Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report
(Unannounced)
Tawe Clinic, Cefn Coed Hospital, Swansea Bay University Health Board

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Tawe Clinic, Cefn Coed Hospital, Swansea Bay University Health Board on 06, 07 and 08 October 2025. The following wards were reviewed during this inspection:

- Clyne Ward – 14 bed female acute inpatient ward
- Fendrod Ward – 20 bed male acute inpatient ward

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. A total of two were completed. We also invited staff to complete a questionnaire to tell us their views on working for the service. We did not receive any completed questionnaires from staff; however, we did speak to staff during our inspection.

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:
Patients generally received timely nursing and medical care and felt treated with dignity and respect. Communication was effective, supported by digital tools, bilingual signage, and weekly advocacy services. Health promotion was evident, with examples seen of the clinic helping patients manage long-term conditions and improve their health.

Staff were consistently praised for kindness, professionalism, and responsiveness. However, the physical environment was a significant concern. Both Clyne and Fendrod wards lacked green space and exercise facilities, leaving patients confined to small courtyards mainly used for smoking. Patients reported that this was affecting their emotional wellbeing and motivation.

Accessibility for patients with mobility needs was poor, with barriers such as stairs and inaccessible bathrooms on both wards. Privacy was limited, as while a private family room was available, this was located off the wards. Patients therefore often met visitors in busy communal areas.

Capacity issues with the psychology service at the health board meant there was limited psychology input available to support patients and staff. Activity schedules were inconsistent, and occupational therapy coordinators were often diverted to clinical duties, leaving patients reportedly feeling bored and unstimulated. Staff shortages and poor transport access further restricted opportunities for community engagement.

While staff showed compassion and commitment, urgent improvements are needed to shift from containment to treatment-focused care to support recovery and wellbeing.

Immediate Assurances:

- Laundry provision was poor. On Clyne Ward, the washing machine had been broken for weeks, leaving some patients washing clothes in the bath. On Fendrod Ward, clothes sent off-site often came back late or went missing. Patients expressed frustration at wearing dirty clothes, which undermined hygiene and dignity.

Details of remedial action taken by the health board are provided in Appendix B.

This is what we recommend the service can improve:

- Improve access to green space and exercise facilities
- Align vaping practices on Clyne Ward with policy standards
- Create private spaces for visits and confidential discussions
- Embed a clear, treatment-focused care model with structured therapeutic interventions
- Improve accessibility for patients with mobility impairments
- Provide clear guidance on supporting transgender patients.

This is what the service did well:

- Staff were kind and professional
- Patients had private rooms they could personalise
- Nursing and medical care were timely and compassionate
- Weekly advocacy services were available
- Tailored support for patients with sensory impairments and use of translation services.

Delivery of Safe and Effective Care

Overall summary:
Our inspection identified significant concerns regarding the environment and safety and quality of care on Clyne and Fendrod wards. Both wards were in poor physical condition, including damaged flooring, corroded fixtures and mould in the shower areas. These issues, highlighted in previous inspections, remain unresolved and continue to compromise patient dignity and safety. While it is positive that an improvement and transformation programme has now been agreed, urgent action is required to address these longstanding deficiencies.

Risk management processes were in place, including ligature assessments, but practical issues such as shortages of essential keys posed serious risks. The absence of a designated seclusion or Extra Care Area meant staff had to manage high-risk situations in corridors, which was neither safe nor dignified.

Infection prevention and control arrangements were partially effective, with good training compliance and audits, but the poor environment hindered cleaning and increased infection risks. Medicines management was generally safe, though some gaps in fridge temperature monitoring was noted. We found nutrition and hydration provision was inadequate, with repetitive meals, slow access to dietetic support, and hygiene risks in food service.

Safeguarding arrangements appeared robust, with appropriate referrals and oversight, but staff awareness of whistleblowing processes was limited. Mental

Health Act compliance was generally satisfactory, but a missed Hospital Managers' Hearing was a serious breach of patient rights. Additional concerns included poor tracking of legal documents during transfers, and lack of mandatory staff training on the Mental Health Act.

Care planning and risk assessments were comprehensive and person-centred, and staff demonstrated commitment to patient safety despite resource challenges.

Immediate assurances:

- We identified a shortage of essential keys on Clyne Ward, including those for observation panels, bedroom doors, and call alarms. Nurses had to carry two separate sets of keys, and all staff reportedly had access to the medication room, which could create additional safety concerns. The shortage affected operational efficiency and limited immediate access to critical areas during emergencies. It was also reported that this issue may have contributed to a delayed response to a ligature incident, which remained under investigation
- We found weaknesses in monitoring Immediate Life Support (ILS) training compliance. At the time of inspection, only 40% of nurses on Clyne Ward were up to date, and one upcoming night shift had no ILS-trained nurse scheduled. There was also no system to check the training status of bank or agency staff. This concern was significant given the rurality of Cefn Coed, and we could not be assured that patients would receive appropriate intervention in a medical emergency
- We reviewed the statutory detention documentation for four patients and found that one patient did not receive a Hospital Managers' Hearing within the required timeframe. This was a serious breach of safeguards designed to protect patient rights and raised concerns about the lawfulness of their continued detention.

Details of remedial action taken by the health board are provided in Appendix B.

This is what we recommend the service can improve:

- Provide access to a safe environment for managing patients during periods of acute distress or heightened risk
- Address IPC risks by repairing damaged areas and improving everyday practices
- Strengthen staff awareness of whistleblowing processes
- Implement robust tracking of legal documentation during transfers
- Allocate resources for structured debriefs after incidents
- Improve food quality, variety, and access
- Develop guidance for meeting nutritional needs while awaiting specialist input.

This is what the service did well:

- Medicines management was generally safe and compliant
- Safeguarding arrangements were robust, with appropriate referrals and oversight
- Care plans and risk assessments were comprehensive and person-centred
- Violence and aggression training was completed, supporting de-escalation practices
- Patient records were well-organised and aligned with Mental Health Measure domains
- Multidisciplinary collaboration was strong, and staff felt supported
- Patients were involved in medication decisions and care planning.

Quality of Management and Leadership

Overall summary:
It was clear that Tawe Clinic continues to face significant challenges despite the health board's Mental Health Transformation Programme, which aims to modernise services. While this initiative is positive, issues identified in previous inspections remain unresolved, requiring urgent action to ensure safe and therapeutic inpatient care.

Staff were committed and worked collaboratively, but morale was low, with many staff reporting that they felt undervalued. Workforce pressures were evident, including staff shortages, reliance on temporary staff, and a reported poor skill mix, which affected patient safety and limited therapeutic opportunities. Compliance with training and appraisals was below expected standards. While an induction booklet was available, this was not always being completed for new members of staff.

Governance arrangements and audit systems were in place, but several key policies were outdated, and a backlog of incident reviews posed risks to learning and safety. Patient feedback mechanisms were limited, with poor visibility of complaints processes and no anonymous options.

This is what we recommend the service can improve:

- Update all out-of-date policies and share with staff
- Increase psychological input and structured interventions
- Allocate protected time for training, supervision, and appraisals
- Ensure all new members of staff benefit from completion of the induction booklet
- Improve visibility of feedback and complaints processes
- Provide resources to clear incident review backlog and embed learning.

This is what the service did well:

- Staff showed commitment and teamwork despite challenges
- Governance arrangements and regular audits were in place
- Positive discharge and admission processes with good partnership working.

3. What we found

Quality of Patient Experience

Patient feedback

Responses to the HIW questionnaire were mixed. Both patients rated the care and service provided by the hospital as 'very good'. Other positive feedback included awareness of care plans, receiving accessible information, and having access to the right healthcare at the right time. However, both respondents raised consistent concerns about the physical environment, activities and food. One respondent reported feeling safe and appeared satisfied with care, while the other expressed serious safety concerns and dissatisfaction across multiple areas. The number of responses was, however, too low to determine any themes or trends.

Person-centred

Health promotion

We saw some examples of the clinic supporting patients to improve their health. Patients were encouraged to engage in health screening, and staff liaised with local GPs to ensure access to well-woman services. Long-term conditions such as diabetes were managed with input from specialist teams, and staff received annual training to support this. Health promotion materials were available, including smoking cessation resources and health conditions awareness, and patients could access online content with staff support.

However, there were significant concerns regarding the therapeutic environment. Both Clyne and Fendrod wards lacked access to green space and exercise facilities. This meant that patients without leave were confined to a small concrete courtyard, which was primarily being used for smoking. This lack of outdoor access, fresh air and physical activity opportunities was having a clear impact on the emotional wellbeing, motivation, and behaviour of the patients we spoke with. Multiple patients expressed frustration, with one commenting "*that they were being treated worse than prisoners in regard to facilities and resources*".

