Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Ty Skirrid Unit, Maindiff Court Hospital, Aneurin Bevan University Health Board

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

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1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Maindiff Court Hospital, Aneurin Bevan University Health Board on 6, 7 and 8 October 2025. The following hospital wards were reviewed during this inspection:

- Ty Skirrid Unit - 15 beds providing male rehabilitation services. At the time of the inspection, the patient cohort included forensic, those detained under the Mental Health Act, and informal patients
- Lindisfarne – three step-down beds providing independent living with a reduced staffing presence.

Our team, for the inspection comprised of one HIW senior healthcare inspector, 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:
The service prioritised patient independence, supporting skill development for successful community reintegration. Patients had access to tailored therapeutic input, needs-based assessments, and meaningful activities. While the overall approach was positive, the structure and consistency of activity provision could be strengthened.

Staff-patient interactions were consistently respectful, calm, and informed, with staff demonstrating a commitment to meaningful engagement. However, aspects of the physical environment require improvement to support patient wellbeing, particularly in relation to sleep hygiene.

Patients were actively encouraged to take responsibility for daily tasks, such as laundry and accessing community services. Staff promoted autonomy through a decreasing degree support, aligned with the rehabilitation model of care.

For detained patients, leave was generally well facilitated and balanced against individual risks and preferences. Leave arrangements were reviewed regularly to ensure continued appropriateness.

Patients' rights under the Mental Health Act were upheld, with access to written information, advocacy services, and involvement from families and carers where appropriate.

There was clear evidence of patient engagement in care planning and treatment, including participation in ward rounds and pre-meeting check-ins. Overall, patient engagement levels were found to be good.

This is what we recommend the service can improve:

- The roles, responsibilities and ownership of activities could be strengthened
- Aspects of the environment should be strengthened
- Proximity of the smoking area to the main unit building should be reviewed

This is what the service did well:

- Staff-patient interactions were respectful and calm
- There was good relational security between staff and patients
- There was a good range of therapeutic input available to patients, with a focus on skills development and community re-integration

Delivery of Safe and Effective Care

Overall summary:
The unit operates an unlocked rehabilitation model of care, underpinned by robust individual risk assessments and strong relational security between staff and patients.

Admissions were carefully managed; however, an inherent level of risk remains. We recommend the health board uses this inspection to reinforce the importance of continuing to stringently assess patient moves and admissions, as far as possible and despite wider bed pressures.

The multidisciplinary team (MDT) comprised a broad range of healthcare professionals. Staff reported feeling heard and respected during ward rounds and MDT forums. Patients confirmed consistent involvement in ward round meetings, receipt of information about their care and treatment, and opportunities for family and carer involvement where desired.

Patients benefited from dedicated occupational therapy and psychology input, tailored to individual needs. This included one-to-one, group, and focused support.

Care planning was well aligned with the Mental Health (Wales) Measure, with comprehensive care and treatment plans that reflected the Measure's domains and were regularly reviewed. All patients had access to a named nurse acting as care co-ordinator.

Records for patients detained under the Mental Health Act 1983 were reviewed and found to be legally compliant.

Incidents of challenging behaviour requiring escalation were low. The unit worked collaboratively to minimise escalation risks through individualised, evidence-based risk assessments, reviewed regularly and as needed.

While some environmental improvements had been made, such as the renovated kitchen, the overall indoor and outdoor spaces would benefit from further enhancement to support a therapeutic setting.

This is what we recommend the service can improve:

- Patient moved and admissions to the unit must continue to be stringently assessed to ensure staff and patient safety and well-being
- Estates issues affecting the unit should be given sufficient attention and priority to maintain a therapeutic environment
- Aspects of care documentation recording

This is what the service did well:

- There was a good range of therapeutic input available to patients from dedicated Occupational Therapy staff and Psychology provision, as required
- There was evidence of effective MDT arrangements
- Care Planning was well aligned with the Mental Health (Wales) Measure, and all detained patients were done so legally.

Quality of Management and Leadership

Overall summary:

Governance and oversight processes were found to be effective, supporting clear information flow between the unit, senior nursing leadership, and divisional-level forums.

