice and safeguard both staff and patients.	Managing risk and health and safety	A personal alarm system is available to staff and is linked to the fixed alarm system already in place within the Ty Gwyn building. Additional personal alarms have been purchased and are available on the ward for staff to use. Training sessions will be scheduled for all staff to be instructed in its use.	Hospital Director Hospital Director	November 2025 November 2025

				The Annex is covered by the Skirrid View alarm system. Staff working within this area have been reminded to wear their alarm and this will be monitored for compliance by the Nurse in Charge.	Ward Manager	November 2025
5.	During our tour of Ty Gwyn Hall Ward, we found a cupboard unlocked which contained gardening equipment such as scissors and shovels.	The service must implement a regular check system to ensure all cupboards containing potentially hazardous items are kept locked when not in use to safeguard both patients and staff.	Managing risk and health and safety	We have implemented a daily check for the Ward Manager/Nurse in Charge to walkaround and check the security of doors and cupboards within Ty Gwyn Hall. Compliance with this routine will be monitored by the Ward Manager and Clinical Services Manager.	Ward Manager	November 2025
6.	We saw that one patient's AMHP form	The service must strengthen its processes to ensure all	Mental Health Act monitoring	The Mental Health Act Manager has updated	Mental Health Act Manager	November 2026

	from a previous placement lacked a 'date seen' entry. We also noted that one AMHP form for another patient, also from a previous placement, could not be located.	statutory documentation relating to each patient is accurate, retained, and accessible.		the "Scrutiny Forms" to ensure that all aspects of the AMHP forms are robustly reviewed when a patient is admitted. Any deficits will be addressed by communications with the previous placement.		
7.	One renewal form lacked a rationale for continued detention.	The service must ensure that all renewal forms include a clearly documented rationale for continued detention to support transparency and ensure decisions are clinically justified and auditable.	Mental Health Act monitoring	The RC has been reminded to clearly state the rationale for the detention when he completes MHA renewal forms.	Responsible Clinician	November 2026
8.	We saw that unmet needs had not been identified in the care plans we reviewed. Additionally, care plans tended to focus	The service must: • Ensure care planning includes active identification and	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	Unmet needs will be added to the agenda of monthly ICR meetings to ensure they remain a priority	Clinical services Manager	November 2025

on short-term goals, with limited visibility of future discharge planning.	escalation of unmet needs • Ensure that discharge planning has a clearer and more consistent focus throughout care planning, even where timelines are uncertain, to support recovery and continuity of care.		for the MDT to monitor and address. After each meeting, actions related to unmet needs will be identified, and care plans updated accordingly. Primary Nurses will conduct monthly care plan evaluations, documenting clear discussions with patients about discharge planning. These discussions will be recorded both in the care plan evaluation section and in the ICR document. Monthly ICR meetings will also review and document discharge planning, with details captured in the	Ward Manager Primary Nurses Clinical Services Manager	November 2025 November 2025 November 2025

				meeting minutes alongside unmet needs and agreed actions. During quarterly planning week, the accuracy of discharge planning information will be validated, and unmet needs addressed if necessary.	 Clinical Services Manager	 January 2026
9.	Some staff raised concerns in their HIW questionnaires about management priorities, patient suitability, and lack of debriefing after incidents.	The service must reflect and discuss this feedback with staff and provide assurance to HIW on the issues raised, particularly in relation to staff debriefs following incidents and the suitability of patient admissions.	Governance and accountability framework	The Hospital Director will continue to run a monthly Staff Forum where he will be available to answer any concerns or questions staff want to raise. The Hospital Director will develop an action plan following the completion of the annual staff survey. This action plan will be co-produced with	Hospital Director Hospital Director	December 2025 December 2025

				staff to ensure their views are fully engaged. All incidents are reviewed within the senior team meeting and where identified will ensure that staff have been sign-posted to run debrief meetings.	Clinical Services Manager	November 2025
10.	During the inspection we found two policies that were out-of-date according to their review dates.	The service must review any out-of-date policies and procedures to help staff provide safe and effective care and share with staff once ratified.	Governance and accountability framework	The Policy Manual provided to HIW at the time of the inspection held two policies that had not been replaced with the updated version. I can confirm that the Health and Safety Policy Statement was updated in October 2025 and is due to expire in October 2028. The recruitment Policy was reviewed and updated in May	Hospital Director	November 2025

				2025. We have updated the Hard Copy Policy Manual accordingly.		
11.	Some staff feedback suggested inconsistencies in staff wellbeing support.	The service must reflect on this feedback with staff to strengthen its wellbeing support to ensure staff feel valued and supported, particularly following incidents of abuse from patients.	Workforce recruitment and employment practices	Ty Gwyn Hall has an embedded wellbeing network including an Employee Assistance Programme that provides independent support via BUPA. We have a monthly Staff Forum where all staff are invited to meet with the Hospital Director and share their views, ideas and concerns. We run a monthly recognition award; “The Kite Awards”, where staff are recognised for great performance. We run monthly raffles for staff compliant with training and for attending the Staff	Hospital Director	November 2025

				Forum. All incidents are reviewed by the SMT weekly and where abuse or racism is identified we will contact the staff member to check on wellbeing. We have embedded “Speak Up” within our culture with 2 x “Speak Up” champions on site and a “Speak Up” Guardian overseeing the service. We run an annual staff survey and develop action plans to address issues raised. As a team we will continue to monitor and listen to the feedback of our staff and respond appropriately to any wellbeing issues that are raised.	Hospital Director	November 2025

12.	One staff member raised some concerns about the supervision process.	The service must work with staff to review the supervision process to ensure it is purposeful to support staff growth and service improvement.	Workforce planning, training and organisational development	The Senior Team review supervision compliance on a weekly basis to ensure we achieve <90% compliance month on month.	Hospital Director	November 2025
				We will continue to support staff to make sure they receive regular supervision, and this is of a quality that makes this both purposeful and supportive.	Hospital Director	November 2025
				The Clinical Services Manager will link in with our training team to provide all supervisors with additional training in the delivery of Clinical and Managerial Supervision.	Clinical Services Manager	March 2026

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): **Shaun Cooper**

Job role: **Hospital Director**

Date: **18 November 2025**