The health board must improve access to green space and exercise opportunities and look to enhance the physical environment with simple wellbeing features, such as benches and plants to support emotional and physical health.

During the inspection, patients were observed vaping in communal areas on Clyne Ward. In contrast, Fendrod Ward displayed clear 'no vaping' signage and no vaping

by patients was observed. This inconsistency presented potential risks to patient wellbeing and staff safety, and undermined efforts to maintain a healthy environment.

The health board must align practice on Clyne Ward with policy standards on vaping, including the display of appropriate signage, consistent staff reinforcement of the rules, and regular monitoring to ensure compliance.

Dignified and respectful care

Patients consistently told us they felt treated with dignity and respect by staff. Staff were observed to be kind, compassionate and professional in their interactions. Patients described staff as approachable, supportive and willing to listen, with one patient commenting that "*the strength of this place is the people.*" Staff were also seen to knock before entering bedrooms and support personal care needs in a sensitive way.

Patients had access to their own rooms and were able to personalise them with photos and belongings. Observation panels on bedroom doors were in place and used appropriately.

However, the environment did not always support dignified care, with a notable lack of private meeting spaces across some wards. On Clyne Ward, patients were observed meeting visitors in the main lobby, a busy area with frequent staff and patient traffic, offering little privacy. Additionally, there were no dedicated quiet rooms or private areas for confidential conversations or for patients needing time away from others. Patients were encouraged to meet visitors off the ward, but this was not always feasible for those without leave.

The health board must ensure that all wards provide appropriate private spaces for patient visits and confidential discussions, in line with the principles of dignified and person-centred care.

During the inspection, concerns were raised about the laundry provision on both wards. On Clyne Ward, staff and patients reported that the washing machine had been broken for several weeks. Even when operational, it was described as too small to meet the needs of the patient group and the frequency of use required. As a result, some patients were reportedly washing their clothes in the bath. Several patients expressed frustration, stating there was little point in washing or showering if they had to put dirty clothes back on afterwards.

On Fendrod Ward, patient clothing was sent off-site for laundering, but it was often not returned for up to seven days. There were also reports of clothing going missing during this process, which caused distress and inconvenience for patients.

These issues had a clear impact on patient dignity, hygiene, and wellbeing, and highlighted a lack of appropriate facilities to support basic personal care needs.

Our concerns were dealt with under our immediate assurance process. This meant that we wrote to the health board following the inspection issuing an immediate improvement plan requiring urgent remedial actions to be taken. Further details on the measures implemented by the health board are provided in Appendix B.

Individualised care
Staff and patients reported that the current model of acute care being delivered on both wards was unclear, with limited input from occupational therapy and psychology. This lack of therapeutic support affected both patient care and staff's ability to understand and manage patient needs.

Instead of a treatment-focused approach, the environment felt more like containment. We found that activity provision for patients was inconsistent. Although both wards had activity coordinators who were valued by patients, there was no structured activity schedule in place. It was reported that coordinators were often pulled into clinical duties, which reduced their ability to offer meaningful engagement. Patients reported feeling bored and unstimulated, which may contribute to low mood and behavioural issues.

Staff shortages made it difficult to support group leave, and both wards had to share one car, with no regular access to a van or bus. Even when patients had ground leave, the surrounding area was run-down and not therapeutic, and the isolated location made it hard for patients to stay connected with their communities.

The health board must provide assurance to HIW on how it will embed a clear, treatment-focused approach across both wards to deliver consistent, structured therapeutic interventions to patients.

Timely

Timely care
We found that patients generally received nursing and medical care in a timely and compassionate manner. Staff were observed responding appropriately to emotional distress and physical discomfort, and patients reported feeling adequately supported. Urgent care needs were well managed on the ward, although delays sometimes occurred when patients needed to be transferred elsewhere. We saw that staff worked hard to minimise these delays despite logistical challenges.

Equitable

Communication and language

We were told that staff used digital tools such as Teams and Signal to help patients stay in touch with families and professionals, especially when face-to-face contact was limited. Patients were encouraged to use their bedrooms for privacy during video calls, as space for confidential conversations was limited as mentioned previously.

Staff showed awareness of patients' language preferences. Staff were able to participate in Welsh language training and were encouraged to wear the 'Iaith Gwaith' badge to indicate they could speak Welsh. Recruitment processes included Welsh language considerations, and bilingual signage was observed throughout the buildings.

There was a wide range of information available to patients across both wards. Patients were given information leaflets on admission, and Clyne Ward had a helpful "who's who" board to support orientation. However, we advised that information about HIW should also be displayed so patients know how to contact us if required.

Rights and equality

We found that both wards had systems in place to promote equality and protect patients' rights, but some improvements were needed. Staff had completed Equality, Diversity and Inclusion (EDI) and anti-racism training, and both wards followed health board policies aimed at preventing discrimination. Staff were aware of the importance of using preferred names and pronouns.

Fendrod ward demonstrated good practice by providing tailored support for patients with visual or hearing impairments, using translation services including Language Line and university-based interpreters, and offering access to advocacy, housing, and wellbeing services. Clyne Ward also made efforts to support patients with sensory impairments and used translation services when needed. Advocacy services were available weekly on both wards, helping patients feel involved in their care and empowered to express their views.

However, both wards faced challenges in supporting patients with mobility issues. For example, Clyne Ward was particularly unsuitable for patients with mobility needs, with steps leading to showers and outdoor areas, no disabled toilets or wet rooms, and a bath that was inaccessible without a hoist. Fendrod Ward also had stairs leading to the ward and to the outdoor space. We were told that patients with mobility issues would typically be accommodated on Ward F in Neath Port Talbot Hospital, which offers ground-level facilities and improved ease of access.

The health board must continue to prioritise placement of patients with mobility needs in Ward F, given its accessible facilities. Action should also be taken to further improve accessibility within the clinic to reduce the challenges faced by patients with reduced mobility.

There were also concerns about the placement and support of transgender patients, with staff reporting a lack of clear guidance, especially considering recent legal rulings.

The health board must provide clear, practical guidance on supporting transgender patients, including placement decisions, and communicate this appropriately with staff.

Delivery of Safe and Effective Care

Safe

Environment
We found that the environments of both wards were not fit for purpose, lacking the qualities expected of a modern inpatient mental health service and therefore, did not support safe, dignified, or therapeutic care. This aligned with a recent Assurance Assessment undertaken by NHS Wales Performance and Improvement which noted that the environment did not demonstrate a good quality or safe experience for either patients or staff.

Across both wards, there were significant concerns about the physical condition of the buildings. Flooring was damaged and patched with hazard tape in places, radiators were rusty, and mould was present in some shower areas and ceilings. Fixtures such as kitchen surfaces were broken or worn, and some areas had visible signs of disrepair, including duct tape on worktops and writing on walls. These issues had been longstanding, with similar concerns raised in previous inspections in 2019 and 2022.

Senior managers outlined a programme of investment and improvement work that had been agreed for Tawe Clinic. However, it was reported that the work had been due to start but had been delayed. Given the severity and persistence of the issues, it is essential that this work begins without further delay.

The health board must provide HIW with an update on progress for the programme of improvement work agreed for Tawe Clinic.

Risk management
We saw that ligature risk assessments had been carried out across both wards. We noted that part of the planned environmental improvements included work to reduce ligature risks, which reinforces the need for this work to begin as soon as possible to support patient safety.

We noted that ligature cutters were available on both wards; however, we had some concerns regarding how they were stored. On Clyne Ward, two cutters were kept in a drawer alongside unrelated items, such as vapes, which made them difficult to locate quickly during an inspection. On Fendrod Ward, the cutters were stored loosely on the resuscitation trolley, which could pose a safety problem if the trolley is needed for a medical emergency. We discussed these concerns with staff, who suggested that the cutters could be mounted on the wall in a designated, secure location.

The health board must review and standardise the storage of ligature cutters at the clinic to ensure they are easily accessible, visible, and separate from unrelated items to improve emergency response times.

One patient who responded to the HIW questionnaire said that they felt safe at the clinic. However, the other patient said they did not feel safe, and said:

> *"I nearly got bladed – in own bedroom and quiet room. Got away."*

Although we cannot verify the validity or circumstances surrounding this comment, any suggestion of violence or threat to patient safety raises serious concerns.

The health board must provide assurance to HIW on how it is maintaining a safe and secure environment for patients, particularly in areas with limited supervision.

During the inspection, concerns were raised about a shortage of essential keys for staff working on Clyne Ward. This included limited staff access to observation panel keys, bedroom door keys, and call alarm keys. Nurses were required to carry two separate sets of keys, and it was reported that all staff could access the medication room, which could present additional risks. The shortage of keys not only impacts operational efficiency but also posed a potential safety risk with a lack of immediate access to critical areas or equipment during emergencies. It was reported that the issue had potentially already had serious implications, as it may have contributed to a delayed response to a ligature incident on Clyne Ward, which remained under investigation at the time of the inspection.