We observed good nursing and medical leadership on the unit. Staff worked collaboratively throughout the inspection, with positive feedback received regarding the ward manager. The senior nurse was visible, knowledgeable, and actively engaged with patients.

The workforce was generally stable. While bank staff were used to some extent, efforts were made to ensure consistency by deploying regular bank staff familiar to patients.

Mandatory training and annual appraisal rates were maintained at a good overall level, except for basic life support (BLS) and Mental Health Act training. Imminent plans were in place to address these gaps. Staff were supported to pursue further learning and development aligned with their roles and career aspirations, including formal management, vocational, and nursing training.

The unit maintained close working relationships with other mental health services, the local authority, and supported living providers to facilitate appropriate placements and timely discharge planning. Although some delays were noted, discharge planning remained a central focus, with regular meetings held to monitor progress.

This is what we recommend the service can improve:

- Staff training gaps must be strengthened at the earliest opportunity
- Staff feedback should be reviewed and considered by the health board
- Policies and procedures must be reviewed and updated, according to their clinical priority and level of risk

This is what the service did well:

- Staff feedback in relation to line management and senior managers was generally positive
- There was evidence of good partnership working for the benefit of patients and effective operation of the unit
- Audit activities were undertaken and generally well scored.

3. What we found

Quality of Patient Experience

Patient feedback

We spoke to number of patients informally during the inspection and received seven completed patient questionnaires, and one patient/ carer questionnaire.

Patient comments included:

> *" I don't have much to say. It is the best place I've been… It would be good for more activities though"*
>
> *" More outdoor activities"*

Family and carer comments included:

"Bigger visitors room, it's very small"

"It's costly [to get to the hospital] and public transport is poor to hospital"

Person-centred

Health promotion
The service focused on maintaining and building patients independence to aid skills development and independence for community living. This included access to dedicated unit staff and a range of needs-based assessments, focused and individualised therapeutic input, and a structured approach to each day.

Physical health needs were assessed, monitored and acted upon. This included smoking cessation advice and the offer of nicotine replacement therapy. Despite efforts, smoking outside the unit was prevalent and the health board should consider the proximity of the smoking area to the main unit building, in line with Welsh Government smoke-free legalisation.

The health board must review the proximity of the smoking area to the main unit building in line with smoke-free legislation.

It was positive to see that blanket restrictions were limited and that there was a positive risk-taking approach adopted, underpinned by individual risk assessments and care planning. One example was the consumption of energy drinks on the unit,

whereby a health promotion and educative approach was favoured, with information boards displayed and verbal advice offered to patients.

There were a range of meaningful activities on the unit for the patients to access, with a good focus on accessing the community to aid independence and re-integration. Whilst engagement reportedly fluctuates, staff were knowledgeable of the individual needs and preferences in how patients choose to engage and spend their time. To support uptake and engagement with the structured approach of timetabled activities, we recommend that roles, responsibilities and ownership of these activities are more clearly defined.

The health board should ensure that roles, responsibilities and ownership of structured activities is strengthened.

Dignified and respectful care
We observed positive interactions between staff and patients. This included knowledgeable, respectful and calm conversations, with staff taking the time to engage meaningfully with patients.

Staff were seen to knock on patient doors before entering. All patients had access to their own bedrooms, which they could lock and personalise, if desired. There were two bathrooms, both of which were communal spaces. However, bedroom doors did not have vision panels, which meant that staff were required to open patient doors at least hourly during the night, dependent upon each patient's observation level. This affects good sleep hygiene, which is an important aspect of rehabilitation care.

The health board must explore if vision panels can be installed to improve sleep hygiene.

We noted that available rooms and space on the unit were extremely limited. This meant that there was limited space for MDT meetings, visiting, and one-to-one work with patients. This resulted in patients having restricted space at times, including inappropriate spaces sometimes being used for meetings which would benefit from a private space.

The health board must explore if a room on the site can be made available to the Unit on a more consistent, if not permanent, basis.

Individualised care
Staff demonstrated a good knowledge of the patients on the unit, which was reflected in care planning documentation and day-to-day engagement between staff and patients.

Patients were supported according to their needs, preferences and goals. This included skills development, such as kitchen assessments. One patient that we spoke with commented positively about the skills he had learnt in this respect, noting that they had moved from eating ready meals each day to now cooking their own meals.

