Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Tŷ Grosvenor

Inspection date: 15, 16 and 17 December 2025
Publication date: 19 March 2026

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Digital ISBN 978-1-83745-315-3

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at Tŷ Grosvenor on 15, 16 and 17 December 2025.

The following hospital wards were reviewed during this inspection:

- Alwen Ward – an acute emergency admission service for 14 patients
- Brenig Ward – a rehabilitation inpatient service for 15 patients.

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

During the inspection we spoke with patients about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of nine questionnaires were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Overall, patients provided positive feedback about their care at the hospital. They told us they were treated with kindness and respect, felt safe on the wards, and could raise concerns easily with staff and managers. Staff monitored patients' physical health, supported them with long-term conditions and helped them attend external appointments. Patients also benefitted from a wide range of activities, including exercise opportunities, therapy sessions and access to communal spaces.

Patient bedrooms were clean, personalised and supported privacy, and we observed staff knocking before entering. Patients had access to clear information about their rights, advocacy services and how to raise concerns. Digital tools were used safely to support communication, with translation services available when required.

Patients were encouraged to share their views through meetings, surveys and suggestion boxes, and they felt their feedback was listened to.
Care and Treatment Plans (CTPs) were individualised. However, they did not always fully document all domains required by the Mental Health (Wales) Measure 2010, creating a risk that some needs may not be clearly identified.

This is what we recommend the service can improve:

- CTPs must reflect all domains of the Measure 2010 so that all patient needs are fully identified.

This is what the service did well:

- Patients felt safe, respected, and treated with dignity
- A primary care contract with a local GP supported timely access to routine healthcare for patients
- Advocacy services and clear information about rights and feedback were easily accessible.

Delivery of Safe and Effective Care

Overall summary:
Overall, we found that patients received safe and effective care in a clean, well-maintained environment. Wards were tidy, organised and supported patient safety, with suitable infection control arrangements in place. Staff demonstrated good awareness of risk, safeguarding responsibilities and emergency procedures.

Medicines management was safe and well governed, and multidisciplinary working was collaborative and respectful. Patients told us they felt supported, and staff had enough time to provide one-to-one sessions, risk assessments and care reviews. However, staff and patients both indicated that staffing levels did not always allow patients to take their full allocated Section 17 escorted leave.

The service promoted a preventative approach to managing challenging behaviour, with a strong focus on engagement and meaningful activity. Despite the wards being locked, signage and procedures supported the rights of informal patients. Enhanced observations were used safely and in line with the Safe and Supportive Observation Policy. Restrictive practices were used sparingly, and incidents were well recorded, reviewed and overseen through established governance processes.

Care plans were generally detailed and evidence-based, although patient views were not always evident. The service showed good oversight of Mental Health Act duties, with accurate detention paperwork, clear capacity assessments, and well-managed tribunal and rights-reminder processes.

This is what we recommend the service can improve:

- Make sure bathroom facilities include appropriate equipment to support patients with mobility needs
- Ensure oxygen cylinders are stored correctly, and staff understand safe storage procedures
- Review staffing levels so that all patients can take their allocated Section 17 escorted leave
- Ensure care plans clearly reflect patient views, preferences and aspirations.

This is what the service did well:

- Delivered safe, well-structured medicines management supported by effective pharmacy oversight
- Consistent use of risk-assessment tools, including ligature audits and recognised clinical tools to support safe and informed decision-making
- Clinical audits and emergency drills were used routinely to test and improve practice, with findings shared in governance forums.

Quality of Management and Leadership

Overall summary:
Overall, we found that staff were positive about working at the hospital, and feedback indicated confidence in the quality of care provided. Staff told us that patient safety and wellbeing were prioritised.

Recruitment checks, mandatory training and professional registrations were up to date, and supervision and appraisal arrangements were in place. Staffing levels appeared appropriate at the time of inspection.

There were effective governance arrangements to support oversight of quality and safety. Staff used electronic systems to report incidents, record concerns and complete audits, and information was routinely discussed through safety huddles, MDT reviews and governance meetings. Processes for managing concerns and complaints were clear, with opportunities for patients to raise issues in a range of ways.