Our concerns were dealt with under our immediate assurance process. Further details on the measures implemented by the health board in response are provided in Appendix B.

Staff on both Fendrod and Clyne wards reported difficulties due to the absence of a designated seclusion or Extra Care Area (ECA). This lack of space made it challenging to safely de-escalate situations while maintaining patient dignity. One incident on Clyne Ward involved a prolonged three-hour restraint in a corridor, during which staff had to cover windows to protect the patient's privacy. Such situations highlighted the need for a dedicated, safe space to manage patients safely and respectfully and to maintain dignity. We also discussed as a team whether admission screening could be strengthened to identify patients who may require a higher level of psychiatric care. One such patient was later transferred during the inspection, but a tightened assessment could have potentially prevented this.

The health board must provide assurance to HIW on how it will ensure access to a safe, controlled and dignified environment for managing patients during periods of acute distress or heightened risk.

Infection, prevention and control and decontamination
We saw some governance arrangements in place; an IPC lead had been appointed and there was good compliance with mandatory IPC staff training. There was also evidence of audits being undertaken and cleaning schedules being maintained. However, it was clear that the overall environment did not support effective cleaning. Areas of flooring were damaged, kitchen units and worktops were worn, and shower rooms were in urgent need of refurbishment. Issues such as mouldy grouting, rusty vents, and broken fixtures were repeatedly observed. These defects made effective cleaning difficult and increased the risk of cross-infection.

It is hopeful that the programme of improvement work will resolve some of these issues. However, we also found issues, such as items being stored on the floor of both clinic rooms, which hindered effective cleaning.

The health board must review everyday practices (outside of the programme of improvement work) to ensure they meet appropriate IPC standards, such as items suitably stored and not obstructing cleaning.

We were told by staff that estates requests linked to IPC have been outstanding for months, which further compounded risks. Without urgent action, these issues will continue to compromise patient safety.

The health board must ensure that IPC-related estates issues are resolved in a timely manner to prevent prolonged exposure to infection risks.

Safeguarding of children and adults
Appropriate safeguarding arrangements appeared to be in place. We saw reportable incidents discussed in quality and safety committee assurance reports. Staff were supported by the central safeguarding team. Staff had completed relevant training and were knowledgeable about safeguarding procedures and their roles and responsibilities. Safeguarding policies were accessible via the intranet. Patients told us they would speak to the nurse in charge if worried.

Safeguarding concerns were being managed appropriately, with referrals discussed by the multidisciplinary team (MDT) and recorded on Datix. Recent referrals had followed correct procedures, and oversight was maintained by senior staff. Learning from safeguarding investigations was shared through meetings and emails. However, we found limited awareness among staff about the whistleblowing process, which could hinder reporting of serious concerns.

The health board must strengthen staff understanding of the whistleblowing (Raising Concerns) policy to encourage reporting of serious issues.

Management of medical devices and equipment
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.

However, during the inspection we found expired items in service. An oxygen cylinder and defibrillator pads were out of date, and although replacements had been ordered, the expired items had not been promptly removed. This posed a potentially significant risk in time-critical emergencies. Further information on how this issue was resolved is provided in Appendix A.

The health board must enforce immediate removal and replenishment of expired emergency items during weekly checks.

We were also concerned about the arrangements in place to monitor Immediate Life Support (ILS) training compliance among staff. At the time of the inspection, only 40% of nurses on Clyne Ward were up to date with ILS training. When we reviewed upcoming rotas, we identified a night shift where neither nurse scheduled to work held valid ILS certification. There was also no system to monitor the training status of bank or agency staff, meaning their compliance was unknown. This meant we could not be assured that patients would receive adequate intervention in a medical emergency.

Our concerns were dealt with under our immediate assurance process. Further details on the measures implemented by the health board in response are provided in Appendix B.

Medicines management
We found that medicines were generally managed safely and effectively on both wards. Controlled drugs were administered and recorded correctly, with regular stock checks carried out by nursing staff and pharmacy teams. Medicines, including controlled drugs, were stored securely in locked cupboards, trolleys, and fridges, and keys were kept safely. However, we did identify some gaps in the fridge temperature monitoring logs, which could affect the integrity of medicines if not addressed.

The health board must ensure staff maintain accurate temperature records to protect medicine quality and patient safety.

Both clinic rooms were very small and lacked adequate storage space. We were told that the planned improvement programme included relocating these rooms to resolve this issue.

We reviewed a sample of electronic Medication Administration Records (MAR charts) and found they were maintained to a good standard, with clear documentation of administration and reasons for any missed doses. However, the electronic system did not include a field for recording patients' legal status and could not store or link consent to treatment certificates (CO2/CO3) or individualised medication plans. These documents were kept in paper folders on the wards, meaning staff had to cross-reference manually, which increased the risk of delays or errors.

The health board should update the electronic prescribing system to include legal status and allow consent certificates and individualised medication plans to be uploaded and linked.

Patients were involved in decisions about their medication during ward rounds and had opportunities to speak with pharmacists. PRN medication was reviewed weekly, and rapid tranquillisation, when used, was monitored in line with policy. Medicines management policies, including those for controlled drugs and rapid tranquillisation, were up to date and easily accessible to staff.

Effective

Effective care

Overall, staff demonstrated commitment to patient safety and were knowledgeable about managing challenging behaviour. During the inspection, we observed staff responding effectively to a series of difficult incidents.

We were told that work was underway to introduce and embed the Safewards model, which aimed to reduce violence and aggression through structured interventions. Care plans were generally well-developed, incorporating safety strategies and proactive measures tailored to individual patients. These plans reflected collaborative working and patient involvement where possible.

We discussed earlier in the report how limited access to therapeutic activities and exercise, combined with minimal psychology input and the inability to provide escorted leave, was having a negative impact on patient wellbeing. These restrictions increased the risk of agitation and challenging behaviour, which in turn placed additional pressure on staff and heightened the likelihood of restrictive interventions. Despite these challenges, it was positive that restrictive practices,

such as physical restraint appeared to being used only as a last resort, following attempts at de-escalation, distraction, and increased observation.

Staff had completed relevant violence and aggression training, which emphasised de-escalation techniques and safe intervention. Incidents were being recorded appropriately through Datix and clinical documentation. However, staff reported limited time and resources to provide comprehensive debriefs for patients and staff, which may have reduced opportunities for learning and emotional recovery after incidents.

The health board must allocate time and resources to enable structured debriefs with patients and staff following incidents.

Staff generally reported having sufficient time to deliver safe care and keep care plans and risk assessments up to date, although they acknowledged that accommodating daily one-to-one sessions with patients could be challenging. Staff felt supported within the MDT, describing collaborative working as professional and respectful.

Nutrition and hydration

We saw that the nutritional and hydration needs of patients were being assessed and documented on admission using recognised screening tools. However, it was clear that access to specialist support was limited. Staff reported slow access to Speech and Language Therapy and Dietetics through referrals, and in some cases had to pressure external hospitals for soft diets without dietitian approval. Without input from specialists, this may result in unsuitable dietary interventions and inconsistency in care standards.

The health board should develop guidance to help staff safely meet the nutritional and hydration needs of patients while awaiting specialist input.

It was also clear that patients faced significant limitations in accessing varied, nutritious, and individualised food options on both wards. Patients described repetitive meals, often chips or jacket potatoes, with little variety or healthy options, such as salads. Patients told us they had complained about the food but felt that this had not been acted upon. Many patients reported using personal funds to obtain alternatives and relying on food delivery apps. One patient told us they often went without meals because they had run out of money to purchase their own.

The health board must review and improve the food provision offered to patients to ensure patients have access to varied and healthy quality meals, and ensure no patient goes without food due to financial restraints.

We were told that food was prepared and delivered to each ward by the hospital's hostess service. However, staff from the hostess service left after delivery, requiring ward staff, untrained in food hygiene, to serve meals to patients. This diverted clinical staff from patient care and increased the risk of contamination, compromising patient safety.

The health board must liaise with the hostess service to ensure all staff involved in food service are trained in food hygiene, reducing risk and allowing ward staff to focus on clinical duties.

On Fendrod Ward, patients had access to a dedicated kitchen and fridge-freezer, allowing them to store food and prepare light snacks or meals independently. In contrast, the patient kitchen on Clyne Ward was locked and unavailable due to safety concerns in relation to broken furniture and fittings. Patients on Clyne Ward had to request staff assistance to prepare light snacks or meals using the staff kitchen facilities.

The health board must refurbish the kitchen on Clyne Ward and, in the interim, explore safe options to improve patient access to kitchen facilities to promote independence.