Patients were encouraged to take responsibility for their own everyday tasks, such as laundry and accessing services within the community. Staff provided encouragement to empower patients to make decisions for themselves and with a decreasing degree of supervision and support from staff, in line with the rehabilitation mode of care.

For patients who were detained, leave from the unit was balanced against wishes, individual risks, and was generally well facilitated by staff. This was reviewed in weekly ward rounds to ensure its on-going appropriateness.

Patients were able to keep their own devices, such as mobile phones and tablets, on the unit. Wi-Fi was available to encourage patients to stay in touch with friends and family.

Timely

Timely care

In the lead up to, and throughout the inspection, staffing numbers and skill mix was stable. We confirmed that staffing could be adjusted to meet patient needs and acuity, including increased observation levels, when necessary. The need for this, however, was reportedly limited due to the designation of the unit. Use of regular bank staff was favoured, where available, to ensure familiarity with patients and their needs.

The unit and patients benefitted from a well-functioning MDT, which included a consultant psychiatrist, registered mental health nurses, an occupational therapist and technician, healthcare support workers and a psychologist and psychology assistant. Whilst some roles, such as the psychiatrist and psychology team were not based on the unit full-time, we found this to not inhibit professional dialogue or timely patient care and input.

Equitable

Communication and language

Language preferences and communication needs were recorded in each patients care and treatment plan, and we observed staff being mindful of these needs when engaging with patients.

Whilst most patients were able to advocate for themselves, use of advocacy services were available, with regular attendance by the service to the unit. However, we would recommend recording of the offer and uptake or decline of advocacy services could be strengthened. Unit staff may wish to include this in patient notes at the pre-ward round check-in for consistency. It was positive to see clear record of wishes regarding patient instructed involvement of relatives and carers, as desired.

The health board should strengthen the recording of advocacy offer and uptake or decline.

Rights and equality
We confirmed that patient's rights in relation to the Mental Health Act were being upheld. Patients were provided with, or had the offer of, written material to explain their rights. Where desired, access to advocacy and / or family and carer involvement was noted.

There was evidence of patient engagement relating to their care and treatment, including invitations to attend weekly ward round meetings and pre-ward round check in's completed by their named nurse. We found engagement from patients to be generally good.

It was positive to see daily morning meetings taking place on the unit, which facilitated a conversation between staff and patients on a range of topics, including daily activities and feedback. These were well attended, and patients were empowered to speak up. We would recommend that monthly community meetings are undertaken on the ward, as a further means of encouraging wider feedback on the unit and in support of maintaining a therapeutic environment.

The health board should seek to introduce community meetings to supplement daily morning meetings.

Delivery of Safe and Effective Care

Safe

Risk management
The unit operates an unlocked rehabilitation model of care. This was underpinned by appropriately evidenced individual risk assessments and strong relational security between staff and patients.

Admission processes were carefully managed, but there remains an inherent degree of risk for the unit due to its layout, relative isolation, registered nurse staffing by night, and other factors which were provided in the verbal feedback session. We recommend the health board uses this inspection as an opportunity to underline the importance of continuing to stringently assess patient moves and admissions, as far as possible and despite health board wide bed pressures. This is to ensure staff and existing patient safety and wellbeing, on what was found to be an otherwise settled and well-functioning unit.

The health board must continue to stringently assess patient moves and admissions, as far as possible and despite known bed pressures, to ensure staff and existing patient safety and wellbeing.

Positively, there was a low number of incidences of challenging behaviours that required escalation, and the unit worked well collectively to minimise the risk of behaviours escalating. There is, however, potential for behaviours to unexpectedly challenge staff who are not frequently exposed to these events. PMVA (Prevention and Management of Violence and Aggression) training was provided to staff, with good compliance, and is a training area that we would advise continues to promote staff and patient safety and wellbeing.

The environment has not benefitted from an anti-ligature programme of works, but was subject to general and individual risk assessments, as required. We confirmed that any patient with active suicidal ideation would not be admitted to the unit and care would be stepped up accordingly.