Immediate assurances:

- Active CCTV was in use across in-patient areas without HIW approval, and was being reviewed at random intervals, including to check enhanced observations. This raised immediate concerns about inappropriate use, insufficient governance, and risks to patient privacy and dignity.
- The service was required to take urgent action to cease using CCTV in these areas and to submit a formal application for HIW to consider and determine whether CCTV use could be authorised.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

This is what the service did well:

- The service had a stable workforce with no reliance on agency staff, supporting continuity for patients
- Staff were able to raise concerns through the "Speak Up" guardian.

3. What we found

Quality of Patient Experience

Patient feedback

Patients provided positive feedback to our team throughout the inspection. Patients told us that they are treated with kindness and respect and are supported with personal care in a dignified and professional way by staff if required. Patients felt settled and safe on each ward and said they were able to approach staff and hospital management if they had any concerns.

Health promotion, protection and improvement

Patients had clear access to information about healthy lifestyles, including healthy eating, smoking cessation, exercise and immunisations. These materials were displayed in prominent areas across the hospital, making it easy for patients to find and use. Patients also had access to a range of meaningful activities such as books, DVDs, internet facilities, a pool table and occupational therapy sessions, as well as opportunities to exercise in the ward gym and hospital garden.

We saw evidence that staff monitored the physical health of patients through weekly reviews and provided targeted interventions when needed, including support with weight management. A primary care contract with the local GP surgery was in place, and long-term conditions were managed by the medical team with support from the associate healthcare professional.

The care and treatment plans we reviewed showed that patients received comprehensive mental and physical health assessments, along with targeted assessments such as nutrition and mobility checks. Physical healthcare plans were clearly documented, and staff supported patients to attend external appointments including dentists and opticians.

Dignity and respect

We observed kind and compassionate interactions between staff and patients throughout the inspection. Patients told us they felt treated with dignity and respect, and they said staff helped them with personal care in a professional and sensitive manner.

All patients had their own bedrooms with en-suite facilities, which provided privacy. Rooms were clean and personalised, and patients could bring their own belongings where this was risk assessed as safe. We observed staff knocking before

entering bedrooms. Keys were provided where appropriate so patients could lock their rooms. Observation windows on bedroom doors had suitable observation panels.

Patient information and consent
Patients had access to a range of clear and accessible information on the wards and in the reception area. This included information on advocacy services, visiting arrangements, the Mental Health Act and HIW. Detailed patient guides were also provided to patients on admission and were available for them to refer to as needed.

Confidential patient information was kept out of sight of patients in staff-only areas such as office and clinic spaces.

Communicating effectively
We observed staff communicating with patients in a clear and appropriate way. Most written materials were in English, although some Welsh-language information was available. Staff told us that translation services could be arranged when required, and several staff members were able to speak Welsh.

Digital tools were used to support communication. Phone booths were available on both wards, and we saw these being used regularly by patients. Each patient had an individual login to access the intranet, and staff helped patients use computers and mobile devices safely. Risk assessments supported the safe use of digital equipment, and private rooms were available for confidential conversations.

Care planning and provision
During the inspection we reviewed the care and treatment plans of six patients at the hospital. Overall, patients had up-to-date and individualised Care and Treatment Plans (CTPs) that reflected their assessed needs and supported their safety. For most patients, comprehensive mental health risk assessments had been completed.

All patients had an identified Care Coordinator, and their plans set out a wide range of therapeutic, social and physical health interventions. These included input from the wider multidisciplinary team, such as psychology, occupational therapy and nursing, with clear evidence of ongoing risk management.

However, we noted that although the CTPs broadly addressed the areas covered by the Mental Health (Wales) Measure 2010, they did not always fully reflect all the domains. This created a risk that some patient needs may not be clearly identified or recorded.

The service must ensure that all Care and Treatment Plans clearly document each domain of the Mental Health (Wales) Measure 2010 so that all patient needs are fully identified and appropriately planned for.

More findings on the care and treatment plans can be found within the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Equality, diversity and human rights
We found that the service promoted equality and diversity in line with its policies. Staff had completed training and understood their responsibilities in preventing discrimination and supporting patients' rights. Staff described how the placement of transgender patients would be based on individual risk assessments to ensure their dignity and safety was maintained.