Patient records

Patient records were being maintained via paper and electronic formats. Records were stored securely, easy to locate, and accessible. During the inspection we reviewed a sample of four patient records (two from each ward). They were easy to navigate, with relevant sections clearly identified. Care and treatment plans were clear, comprehensive, and aligned with the Mental Health Measure domains. We also saw clear evidence of patient involvement in the care and treatment planning process. Further information on our findings is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Mental Health Act monitoring

We reviewed the statutory detention documentation for four patients at the clinic. Three records were compliant with the Mental Health Act (MHA) and the Code of Practice for Wales. However, one patient did not receive a Hospital Managers' Hearing within the required statutory timeframe. This failure represented a significant breach of the safeguards intended to protect patient rights and raised concerns about the lawfulness and appropriateness of the patient's continued detention. Our concerns were dealt with under our immediate assurance process. Further details on the measures implemented by the health board in response are provided in Appendix B.

While investigating this incident with staff, it was established that the patient's latest admission followed multiple transfers between NHS hospitals and independent facilities in England and Wales. The services used both paper and electronic record keeping systems, which made it difficult to track statutory paperwork.

The Health Board must implement a robust system to ensure original legal documentation is tracked and maintained during patient transfers and admissions to help prevent similar breaches.

Overall, Mental Health Act (MHA) documentation was well organised and securely stored within the MHA office, making it easy to navigate. However, on the wards, paper copies of MHA documentation were held within general patient case notes, which made identifying key legal information more difficult. The Health Board should consider whether improved organisation of ward-held documents would support timely access to essential information and strengthen compliance.

Training in the Mental Health Act was not mandatory within the Health Board. While some training was available for overseas nurses and new doctors, there was no evidence of a structured programme for staff during induction or as part of ongoing updates. This gap increased the risk of staff being unaware of their responsibilities under the Act.

The Health Board must improve its provision of MHA training for all relevant staff, ensuring it forms part of induction and ongoing professional development.

We saw evidence that Section 17 leave forms were being completed appropriately, with conditions clearly stated and risk assessments documented. However, none of the patients had signed their leave forms, and there were no recorded reasons for this. While signatures are not a legal requirement, they are considered good practice as evidence of patient involvement. Staff should record refusals or reasons for non-signature to demonstrate patient engagement and transparency.

Governance arrangements and audit processes were in place and appeared robust, but the missed Hospital Managers' Hearing indicated that learning from audits was not fully embedded.

The Health Board must review its current audit processes to ensure they effectively identify and address gaps in compliance with statutory requirements, such as Hospital Managers' Hearings.

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

We were told that the health board had recently started undertaking 'pseudo HIW visits' to help identify areas for improvement with their services. We reviewed a report from a recent visit to Tawe Clinic, and noted several improvements were identified in relation to the quality of nursing documentation. It was positive that our review of patient records showed progress in several aspects of the care planning documentation since that visit. We found comprehensive entries that supported continuity of care. Risk assessments, particularly those completed using the Wales Applied Risk Research Network (WARRN) tool, were detailed and demonstrated a strong focus on patient safety. These assessments included mitigation strategies, which helped reduce potential harm and supported informed clinical decision-making.

Care and treatment plans generally adhered to the Mental Health Measure (Wales) 2010. They were structured around its domains and included goals for recovery and rehabilitation. In most cases, these goals were realistic and measurable, providing patients and staff with a clear direction for treatment. Safety plans were also well documented and reflected patient preferences, showing evidence of discussions about how individuals wished to be cared for. This approach promoted person-centred care and enhanced patient engagement.

Physical health monitoring was evident across the records. Assessments such as nutrition screening, mobility checks, and wound care were completed, and weekly NEWS observations were recorded. Where necessary, ward doctors referred patients to specialist services, and there was evidence of access to external appointments. These measures helped maintain patients' physical wellbeing alongside their mental health needs.

Efficient

Efficient

We saw clear arrangements for discharge and admission of patients out of and into community services. However, we were told of occasions where the local authority had difficulties allocating social workers promptly for S117 meetings. Addressing these delays is important to reduce uncertainty for patients and families and to minimise the risk of unnecessary reattendance to mental health services.

Quality of Management and Leadership

Leadership

Governance and leadership
During the inspection, we acknowledged the significant transition and scrutiny that acute mental health inpatient services had experienced within the health board. This included previous HIW inspections, internal assurance assessments, and an independent review. These processes had highlighted longstanding challenges in the environment and service delivery.

In response to urgent safety concerns, the health board had recently launched its Mental Health Transformation Programme. The programme's stated aim was to redesign and modernise adult and older persons' mental health care across the health board, which we considered a positive and necessary step. However, despite these intentions, we noted that environmental issues previously identified at Tawe Clinic in 2019 and again in 2022 remained unresolved. This demonstrated that progress had been slow and that urgent decisions were now required to ensure the future model of mental health services reflected the standards expected of a modern, safe, and therapeutic inpatient environment.

The health board must take action to address and fully implement the environmental improvements needed following previous inspections in 2019 and 2022, in addition to those found during this inspection.

Staff we spoke with during the inspection demonstrated commitment to patient care and were receptive to our feedback, despite working within operational limitations. However, it was disappointing that we received no responses to our HIW staff questionnaire. Conversations with staff revealed a common perception that they did not feel valued by the health board. Several described themselves as part of a "forgotten service," citing ongoing environmental concerns and a lack of visible progress in addressing these issues. These perceptions risk undermining staff morale and retention.

The health board must take proactive steps to rebuild staff trust within Cefn Coed and demonstrate that their concerns are being heard and acted upon.

Governance arrangements appeared appropriate across both wards, with regular meetings and oversight processes in place to monitor patient care and identify improvements. We observed positive teamwork and collaboration across disciplines.

However, we found that several key policies, such as the Respect and Resolution Policy, Safe and Supportive Observations Policy, and Recruitment and Retention Policy, were out of date.

The health board must review any out-of-date policies and procedures and update them as appropriate, to help staff provide safe and effective care and share with staff once ratified.

Workforce

Skilled and enabled workforce

Our findings reflected those of the recent assurance assessment, which highlighted persistent workforce challenges. Reported staff shortages and reliance on temporary staff, such as bank, agency nurses and newly recruited nurses had created an inexperienced workforce. Staff reported that they were not receiving the mentoring and support they needed, and the high acuity of patients, particularly on Clyne Ward, had contributed to increased staff absences and requests from international staff to move.

Frequent use of temporary staff, often unfamiliar to patients, appeared to increase patient incidents as individuals felt unsafe and unsettled. Staff reported that daily requests for additional staff were time-consuming and draining, and some were concerned to attend work due to a perceived poor skill mix. We noted the positive development of a business case to increase staffing levels and Band 6 provision, but this must be implemented safely with an appropriate skill mix.

The health board must review the staff establishment and staffing model at the clinic to ensure a safe skill mix is maintained to improve care delivery and support staff wellbeing.

Although we observed staff supporting each other during incidents across wards, this highlighted the risk of insufficient staff to manage emergencies safely within their own ward. We have discussed earlier in the report that some patients have been unable to take granted escorted Section 17 leave due to staff shortages, impacting emotional well-being. Any refusal or Section 17 leave, for whatever reason, contradicts the guiding principles set out in the Mental Health Act Code of Practice for Wales. We spoke with staff about the importance of monitoring incidents of each type to monitor their frequency and potential impact on patients.

The health board must ensure staff record and monitor the incidences where staff must attend other wards to provide support, leaving their own ward temporarily short staffed, and any incidents where patients are unable to take

Section 17 leave. The health board must also consider whether an increase to the staffing establishment is needed to always maintain staff and patient safety and determine whether there is an impact on therapeutic care.

We have previously identified the lack of psychology capacity available to support the clinic, which, given the complexity of the patient group, remains an unmet need likely to affect recovery and emotional well-being. Staff appeared keen to train and learn and would also benefit from additional psychology capacity to deliver group sessions such as emotional regulation.

The health board must explore options to increase psychological input and develop structured interventions that support both patient recovery and staff development.

We noted that compliance with mandatory training was stronger on Fendrod Ward compared to Clyne Ward, although both wards required further improvement to meet expected standards. Low compliance with Personal Annual Development Reviews (PADRs) was also a concern, with only 47% completion on Fendrod Ward and 70% on Clyne Ward.

The health board must ensure staff are allocated protected time for supervision, appraisals, and training, to support professional development and reflective practice.

Newly qualified staff to the clinic benefited from preceptorship to receive support and guidance during their period of transition to the clinic. However, while an induction booklet was in place for other permanent staff, we did not see evidence that this was always being completed.

The health board must improve the consistency and implementation of the induction process to help ensure staff are well-prepared for their roles, promote safe practice, and support workforce stability.