Other aspects of estate issues and ward maintenance were reported by staff and reviewed by the health board's estates department in a generally timely manner. However, remedial works were reportedly not always carried out in a consistently timely way. Whilst certain areas of the environment had been improved, such as the recently renovated kitchen, the overall indoor and outdoor environment would benefit from improvement to ensure patients can benefit from a therapeutic environment, as far as reasonably possible.

The health board should ensure that estates issues affecting the unit are given sufficient attention and priority to maintain a therapeutic environment.

Infection, prevention and control and decontamination
The unit was generally well organised and clean throughout the inspection, against the backdrop of an aging building and generally high footfall on and off and the unit.

Domestic staff were found to be working diligently, and cleaning schedules were comprehensive and up-to-date. However, we would recommend that high level cleaning is included onto these schedules, and a storage solution is found for the patient laundry room.

The health board should ensure that high level cleaning is included in cleaning schedules and that a storage solution is found for the patient laundry room.

Staff compliance with mandatory training was good and there were processes in place to check and maintain effective IPC, which included regular nursing audits, by a nominated nurse with responsibility for IPC.

Safeguarding of children and adults
There were appropriate processes in place to safeguard vulnerable adults. This included a robust recording and understanding of patient histories and associated risk factors. The unit worked to established health board processes and procedures, and there was good compliance with staff training according to their roles and responsibilities.

The overall number of safeguarding incidents on the unit were low, but staff were able to articulate examples of safeguarding concerns and an appropriate set of actions that would be taken in response.

Oversight of safeguarding incidents was monitored within senior nursing and operational governance meetings. Staff confirmed that support and oversight from health board safeguarding teams is provided.

Medicines management
There were good arrangements in place to appropriately manage medication on the unit. The clinic was locked at all times, with keys being held by a registered member of staff.

Medication charts were found to be well completed, with prescribing and administration of medications found to be appropriate. However, there were some

omissions in ensuring that the legal status of patients was consistently completed on the front sheet.

The health board must ensure that patient's legal status is included on medication charts.

The unit benefitted from pharmacy input on a weekly basis, with evidence of pharmacist-led stock checks and audits being undertaken.

Emergency equipment and drugs were readily accessible and routine checks were completed. Fridge temperature checks also consistently recorded to ensure medication efficacy.

Effective

Effective care

The unit MDT comprised of a wide range of healthcare professionals. There was a consensus amongst staff that they felt listened to and had their professional views respected during ward rounds and other MDT forums. Staff commented positively on the fresh direction taken by the consultant psychiatrist who had been in post for several months. Patients shared a similar view that they were consistently invited to ward round meetings, received information about their care and treatment, and felt involved in their care. This included the involvement of families and carers, as desired.

It was positive to note that the patients received dedicated occupational therapy input, together with psychology input-based patient needs. This included individual, group and intensive support, as required. Staff commented that patients are generally able to receive therapeutic support in a timely manner, which was confirmed in the records that we reviewed.

Relational security on the ward was good, which contributed towards a calm atmosphere, with a low number of incidents. It was positive to note that all seven respondents to our patient survey indicated that they felt safe on the unit.

Nutrition and hydration

Patients had access to two kitchens to prepare meals. One kitchen had recently undergone a refurbishment, providing patients with a pleasant environment to prepare and eat meals. Given the rehabilitation designation of the unit and its relative isolation, patients were provided with a weekly allowance to complete food shopping. Essential food supplies, such as bead, cereals and hot drinks, were provided for patients by the service.

Patients were supported to use the kitchen, and assessments were undertaken by a dedicated occupational therapy team. One patient positively expressed that they had only ever eaten microwave meals prior to their admission, and that they are now able to cook their own meals.

Nutrition and hydration needs were appropriately assessed using the All-Wales Nutritional Risk Screening Tool (WASSP). Where required, appropriate follow-up actions had been taken.

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

Care planning was well aligned with the Mental Health (Wales) Measure. This included comprehensive care and treatment plans that reflected the domains of the Welsh Measure and were regularly reviewed. However, care and treatment plan review minutes were not always uploaded onto the electronic records system in a timely manner. All patients had access to a named nurse, who assumed the role of care co-ordinator.