A separate visiting room was available for patients to meet with family and friends. This space included facilities suitable for children, such as seating and baby-changing equipment. Information about patients' rights and how to raise concerns was clearly displayed, and advocacy services were available and promoted well on the wards.

Citizen engagement and feedback
Patients were able to share their views and provide feedback about their care in several ways. Suggestion boxes were available on both wards and in the reception area, and these could be used anonymously. Weekly community meetings also took place, giving patients an opportunity to discuss activities, the ward environment and any issues they wished to raise with staff. We observed one of these meetings and noted that patients appeared comfortable and confident in taking part.

Each ward also had a nominated patient representative who attended clinical governance meetings. They acted as a link between patients and senior management by passing on feedback and concerns from their peers. This helped ensure that patient views were routinely considered as part of service oversight.

Information on how to give feedback, raise concerns or make complaints was clearly displayed throughout the site. A "you said, we did" board on the wards highlighted examples of feedback received during the year and the actions taken in response. The service also carried out patient surveys, including feedback forms completed on discharge, which staff reviewed and summarised. Patients told us they felt encouraged to provide feedback and believed their views were listened to.

Delivery of Safe and Effective Care

Safe Care

Environment
We found that the ward environments were clean, well maintained and generally safe. All areas were tidy and free from clutter, and fixtures and fittings were in good condition. One empty bedroom was awaiting a small repair, but this was due to be completed before the room was used again.

The wards were accessible, with lifts available, and staff confirmed that patients with mobility needs could move around the building. However, the garden on Brenig ward was only accessible via steps so would be difficult to access for patients with mobility needs. The service may wish to explore ways of improving access to this area.

We also noted that the accessible bathrooms on each ward contained a bath but did not have equipment such as a hoist, which meant they were not fully suitable for patients requiring physical assistance.

The service should ensure that bathroom facilities include suitable equipment and adjustments so that patients with mobility difficulties are able to bathe safely and with appropriate support.

Managing risk and health and safety
Overall, we were assured that the service had suitable and effective processes in place to manage and review risks to help maintain the health and safety of patients, staff and visitors at the hospital. The ward entrances were accessible to everyone and were secured throughout the inspection to prevent unauthorised access.

Nurse call points were located within patient bedrooms so that patients could summon assistance if required. Staff wore personal alarms which they could activate in the event of an emergency. There were up-to-date ligature point risk assessments in place and several ligature cutters located throughout each ward for use in the event of a self-harm emergency.

Overall, suitable fire safety measures were in place to protect patients and staff. However, during the first night of the inspection we found that the fire door at the end of the bedroom corridor on Brenig ward was locked, and one of the locks could not be opened. This could have prevented patients from safely exiting the ward in the event of a fire. The issue was escalated immediately and resolved the same

night, and procedures were amended the following morning to prevent it from happening again. Further information on this incident is included in Appendix A.

Infection prevention and control (IPC) and decontamination
We found appropriate infection prevention and control arrangements in place across both wards. An IPC lead and up-to-date policies were in place. All areas we visited were visibly clean, tidy and well maintained, and staff were seen following expected hygiene procedures. Patient bedrooms and en-suites appeared clean, and the environment was set up in a way that supported effective cleaning and isolation when needed.

Cleaning schedules were in place and being followed, and shared equipment was cleaned between use. Hand hygiene facilities and signage were available, and we saw staff encouraging patients to wash their hands, including before meals. Laundry facilities were in good working order.

All staff members who completed a HIW questionnaire agreed that there were effective infection prevention and control practice measures in place. We saw evidence that staff had completed appropriate IPC training and the staff we spoke with during the inspection showed good awareness of their responsibilities.

We noted one minor issue where an office used to store patient belongings had become cluttered and disorganised. The service should ensure storage areas are kept clutter-free to support effective cleaning.

Nutrition
We found suitable arrangements in place to meet the nutritional and hydration needs of patients. Patients received full assessments, including support from speech and language therapy and dietetics where required. Modified diets were provided when needed, and staff encouraged patients to follow recommended dietary plans.

A four-week rolling menu was available, offering a good variety of meals that appeared balanced and appetising. The menu was clearly displayed, and patients could choose from the available options. Individual dietary needs, including cultural or medical requirements, were accommodated. Snacks and fresh fruit were available, and patients also had opportunities to cook their own meals with staff supervision. Dry goods and refrigerated items were stored appropriately, with regular checks carried out to ensure food remained in date and safely managed.