Culture

People engagement, feedback and learning

Patient feedback was sought through service user surveys undertaken by the health board. The responses we reviewed included positive comments about the care patients received at the clinic. Patients were also able to speak with the patient advisory team and their key worker when needed, which reflected good practice.

However, other feedback routes were limited. Suggestion boxes were not available on the wards, reducing opportunities for patients to share concerns anonymously.

This may discourage patients who felt uncomfortable from raising issues, meaning some problems could have gone unreported. The health board may wish to consider introducing suggestion boxes to provide an additional, discreet way for patients to share their views.

We did not see clearly displayed information on either ward about how patients or families could provide feedback. During the inspection, a family member reported they did not know who to contact or how to give feedback, and no guidance was visible in family visiting areas. There were also no leaflets or signage for the NHS Wales 'Putting Things Right (PTR)' process, which explains how to make formal complaints. Although this information was included in admission booklets, its poor visibility meant patients and families were unlikely to access it when needed.

The health board must ensure patients and visitors know how to, and are able to provide feedback about the ward, and how to make a complaint via the PTR process and ensure this is more visible and accessible to all patient and families, in addition to the ward information leaflet.

Learning, improvement and research

Quality improvement activities

We found that regular audit activities were taking place with support from the Audit Management and Tracking (AMAT) system, which helped monitor compliance effectively. A recent 'pseudo HIW visit', referenced earlier in this report, identified several areas for improvement and was regarded as a positive step towards strengthening governance and patient safety. We considered that this type of exercise would be beneficial if extended across the health board and other services to promote consistent standards and continuous learning.

We were informed that limited capacity and staffing resources were affecting the ability of ward managers to review and manage patient safety incidents promptly. At the time of our visit, there was a backlog of approximately 150 incidents awaiting review on Datix for Clyne Ward. Although managers applied prioritisation to ensure higher-risk incidents were addressed first, delays in reviewing other incidents created a risk that improvement are not made in a timely manner and sharing important lessons could be missed. This could potentially compromise patient safety and the quality of care delivered.

The health board must ensure ward managers have sufficient time resource to review, investigate and close incidents in a timely manner, to reduce the current backlog, prevent delays in addressing incidents, identify lessons learned and help embed a culture of safety and continuous improvement.

Whole-systems approach

Partnership working and development

We found that discharge and admission processes were generally clear and well-structured, with staff working collaboratively with families, community mental health teams, and advocacy services to support safe transitions.

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 the inspection we found expired items in service. An oxygen cylinder and defibrillator pads were out of date.	This posed a potentially significant risk in time-critical emergencies of using the expired items.	This was reported immediately to senior managers during the inspection.	We were told that replacements had already been ordered and staff arranged to immediately remove the expired items to remove confusion. Staff were also reminded of the requirement to remove expired items once identified in future.

Appendix B – Immediate improvement plan

Service: Tawe Clinic

Date of inspection: 06, 07 and 08 October 2025

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

Findings

HIW was not assured that the current key management procedures were sufficiently robust to uphold patient safety. This was because there was a reported shortage of essential keys for staff working at Clyne Ward. This included observation panel keys, bedroom door keys, and call alarm keys. Such shortages compromise staff's ability to respond promptly to incidents which pose significant safety, operational, and clinical risks. This practice has already had a potential impact, with key availability possibly contributing to a ligature incident, which remains under investigation. Additionally, it was reported that all staff could access the medication room which raised concerns around controlled access and accountability. Nurses were also required to carry two sets of keys which increased the risk of misplacement or delayed response during emergencies.

We were told that ward staff had repeatedly reported and escalated their concerns over the shortage of keys. We noted that action was taken immediately during the inspection, with a replacement lock installed on the medication room and additional keys purchased. However, it is concerning that action had not been taken to resolve these issues immediately once staff had raised their concerns or following the ligature incident with the shortage of keys being a potential contributing factor.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	HIW requires assurance on the implementation of a	Delivery of Safe and Effective	The service has created additional sets of ward keys which are	Ward Manager	Complete

	sustainable and sufficient key management system which will ensure all staff have timely access to necessary keys at all times on both wards.	Care – Risk Management	allocated during handover at the start of each shift.		
			The service has ordered additional keys for the observation windows, the alarm reset and master keys. All observation and room keys have been replaced to ensure there is a set of keys for staff members working on shift.	Ward Manager	Complete
			The service has developed a sign in and sign out process. The nurse in charge will check that keys are allocated per shift and the process has been followed.	Ward Manager	Complete
			The service has changed the lock on the clinical dispensary room. The medication nurse has access to the key, and the Ward Manager has an additional spare key.	Ward Manager	Complete
			The service is developing a Key Management Standard Operating Procedure. This will be presented for sign off and ratification at the Policy Review Group in November. Audit and assurance will be included. In the interim the key sign in - sign out process described above has been implemented.	Associate Service Group Director	20/11/25

2.	HIW requires a clear account of why the key shortage issue, despite posing an immediate risk to patient safety, was not addressed sooner, and requires assurance on how immediate and significant risks to patient safety will be prioritised and resolved promptly and effectively in future.	Delivery of Safe and Effective Care – Risk Management	This had been escalated by the Ward Manager and added to the capital programme of works which was scheduled for the end of October. The Ward Manager had put in place an interim measure to ensure that the staff member responsible for observations had access to keys required.	Ward Manager	Complete
			An Escalation Process will be developed to ensure immediate actions are implemented where environmental and clinical risks are identified.	Head of Operations	20/11/25
			Immediate assurance can be provided that keys are available for every member of staff on shift, including observation panels and rooms.	Ward Manager	Complete
			There is a key log now in situ which requires the keys to be signed in and signed out for use on the shift which is signed by the staff member and counter signed by the nurse in charge.	Ward Manager	Complete
			The service will utilise the DATIX system to report any future loss of keys to ensure timely investigation and replacement if required. This has been communicated to all ward staff.	Directorate Leads	Complete

Findings

HIW was not assured by the current laundry arrangements in place at the clinic, which presented clear risks to patient dignity, hygiene, and wellbeing. On Clyne ward, it was reported that the washing machine has been broken for several weeks. When operational, the machine was of an inappropriate size to meet the needs of the patient group and the frequency of use required. In the absence of a functioning facility, patients have reportedly resorted to washing their clothes in a bath. Patients also expressed that there was little point in washing or showering, as they were required to put on dirty clothes afterwards — a situation that undermines basic standards of care and dignity.

On Fendrod ward, patient clothing is sent off-site and potentially not returned for up to seven days, with reports of items going missing. This delay and lack of reliability in returning personal belongings further compounds the issue, potentially impacting patients' mental health, sense of autonomy, and trust in the service.

Personal hygiene and access to clean clothing are fundamental to both physical and psychological wellbeing. The lack of timely and reliable laundry provision may also contribute to increased distress, reduced engagement in care, and heightened safeguarding concerns.

We acknowledge that plans are already in place for the provision of a new laundry room for Clyne Ward. However, is it unclear how this will improve the laundry provision for patients on Fendrod Ward.

During the inspection arrangements were also made to purchase a new like-for-like washing machine for Clyne Ward. However, this resolution appears unsustainable given the reported issues with the previous washing machine being unable to handle the required volume of washing.

Improvement needed		Standard/ Regulation	Service action		
3.	HIW requires assurance on how the health board will ensure its laundry facilities and provision will meet the	Quality of Patient Experience - Dignity	The service has procured a new washing machine for Clyne.	Divisional Manager	Complete
			The washing machine will be installed by the 31 October.	Directorate Team and Estates Team	31/10/25

	needs of its patients and uphold dignity and hygiene standards. This should include consideration of turnaround times and tracking of patient belongings for Fendrod and alternative options to using the small washing machine on Clyne.		The service has provided patients on both wards, with the option of utilising a laundrette as an interim offer to ensure patients are able to have fresh clothing. This was reaffirmed and communicated to all inpatients within Tawe Clinic.	Ward Manager	Complete
			Within the capital programme of works for Tawe Clinic there will be a new laundry room accessible for both wards, which will meet IPC standards, including an industrial washing machine.	Capital Planning Team	31/03/26

Findings

HIW was not assured by the current arrangements in place at the clinic for monitoring Immediate Life Support (ILS) training compliance among staff. At the time of the inspection, only 40 percent of nurses were up to date with ILS training on Clyne Ward. This falls short of expected standards for inpatient mental health care. This is particularly concerning given the acuity of the patient population and the potential for medical emergencies on the wards.