The health board should ensure that Care and Treatment Plan review minutes are uploaded onto WCCIS in a timely manner.

The unit used individualised, evidence-based risk assessments for assessing and managing clinical risk in patients. These were reviewed at regular intervals and when necessary.

Physical health needs were met in several ways. This included new and existing arrangements with a local GP practice, although staff noted that GP access can sometimes present challenges and is an area being explored by the service. Ward based nursing and medical input was also provided, and we noted referrals to other healthcare professionals were made in a timely manner. Patients were encouraged to access other services, such as optometry and dentistry, in the local community.

Mental Health Act monitoring

We reviewed the records of all patients who were detained under the Mental Health Act 1983 and found all legal documentation related to their admission to be compliant with the Act. There was documented evidence that patient rights were being upheld in line with the Act, and patients were regularly presented with their rights, and provided with written information to this effect.

Detention documentation could be navigated with ease, and it was positive to identify improvements had been sustained since the last inspection. However, we

recommend that previous Section 17 leave and consent to treatment certificates are clearly marked with ‘no longer valid’ to ensure that staff refer to the most recent document.

We found mental capacity to be assessed and recorded in patients ward round notes, alongside careful consideration of patient views and wishes. However, we recommend that the unit utilises the health board wide corporate checklist for assessments to ensure that there is consistency in approach and remains in line with the code of practice.

The health board should ensure that aspects of Mental Health Act documentation are strengthened, as set out in the body of this report.

Quality of Management and Leadership

Staff feedback

We invited staff to complete a survey about their experience working on Ty Skirrid Unit, as well as for the wider organisation. In total, we received 13 responses.

A representative sample of staff comments included:

> *" The ward team work well together to improve patient experience. The HCSW's have recently been shortlisted for the HCSW Team of the Year within the Health board which they are pleased with."*
>
> *" Another space/room for interventions/activities and MDT meetings to allow patients usual use of the ward."*
>
> *"The only concern I have is the night shift qualified. There is only one qualified by night where they cannot have a break or leave the ward and leaves a lot of responsibility to the one nurse."*
>
> *"I think the ward could improve by employing an activities co-ordinator to work aside the OT s and ward staff to support social interaction with some of the patients who struggle and then work on their strengths and weaknesses…"*
>
> *"The ward manager is very supportive, friendly, approachable, knowledgeable, very professional and a really good role model for junior members of staff. In all of my roles in and outside of the NHS this manager is the best one I have had by far!"*

The health board should consider the staff feedback regarding only on registered nurse on duty by, which impacts on their ability to take a break or leave the ward. This must include mitigations for any risks, such as appropriate level of skill mix on duty, a two-nurse checks for certain medications, and they needs for the registered nurse to leave the ward.

Leadership

Governance and leadership
Governance and oversight processes appeared to work well, enabling a flow of information between the unit, senior nursing, and divisional level meetings.

Matters raised in these meetings involved patient care, workforce, quality and safety.

We found evidence of good management and leadership on the unit. All staff on the ward appeared to work well together throughout the inspection. Positive feedback was provided about the ward manager, and the senior nurse was visible and actively engaged with patients in a knowledgeable manner during the inspection.

All staff who responded to the staff survey confirmed that their immediate manager can be counted on to help them with a difficult task at work. All but one agreed that they are given clear feedback and slightly fewer agreed that they are asked for their opinion before decisions are made that affect their work

In relation to senior managers, most staff members agreed that senior managers are visible and that communication is effective, and all agreed that they are committed to patient care.

Several policies and procedures were in the process of being updated. We recommend that review and ratification of policies and procedures are prioritised, according to their level of clinical risk. This must include the policy relating to patient restraint, which was due for review in 2019.

The health board must ensure that policies and procedures are reviewed and ratified in a timely manner. These should be prioritised according to their level of clinical risk.

Workforce

Skilled and enabled workforce

It was positive to find a generally stable workforce, with a committed team of staff, several of whom had worked on the unit for several years. There was a degree of bank usage on the unit, but staff confirmed that they make every effort to ensure regular bank staff are used to help ensure patients are familiar with the staff who are providing their care and treatment.