Mealtimes were set each day to support routine, and drinks were available at regular intervals. Patients had access to a kitchen area, with individual cupboards

and labelled fridge space to store their own food items. Staff encouraged healthy eating, with some restrictions in place to limit access to unhealthy snacks.

Throughout the inspection we discussed the situation of one patient who was at risk of choking but had capacity to make their own choices about food. Records showed occasions where the patient requested items such as crumpets, and some staff declined to provide them because of the identified risk. This highlighted the challenges staff faced when a patient chose food that did not align with clinical advice. The service should continue to support staff with clear guidance to help them manage these risks while still respecting individual choice.

Medicines management

Overall, medicines management was well organised, safely delivered and supported by clear governance and oversight. Systems for ordering medicines, reporting errors and carrying out audits were well established. Weekly pharmacy audits provided regular feedback, and staff described good learning processes, including reflective practice and team huddles. Support from pharmacy was described as excellent.

Medication, including controlled drugs, were stored securely in locked cupboards, fridges and trolleys, with appropriate key security. We did note that on Alwyn ward, the medicines trolley lock and its wall-fixing were not secure when we checked it during the first night of the inspection; however, staff resolved this immediately so that the trolley was safely secured. Fridge temperatures were being monitored daily in line with policy. Controlled drugs were recorded, administered and checked correctly, with twice-daily stock checks in place.

Medication Administration Records (MAR) charts were being completed accurately, with clear records of administration, legal status and CO2/CO3 forms stored with each chart. Staff followed relevant policies for medicines management, including controlled drugs, rapid tranquilisation and high-dose antipsychotic monitoring. Prescribing practices were in line with current guidance, and physical health monitoring supported the safe use of regular and PRN medication.

Patients were involved in discussions about their medication during MDT meetings and in one-to-one sessions, and medication reviews took place weekly or more frequently when required.

Safeguarding children and safeguarding vulnerable adults

We found suitable safeguarding arrangements in place across the wards. The service employed a social worker who acted as the designated safeguarding lead. They provided guidance to staff, and we found they played an important role in strengthening safeguarding oversight across the service.

The staff members we spoke with knew where to find safeguarding procedures and were clear about their responsibilities, including how to escalate concerns and how to use the whistleblowing process. Safeguarding information and flowcharts were visible on noticeboards. We reviewed training data and found that staff had completed regular training relevant to their roles.

Patients we spoke with said they felt safe on the wards and knew who they could approach if they had any concerns. Appropriate safeguarding considerations were applied to visiting arrangements. Visits involving children or families took place off the wards, and visitors were asked to provide identification before meeting patients.

We saw evidence that safeguarding concerns and referrals were managed appropriately, with a tracker in place to record incidents. Staff told us that concerns were discussed in MDT meetings, and senior managers had oversight through daily management meetings. Learning from safeguarding incidents was shared with the wider team to ensure consistency. Staff also described how they managed occasional conflict between patients in a calm and proportionate way, supported by a stable patient group and staff familiarity with individuals.

Medical devices, equipment and diagnostic systems
We saw evidence of weekly checks being undertaken on resuscitation and emergency equipment held on each ward. Staff had documented when these had occurred to ensure that the equipment was present, in date and safe to use in the event of an emergency such as patient collapse.

However, we noted that an oxygen cylinder had been left in the clinic room on Alwyn ward during the first night of the inspection. Staff were unsure why it had been placed there and immediately moved it to a more suitable location.

The service should ensure oxygen cylinders are always stored in their appropriate designated area and that staff are clear on the correct storage arrangements.

Safe and clinically effective care
We found that the service had effective arrangements in place to support safe and clinically appropriate care. Multi-disciplinary working was observed to be collaborative and respectful. Staff reported feeling included and valued, and their professional views were listened to during meetings and case reviews. The responsible clinician felt their caseload was manageable, had no concerns about team functioning, and described the MDT as professional and cohesive.