Our review of upcoming rotas identified a night shift on Clyne Ward during which neither of the nurses scheduled to work held valid ILS certification. In addition, there was no oversight of ILS compliance among bank and agency staff, and no system in place to monitor or verify their training status. This lack of visibility and governance meant we could not be assured that appropriately trained staff are present on every shift which could result in delayed or inadequate intervention, placing patients at serious risk of harm.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	
4.	HIW requires assurance on how staff compliance with	Delivery of Safe and Effective	The service has undertaken a roster review to ensure there is a staff	Ward Manager and Lead Nurse	Complete

	ILS training can be improved in a timely manner to ensure enough ILS-trained staff are present on each shift.	Care - Resuscitation	member on each shift who is ILS trained.		
			The service has booked all staff onto a training session for ILS. There are 9 staff requiring training across Tawe Clinic.	Ward Manager	Complete
			The remaining 9 staff have been allocated the earliest available training dates.	Ward Manager	23/01/26
5.	HIW requires details on how the health board will obtain assurance that bank and agency staff are compliant with ILS training and other training deemed necessary to work at the clinic.	Delivery of Safe and Effective Care - Resuscitation	The agency used by the Health Board is on an All-Wales Framework which includes checks on the staff members training including ILS. All Bank Staff are ILS trained with an audit and monitoring process already in place, which prevents staff booking for shifts if non-compliant with the necessary training requirements.	Bank Manager	Complete
6.	HIW requires assurance on how oversight of ILS compliance will be monitored and what escalation protocols will be put in place where appropriate ILS coverage cannot be guaranteed.	Delivery of Safe and Effective Care - Resuscitation	The service has developed a training compliance log for unscheduled care, which includes a rolling programme to avoid staff training compliance expiring.	Ward and Directorate Team	Complete
			The service has identified areas where compliance is due to decrease so training can be scheduled, preventing compliance expiring.	Ward Team and Directorate Team	Complete

Findings

HIW was not assured by the governance and oversight arrangements in place to ensure timely compliance with the Mental Health Act. During our review, we identified that one patient had not received their managers' hearing within the required timeframe. This delay raises serious concerns about the legal safeguards underpinning the patient's detention and could potentially call into question its appropriateness and lawfulness.

It was positive that the Mental Health Act administrator undertook an immediate review of all outstanding Mental Health Act hearings to ensure compliance with statutory timeframes, and we were assured that the instance we identified was the only one outstanding.

Improvement needed		Standard/ Regulation	Service action		
7.	HIW requires assurance on actions taken since the inspection to confirm when the manager's hearing will be held and on how the patient will receive appropriate support through the process given their lack of capacity to consent.	Delivery of Safe and Effective Care – Mental Health Act	Hospital Manager's hearing was arranged immediately.	Mental Health Act Team	Complete
			Hospital Manager's hearing for identified patient will be held on 5/11/25.	Mental Health Act Team	05/11/25
			The Responsible Clinician provided a capacity statement for the patient in relation to understanding the hospital manager process.	Mental Health Act Team	Complete
			The patient has been referred to Advocacy Support Cymru.	Mental Health Act Team	Complete
			The patient has been offered support throughout this process. This has included information and explanation of the Hospital Manager's hearing process, their legal rights, and an easy read	Mental Health Act Team	Complete

			information leaflet. The IMHA will also be supporting the patient with this.		
			The patient's Nearest Relative has been written to and informed of the relevant information required of them.	Mental Health Act Team	Complete

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): **Michelle Forkings**

Job role: **Nurse Director for Mental Health and Learning Disabilities**

Date: **15 October 2025**

Appendix C - Improvement plan

Service: Tawe Clinic

Date of inspection: 06, 07 and 08 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.	There were significant concerns regarding the therapeutic environment, with both wards lacking access to adequate green space and exercise facilities.	The health board must improve access to green space and exercise opportunities and look to enhance the physical environment with simple wellbeing features such as benches and plants to support	Health promotion	The service will increase the exercise opportunities available to the patients across Tawe Clinic. The wards will co-produce a list of activities that the patients would like to engage with and strengthen a structured, scheduled activity plan.	Tawe Clinic MDTs	28/02/26
				The improvement works on Tawe Clinic include the improvement of the outside space. This includes new fixed furniture, planters and painting of the garden area with a mural within the Clyne Garden.	Assistant Director of Estates and Associate Service Director MH	31/03/26

		emotional and physical health.			(Project Board Lead)	
2.	During the inspection, patients were observed vaping in communal areas on Clyne ward.	The health board must align practice on Clyne Ward with policy standards on vaping, including the display of appropriate signage, consistent staff reinforcement of the rules, and regular monitoring to ensure compliance.	Health promotion	Signage is now on ward with reinforced compliance through conversations and community meetings. Compliance is discussed within MDTs if there are any concerns.	Tawe Clinic MDTs	Complete
3.	The environment did not always support dignified care, with a notable lack of private meeting spaces across some wards, and no	The health board must ensure that all wards provide appropriate private spaces for patient visits and	Dignified and respectful care	Tawe Clinic is undergoing a program of refurbishment. This refurbishment includes the repurposing of rooms, creating additional rooms where meetings and patient intervention can be offered in quiet and private areas.	Assistant Director of Strategic Capitol Planning and Associate Service Director MH	30/11/26

	dedicated quiet rooms or private areas for confidential conversations or for patients needing time away from others.	confidential discussions, in line with the principles of dignified and person-centred care.		Staff and patients are encouraged to use alternative areas, such as the family room, the OT hub and community settings where appropriate in the interim.	(Project Board Lead)	
4.	Both wards faced challenges in supporting patients with mobility issues.	The health board must improve accessibility at the clinic by addressing physical barriers such as inaccessible bathrooms to ensure patients with mobility impairments can access facilities safely and with dignity.	Rights and equality	To ensure patients receive appropriate support, where accessibility or mobility concerns are identified, patients will be accommodated on Ward F, which offers ground-level facilities and improved ease of access.	Adult MH directorate leads	Complete
				Clyne Ward's refurbishment includes the repositioning of toilets and showers to ensure these are accessible for patients with mobility issues.	Assistant Director of Strategic Capitol Planning and Associate Service Director MH (Project Board Lead)	30/06/26

5.	Staff reported a lack of clear guidance about the placement and support of transgender patients.	The health board must provide clear, practical guidance on supporting transgender patients, including placement decisions, and communicate this appropriately with staff.	Rights and equality	As a health board, we have withdrawn the Single Sex Occupancy Policy due to the recent Welsh Government announcement. A refreshed policy is required to provide clear guidance for staff. However, this policy refresh cannot take place until the new legislation is passed.	SBU Corporate Policy Leads & Service Group Director	30/6/26
				Transgender patients who require admission are admitted to Ward F. Ward F offers single occupancy with en-suite facilities in all rooms.	Adult Mental Health Directorate Leads	Complete
				Due to the delay in the availability of formal guidance, the Lead Nurse has provided an email communication to clinical staff, ensuring all staff are aware of the current plan, to use Ward F when transgender patients require admission.	Lead Nurse	Complete
6.	Across both wards, there were significant concerns about the physical	The health board must provide HIW with an update	Environment	The program of work has commenced, and it is divided into three phases. Phase 1 is due to be completed by mid-	Associate Service Director MH	Complete

	condition of the buildings, which were not fit for purpose and therefore did not support safe, dignified, or therapeutic care.	on progress for the programme of improvement work agreed for Tawe Clinic.		January and is currently progressing well against the target date. The program is mapped and anticipated to be fully completed by the end of November 2026.	(Project Board Lead)	
7.	We had some concerns regarding how ligature cutters were being stored on each ward.	The health board must review and standardise the storage of ligature cutters at the clinic to ensure they are easily accessible, visible, and separate from unrelated items to improve emergency response times.	Risk management	An urgent review was undertaken on both wards to ensure the ligature cutters are stored safely, easily accessible for staff, and all staff are informed of where they can access them in an emergency.	Ward Managers	Complete
				The Directorate team will review the standard operating procedure regarding the accessibility and storage of ligature cutters, to formalise the process as outlined above.	Adult Directorate Team Leads	31/01/26
8.	One patient said they did not feel safe at the clinic and suggested they	The health board must provide assurance to	Risk management	Tawe Clinic follows safeguarding procedures, safety plans and adapt observation levels where required in line	Ward MDTs	Complete

	had been threatened with violence.	HIW on how it is maintaining a safe and secure environment for patients, particularly in areas with limited supervision.		with risk management plans and care plans. Where necessary, onward referrals and police reports would be completed as required. Support is offered following any incident, and when required, this is documented in the notes. All patients are encouraged to meet with their named nurse regularly, creating an opportunity to discuss concerns and worries they may have. Both wards have weekly community meetings, and patients are encouraged to attend, giving opportunity to discuss concerns if they feel able to. Staff report incidents of violence & aggression through Datix. Datix incidents are		

				investigated, learning themes identified and discussed with the MDTs, and presented at the MH Divisional and service group Q&S forums.		
				Within the adult inpatient wards, Ward F is participating in the NHS Wales Performance and Improvement Safewards pilot. As this progresses, the initiative will be extended into Fendrod and Clyne Ward.	Lead Nurse for Adult USC	30/06/26
				The Tawe Clinic program of works includes a review and improvement of the CCTV and observation mirrors to further improve lines of sight and supervision. This work will be action throughout phase 2 & 3 of the programme of work, due for completion at the end of November 26.	Assistant Director of Strategic Capitol Planning and Associate Service Director MH (Project Board Lead)	30/11/2026
9.	There was no designated area on either ward to manage distressed patients safely and	The health board must provide assurance to HIW on how it	Risk management	We are continuing to work with Welsh Government to secure the permanent long term solution to improved environment for the acute	MH&LD Service Director	30/06/26 to have a firm plan with timelines.