There was evidence of good medical leadership on the unit, with staff and patients complementing the care provided by the consultant psychiatrist. Staff and patients were also complementary of the therapeutic offer available to patients.

When asked in our survey if there are enough staff to do their job properly, two staff disagreed. This is reflective of comments received and set out earlier in this

report relation to nurse staffing by night. However, all staff responded that they can meet conflicting demands on their time at work.

Positively, mandatory training and annual appraisal completion rates were maintained to an overall good level, except for basic life support (BLS) and Mental Health Act training. However, we confirmed that there were imminent plans in place to resolve this.

Several staff were supported to undertake additional learning, development and training relevant to their roles, responsibilities and future career intentions. This included formal management, vocational and nursing training.

Culture

People engagement, feedback and learning

There were opportunities for patients, relatives and carers to provide feedback, complements and complaints. Patients were provided with a booklet upon admission, which encourages patients to speak with the ward manager. We confirmed that the ward manager has an open-door policy.

Patients could attend morning meetings to resolve any minor worries or concerns and could also speak with their named nurse. We have recommended earlier in this report that the unit should explore re-instating community meetings to ensure that wider feedback and concerns can be captured and responded to.

There were a low number of formal complaints, however, we confirmed that patients wishing to make a formal complaint would be directed to the appropriate NHS Wales Putting Things Rights process and with the support of an advocate, if required.

Information

Information governance and digital technology

Patient records were found to be securely stored on the unit. This included paper and digital records. The patient status board was always kept out of view, to maintain patient privacy and confidentiality.

Learning, improvement and research

Quality improvement activities

There were several nursing led audits undertaken on the unit. Some of these included audits in infection prevention and control, the environment, and patient records. The audits were generally well scored, using a health board audit

template and system, ensuring consistency in completion and reporting. Audits were monitored by ward management, senior nurse and fed into divisional quality, performance and safety meetings to ensure senior oversight.

Whole-systems approach

Partnership working and development
The unit works closely with other mental health services within the health board. This helps to ensure that wards and units and can share a professional dialogue in a timely manner, including highlighting and resolving concerns, and to aid patients in accessing the right level of care and in a timely manner.

The unit and divisional team maintained close working relationships with the local authority and supported living providers to help identify suitable placements for patients to aid timely discharge planning. Whilst there were some delays experienced in this regard, discharge planning was a prominent feature of patients care on the unit and regular meetings take place to monitor progress.

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
One recently outdated palperidone injection was found in the clinic	Outdated medication can affect its efficacy	This was flagged to the nurse in charge	We confirmed that routine checks are undertaken by the pharmacy department, who attend the ward on a weekly basis. Ward staff confirmed that this would be flagged for their attention.

Appendix B - Immediate improvement plan

Service:

Date of inspection:

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

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Not applicable					
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:

Appendix C - Improvement plan

Service: Ty Skirrid Unit, Maindiff Court Hospital

Date of inspection: 6-8 October 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.	Page 11	The health board should ensure that roles, responsibilities and ownership of structured activities is strengthened.	Health and Care Quality Standards 2023 Person-centred / Effective	1. Ward to update activities timetable to reflect role of staff to undertake each activity.	Ward manager/ Occupational Therapist	1/12/2025
				2. Activity timetable is on display on main ward and individualised available in each patient bedrooms		Complete
2.	Page 11	The health board must explore if vision panels can be installed to improve sleep hygiene.	Person-centred / Effective	3. Minor Works costings to be obtained to determine next steps.	Service Improvement Manager	April 2026 due to Health Boards minor works procedures

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				4. To be added to the Mental Health Capital Priorities register for funding.		Complete
3.	Page 11	The health board must explore if a room on the site can be made available to the Unit on a more consistent, if not permanent, basis.	Person-centred / Effective / Workforce	5. Ward Manager to re-explore availability of a room on site to use on a regular basis with the Senior Nurse	Ward manager	Meeting with Senior Nurse 5/12/2025 to discuss options
4.	Page 13	The health board should strengthen the recording of advocacy offer and uptake / decline.	Person-centred / Effective	6. Discuss and offer advocacy in patients' 3-weekly ward rounds.	Ward Manager	4/12/2025 (1st Patient Ward Round)
				7. Document advocacy discussions and outcomes in the ward round entry.	Ward Manager	4/12/2025 (1st Patient Ward Round)
5.	Page 13	The health board should seek to introduce community meetings to supplement daily morning meetings.	Person-centred / Effective	8. Meetings are now in place on a monthly basis	Ward Manager	Complete
6.	Page 14	The health board must continue to stringently assess patient moves and admissions, as far as	Effective / Safe / Leadership	9. Maintain established process for rehab referrals, overseen by the Responsible Clinician and agreed via MDT.	Clinical Director for Adult Mental Health	Complete and continue to monitor