	with dignity, sometimes resulting in prolonged restraint in unsuitable spaces like corridors.	will ensure access to a safe, controlled and dignified environment for managing patients during periods of acute distress or heightened risk.		adult mental health inpatient service.		
				Staff always adopt procedural and professional standards to support patients experiencing acute distress and increased risk within the current environment.	MH Divisional Team	Complete
				In the improvement programme of work, there will be an additional extra care room on Clyne.	Assistant Director of Strategic Capitol Planning and Associate Service Director MH (Project Board Lead)	31/03/26
10.	It was clear that the overall environment did not support effective cleaning. We also found issues such as items being stored on the floor of both clinic	The health board must review everyday practices (outside of the programme of improvement work) to ensure they meet	Infection prevention and control (IPC) and decontaminat ion	Wards have been reviewed, excess stock/boxes have been removed from floors, allowing for effective cleaning.	Tawe Clinic Ward Managers	Complete
				Audits via the AMaT system will be completed to monitor compliance.	Ward Managers, Lead Nurse for USC and	Complete

	rooms, which hindered effective cleaning.	appropriate IPC standards, such as items suitably stored and not obstructing cleaning.		Current performance on Fendrod Ward is 95% for the IPC core audit and bare below elbows is at 100%. Clyne Ward is 93% for IPC and bare below elbows is and 100%.	Lead Nurse for QI	
11.	We were told by staff that estates requests linked to IPC have been outstanding for months.	The health board must ensure that IPC-related estates issues are resolved in a timely manner to prevent prolonged exposure to infection risks.	Infection prevention and control (IPC) and decontamination	IPC/environmental audit via the AMaT system will be completed to monitor compliance and link actions to an action plan for the estates team.	Ward Manager, Lead Nurse for USC, Lead Nurse for QI and Assistant Director of Estates	31/01/26
				The Corporate IPC team complete annual IPC audit.	Corporate IPC Lead	30/6/26
12.	We found limited awareness among staff about the whistleblowing process.	The health board must strengthen staff understanding of the whistleblowing (Raising Concerns) policy to	Safeguarding of children and adults	Raising Concerns Policy will be shared via emails, and Guardian service and posters will be displayed on the ward.	Adult MH Directorate Manager	Complete
				Speaking up safely, the Raising Concerns policy, and the Guardian service will be a standing agenda item for staff meetings.	Ward Managers	31/01/26

		encourage reporting of serious issues.		The service group is currently reviewing the induction pack, and the Raising Concerns policy will be included. The draft will be presented to the Professional Nursing Forum on the 2/2/26.	Lead Nurse for QI	31/03/26
13.	We identified gaps in the fridge temperature monitoring logs.	The health board must ensure staff maintain accurate temperature records to protect medicine quality and patient safety.	Medicines management	An updated temperature log form has been created and currently being used. This includes a daily log by nursing staff and a weekly check completed by pharmacy technicians.	Ward Manager and MH Pharmacy Lead	Complete
14.	The electronic prescribing system did not include a field for recording patients' legal status and could not store or link consent to treatment certificates	The health board should update the electronic prescribing system to include legal status and allow consent certificates and	Medicines management Should be digital	HEPMA does not have the functionality to accommodate this, but it does have the functionality to alert staff that a C02/C03 is required, but this cannot be attached to the digital system. These are stored in the paper files in the clinical room to be reviewed with HEPMA chart. The paper files	Ward Manager and MH Pharmacy Lead	Complete

	(CO2/CO3) or individualised medication plans.	individualised medication plans to be uploaded and linked.		are audited during night shifts to ensure it correlates to the digital system.		
15.	Staff reported limited time and resources to provide comprehensive debriefs for patients and staff following incidents.	The health board must allocate time and resources to enable structured debriefs with patients and staff following incidents.	Effective care	A review of resources available has been undertaken by the directorate leads. The importance of comprehensive debriefs for patients and staff following incidents has been refocused to ensure priority and time is dedicated to this. The following is available for staff: TRiM support, managerial debrief, and Datix management reviews evidence that debriefs are captured. The psychologist at Tawe Clinic provides a reflective space once a month for staff called 'talk time'.	Professional Leads	Complete

				The ward managers cross-cover to provide staff teams with access to clinical supervision. The following is available for patients: MDT support, nurse support immediately.		
				The wider MDT are available to access for support following an incident; this offer will be widely shared across the teams.	Tawe Clinic MDTs	Complete
				Datix incident management review to include the informal support that has been provided.	Ward Managers, Clinical Leads and Lead Nurse USC	Complete
				Psychology to generate guidance regarding post incident support.	Psychology Lead for MH	28/02/26
16.	Staff reported slow access to Speech and Language Therapy and	The health board should develop guidance to	Nutrition and hydration	SALT input is currently provided on a case-by-case basis when requested by wards and cross-charged back to the division	MH Division Manager and Head of	31/3/26

	Dietetics through referrals.	help staff safely meet the nutritional and hydration needs of patients while awaiting specialist input.		when intervention is deemed required. SALT colleagues continue to pilot this and will report on their findings with a long-term solution. However, it is recognised that the current process is not timely for patients. Development of a pathway is required collaboratively between the Service Group and SALT, with the first meeting set for 19/1/26.	Nutrition and Dietetics	
17.	Patients described repetitive meals with little variety or healthy options such as salads. One patient told us they often went without meals because they had run out of money to purchase their own.	The health board must review and improve the food provision offered to patients to ensure patients have access to varied and healthy quality meals, and ensure no	Nutrition and hydration	Plan devised by the catering team to review the current menu offerings and introduce a rotating weekly menu with seasonal and dietary options.	Support Services Manager and Adult MH Directorate Manager	Complete
				The revised menu has been shared with the patient group for feedback and implementation.	Ward Managers	31/01/26

		patient goes without food due to financial restraints.				
18.	Ward staff, untrained in food hygiene, were serving meals to patients on both wards.	The health board must liaise with the hostess service to ensure all staff involved in food service are trained in food hygiene, reducing risk and allowing ward staff to focus on clinical duties.	Nutrition and hydration	It is recognised that the serving of meals by nursing staff is not ideal. The MH divisional team will work collaboratively with the catering service to ensure that catering is overseen by the catering service.	Support Services Manager and Associate Service Director	31/03/26
				Training required to for staff involved in food service has been identified to ensure they are appropriately trained in food hygiene. A rolling program of training to ensure all staff are compliant by the end of March 26.	Ward Managers and Support Services Manager	31/03/26
19.	The patient kitchen on Clyne Ward was locked and unavailable due to safety concerns in relation to broken	The health board must refurbish the kitchen on Clyne Ward and, in the	Nutrition and hydration	The patient kitchen on Clyne ward is open and the kitchen has been fixed. The kitchen is risk assessed to ensure patient and staff safety and this will adapt as required.	Ward team	Complete

	furniture and fittings.	interim, explore safe options to improve patient access to kitchen facilities to promote independence.		The patient kitchen will be refurbished within phase 2 of the programme of works.	Assistant Director of Strategic Capital Planning and Associate Service Director MH (Project Board Lead)	31/05/26
20.	We were told about the difficulties faced by the clinic in tracking and maintaining statutory paperwork during transfers.	The Health Board must implement a robust system to ensure original legal documentation is tracked and maintained during patient transfers and admissions to help prevent similar breaches.	Mental Health Act monitoring	There is a system in place to deal with any paperwork of transferred patients, which involves regular communication with the sending or receiving provider to ensure that the Mental Health Act Team are satisfied with the papers. All original legal documents should always be posted to the MHA Department, which will then advise ward staff when they are ready to be viewed and printed from the virtual drive for the patient's health record. Transfers are discussed in the daily meetings, and the chair of	Adult MH Directorate Manager and Mental Health Act Team Manager	Complete