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
		possible and despite known bed pressures, to ensure staff and existing patient safety and wellbeing.		10. Any patients transferred outside of this process are agreed with the locality responsible clinician.		Complete and continue to monitor
7	Page 15	The health board should ensure that estates issues affecting the unit are given sufficient attention and priority to maintain a therapeutic environment.	Person-centred / Effective / Safe	11. Outstanding maintenance lists to be reviewed weekly by dedicated housekeeper and escalations sent to the directorate Service Improvement manager to escalate appropriately.	Ward Manager	Complete and continue to monitor
				12. Escalate issues to the directorate Service Improvement Manager as needed.		Complete and continue to monitor
8.	Page 15	The health board should ensure that: • High level cleaning is included in cleaning schedules • A storage solution is found for the	Person-centred / Safe	13. Meeting scheduled for the facilities manager to address these issues.	Ward Manager/ Facilities Manager	Meeting scheduled 12/12/25
				14. All Patients' belongings have now been returned to bedrooms and areas decluttered.		Complete and continue to monitor

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
		patient laundry room.				
9.	Page 16	The health board must ensure that patient's legal status is included on medication charts.	Effective / Safe	15. Continue weekly checks of medication charts to ensure patient legal status is included.	Pharmacist/ SHO/Responsible Clinician	Complete
10.	Page 17	The health board should ensure that Care and Treatment Plan review minutes are uploaded onto WCCIS in a timely manner.	Effective / Safe	16. Remind all staff of the correct procedure for uploading review minutes onto WCCIS.	Ward Manager/ Senior Nurse	Complete and continue to monitor via AMAT and Divisional Audit processes
				17. Monthly audit of compliance with WCCIS		January 2026
11.	Page 18	The health board should ensure that aspects of Mental Health Act documentation are strengthened, as set out in the body of this report.	Effective / Safe	18. Capacity Checklist for Mental Health Act is now in place to ensure there is consistency in approach and remains in line with the code of practice.	Responsible Clinician/ Mental Health Act Admin Manager to	Complete and continue to monitor via Clinical Director

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				19. Monthly audit of MHA documentation	provide oversight	Complete and continue to monitor via Clinical Director
12.	Page 19	The health board should consider the staff feedback regarding only on registered nurse on duty by, which impacts on their ability to take a break or leave the ward. This must include mitigations for any risks, such as appropriate level of skill mix on duty, a two-nurse checks for certain medications, and they needs for the registered nurse to leave the ward.	Workforce	20. Ward is currently undergoing an establishment review to consider options or alternatives to address the staffing levels	Lead Nurse	Establishment reviews to be completed by January 2026
				21. Options Appraisal has been developed to address immediate safety concerns on site.		Options appraisal complete. Awaiting discussions – to take place in December 2025
				22. The future of Maindiff Court site is currently under review as part of the wider health board Mental Health		Ongoing

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				& Learning Disability & estates strategy		
12.	Page 20	The health board must ensure that policies and procedures are reviewed and ratified in a timely manner. These should be prioritised according to their level of clinical risk.	Effective / Safe / Leadership	23. Ensure all policies and procedures are reviewed in the Divisional Policy Group and prioritized by clinical risk.	Divisional Policy Group	Ongoing

Oversight and monitoring of the improvement plan will be undertaken by the following groups: -

- Action Plan meeting
- Directorate Quality Patient Safety Meeting
- Divisional Quality Patient Safety Meeting
- Senior Management Team
- Quality Management Group
- Quality Patient Safety Outcomes Committee

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): Nadine Gould

Job role: Divisional Nurse

Date: 27/11/25