				the meeting will inform the MHA team of the planned transfer. The MHA team will then lead on communication with the relevant MHA department.		
21.	There was no evidence of a structured programme of MHA training for staff during induction or as part of ongoing updates.	The Health Board must improve its provision of MHA training for all relevant staff, ensuring it forms part of induction and ongoing professional development.	Mental Health Act monitoring	The Learning and Development team will review the provision of MHA training, including availability for staff induction.	Learning and Development Team Manager and Mental Health Act Team Manager	31/03/26
				The MHA Team will provide bespoke training where there are concerns.	Mental Health Act Team Manager	Complete
22.	While audit processes generally appeared robust, the missed Hospital Managers' Hearing indicated that learning from audits was not fully embedded.	The Health Board must review its current audit processes to ensure they effectively identify and address gaps in	Mental Health Act monitoring	A representative lead from each division will work collaboratively with the MHA Team lead to review the current audit processes and revise them to ensure they are effective	MH HoN, Service Group representatives and Mental Health Act Team Manager	31/01/26

		compliance with statutory requirements, such as Hospital Managers' Hearings.				
23.	Environmental issues previously identified at Tawe Clinic in 2019 and again in 2022 remained unresolved.	The health board must take action to address and fully implement the environmental improvements needed following previous inspections in 2019 and 2022, in addition to those found during this inspection.	Governance and leadership	Outstanding actions will be reviewed in line with this action plan and in conjunction with the scheduled program of capital improvement works to ensure all identified work is included.	Assistant Director of Strategic Capital Planning and Associate Service Director MH (Project Board Lead)	31/01/26
				Ward Managers complete a Bi-Monthly environmental audit, which is uploaded to an operational team's channel for oversight. Further work with the operational team and estates team leads is required to ensure timely action of environmental issues is resolved.	MH Divisional Team Manager and Head of Operations	31/01/26

24.	Conversations with staff revealed a common perception that they did not feel valued by the health board. These perceptions risk undermining staff morale and retention.	The health board must take proactive steps to rebuild staff trust within Cefn Coed and demonstrate that their concerns are being heard and acted upon.	Governance and leadership	The ward teams were encouraged to complete the staff survey for NHS Wales. Staff are aware of speaking up safely via the guardian service, posters have been placed in staff areas and added as a standing agenda item for team meetings.	Ward Manager and Adult MH Directorate Manager	Complete
				Clear governance pathway in place for staff to raise concerns to the ward manager and to escalate to the lead professional where appropriate.	Ward Managers, Professional Heads of Service for Therapies and Adult MH Directorate Manager	31/01/26
				Question and answer session to be scheduled for senior managers within the directorate to meet with the wards, commencing 15/01/2026.	Divisional Triumvirate	31/01/26
				Senior team visit will be conducted in February 2026.	Service Director	28/02/26

				A staff room will be created to provide staff with a space to take their breaks.	Assistant Director of Strategic Capital Planning and Associate Service Director MH (Project Board Lead)	Completed
				Trauma-informed care pilot is taking place on Clyne, and this will be evaluated. This will include impact on staff, which will be measured via ReQol. The learning from this will be applied across USC.	Psychology Lead for Adult MH	30/06/26
25.	During the inspection we found several health board policies that were out-of-date according to their review dates.	The health board must review any out-of-date policies and procedures and update them as appropriate, to help staff provide safe and effective	Governance and leadership	The Health Board is reviewing the following policies to ensure that they are up to date. Health Board Policies include: Respect and Resolution Policy and Recruitment and Retention Policy. MHLD Service Group Policy:	MH & LD Policy Review Group Chair and Health Board Policy Lead	31/03/26

		care and share with staff once ratified.		Safe and Supportive Observations Policy The above policy was published onto COIN on 12/04/2022 with an initial expiry date of February 2024. The policy on COIN remains live, whilst it has been discussed at the MHLD Policy Review Group and extensions have been granted while it is in the process of being updated. The latest extension to the policy expires on 30/01/2026. The next Policy Review group is 22/01/26.		
26.	Reported staff shortages and reliance on overseas nurses, bank, and agency staff had created an inexperienced workforce.	The health board must review the staff establishment and staffing model at the clinic to ensure a safe skill mix is maintained to improve care delivery and	Skilled and enabled workforce	A review of skill mix has been undertaken, and additional support from the learning and development team to support individuals is in action where required. Preceptorship is being monitored through Nurse Workforce meetings.	Lead Nurse for USC & Ward Managers	Complete

		support staff wellbeing.		Effective rostering by Ward Managers ensures appropriate staffing are rostered.		
				Nurse staffing review panels were held in August 2025 in accordance with the Nurse Staffing Levels (Wales) Act to review current staffing establishments. Awaiting the formal outcome and confirmation of next steps as part of the MH Transformation programme. This will include ensuring right sizing of staff to meet patient acuity needs.	MH & LD Nurse Director	30/03/26
27.	Staff were required to leave their own ward to support staff on the other ward during incidents. Some patients have been unable to take granted escorted Section 17 leave	The health board must ensure staff record and monitor the incidences where staff must attend other wards to provide support, leaving	Skilled and enabled workforce	In the case of an emergency alarm, it is the expectation that staff support where appropriate, however only when it is safe to do so.	Ward Manager	Complete
				The wards use the SafeCare metrics integrated on the Health Roster which generates audit ready reports on staffing, acuity, red flags and staffing	Ward Managers & Lead Nurse for USC	Complete

	due to staff shortages.	their own ward temporarily short staffed, and any incidents where patients are unable to take Section 17 leave. The health board must also consider whether an increase to the staffing establishment is needed to always maintain staff and patient safety and determine whether there is an impact on therapeutic care.		mix. This provides real time visibility, alerts and data driven support so that ward teams can proactively fill gaps and report confidently on staffing safely.		
				A review of nurse staffing was completed during August 2025 in accordance with the Nurse Staffing Levels (Wales) Act to review current staffing establishments. Awaiting the formal outcome and confirmation of next steps from the Health Board.	MH&LD Nurse Director	30/03/26
28.	There was a lack of psychological interventions at the	The health board must explore options	Skilled and enabled workforce	Since the inspection, the psychology provision in Tawe Clinic has increased to 1.4 WTE	Psychology Lead for Adult MH	28/02/26

	clinic. Staff would also benefit from additional psychology capacity.	to increase psychological input and develop structured interventions that support both patient recovery and staff development.		psychologists across Tawe Clinic. Therapy groups will commence Jan/Feb to form part of the therapeutic offer.		
29.	Compliance levels with mandatory staff training and PADRs required improvement.	The health board must ensure staff are allocated protected time for supervision, appraisals, and training, to support professional development and reflective practice.	Skilled and enabled workforce	Ward managers are to allocate protected time for training, PADR and supervision. There is an agreed target for 85% and above compliance by 31/01/26.	Ward Managers & Lead Nurse for USC	31/01/26
30.	We were told that there was no structured	The health board must develop and	Skilled and enabled workforce	A review of the induction documents has been conducted across the service group to	Learning and Development team	Complete

	induction for other permanent staff.	implement a structured induction process to help ensure staff are well-prepared for their roles, promote safe practice, and support workforce stability.		ensure it is a robust and supportive process.		
				A draft induction document has been developed and will be presented to the relevant Professional forums throughout February 26.	Heads of Nursing and Professions	31/03/26
				Once ratified, the revised and improved process of induction will be implemented in practice across Tawe Clinic	Ward Managers and Professional Leads	30/04/26
31.	During the inspection, a family member reported they did not know who to contact or how to give feedback, and no guidance was visible in family visiting areas. There were also no leaflets or signage for the 'Putting	The health board must ensure patients and visitors know how to, and are able to provide feedback about the ward, and how to make a complaint via the PTR process and ensure this is more visible	People engagement, feedback and learning	Ward teams to ensure the PTR leaflet is displayed on the wards. A new bilingual PTR poster is being developed and will also be displayed alongside the PTR leaflet.	Ward Managers	31/01/26

	Things Right (PTR)' process.	and accessible to all patient and families, in addition to the ward information leaflet.				
32.	We were told that there was a backlog of approximately 150 incidents awaiting review on Datix for Clyne Ward.	The health board must ensure ward managers have sufficient time resource to review, investigate and close incidents in a timely manner, to reduce the current backlog, prevent delays in addressing incidents, identify lessons learned and help embed a culture of	Quality improvement activities	Managers have been asked to introduce scheduled blocks of time for incident review scheduled within diary to ensure protected time The MH Division have sourced additional resource to support with the backlog of incidents The division are tracking monthly progress and reporting into the quality and safety meeting. For Clyne there are currently 32 open incidents at ward level.	Ward Manager & Lead Nurse for USC	Completed

		safety and continuous improvement.				

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): **Michelle Forkings**

Job role: **Nurse Director**

Date: **07 January 2026**