The staff we spoke with knew how to access clinical policies, guidance from the National Institute for Health and Care Excellence (NICE), and the Code of Practice. They told us they were informed of any changes through handovers, meetings and email updates. Routine audits were in place to monitor clinical standards, and staff described how audit findings were shared with the team.

Staff told us they had enough time to care for patients safely, and we saw that one-to-one sessions, care plans and risk assessments were completed in a timely manner. However, both staff and patients reported that staffing levels did not always allow patients to take their full periods of Section 17 escorted leave. Patients told us this could be frustrating and felt restrictive, limiting their opportunities to build independence and sometimes causing tension between patients and staff.

The service must ensure staffing levels support all patients to access the Section 17 leave they have been granted as part of their care and recovery.

Staffing on the wards was otherwise stable, with no reliance on agency staff, and the skill mix appeared appropriate.

We found that the service took a positive and preventative approach to managing challenging behaviour. Staff promoted patient engagement through a range of meaningful activities, including creative groups, physical recreation, independent living skills and paid employment opportunities. Although both wards operated locked-door policies, appropriate signage and procedures were in place to uphold the rights of informal patients.

Enhanced observations were used safely and appropriately, and only one patient required them during the inspection. Staff were knowledgeable about their roles and responsibilities, and the documentation reviewed was compliant with the Safe and Supportive Observation Policy. Incidents of restrictive practices were shared in community meetings, reviewed weekly and recorded through the IRIS system.

Records included clear details of restraint incidents, such as the type of intervention, duration, immediate actions taken and follow-up support. Established governance groups provided effective oversight and analysis of themes.
Policies and procedures covering restrictive practices were up to date and reflected the needs of the service. We saw positive progress in reducing previous blanket restrictions on Alwen ward. Patients were involved in discussions through community meetings, and restrictive practices were used sparingly. The therapeutic environment was supported by psychology and occupational therapy provision, alongside appropriate internet access with safe limitations in place.

Participating in quality improvement activities
A wide range of clinical audits were regularly being conducted using Tendable. Audit findings were being discussed in monthly clinical governance meetings.

The service held regular medical emergency drill reviews in which different scenarios were tested to check the effectiveness of the emergency arrangements in place. We viewed this as good practice and an effective method for evaluating teamwork and communication across the service.

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

Mental Health Act monitoring
We reviewed the statutory detention documents of five patients at the setting and were assured that the service was meeting its responsibilities under the Mental Health Act (the Act) and Code of Practice. All patients were legally detained, and the required statutory forms had been completed accurately and within timescales.

Medical and Approved Mental Health Professional (AMHP) recommendations set out clear reasons for detention and demonstrated appropriate application of the Act. Documentation and arrangements relating to capacity assessments and consent to treatment had improved significantly since our last inspection in November 2023. Capacity assessments were completed as required and stored appropriately with medication charts. CO2 and CO3 certificates were valid, up to date and accessible, and patients had been informed of outcomes.

Section 17 leave arrangements were clearly documented, with risk assessments undertaken during ward rounds and recent photographs held in patient files. Conditions were recorded in a way that supported staff and patient understanding, and leave outcomes were consistently updated in clinical notes. Forensic leave revocations were appropriately authorised by the Ministry of Justice.

Patients were being reminded of their rights at suitable intervals, with clear evidence of this across all files. Tribunal and Hospital Managers' processes were well organised, with patients receiving reports in advance and applications submitted within deadlines.

The Mental Health Act administrator demonstrated strong oversight of statutory duties through robust tracking systems. However, the role had no dedicated cover, and competing administrative demands, including reception duties, created potential risks to the continuity of MHA processes. The service should consider how it could strengthen its administrative cover arrangements to build resilience and protect the good practice currently in place.

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

Across the sample of records we reviewed, there was clear evidence of proportionate and comprehensive assessments being undertaken. These included detailed risk assessments updated regularly and informed by recognised tools such as START, HCR-20 and Positive Behaviour Support plans.

Care plans were generally detailed and evidence-based, reflecting a wide range of psychological, occupational, social and nursing interventions tailored to patients' assessed needs. However, the care plans often read as prescriptive, and there was limited evidence of patient views, preferences or aspirations within the plans, and the "patient voice" was not consistently visible. This contrasted with the more detailed CTP review minutes, where patient contributions were clearly represented.

The service must ensure that care plans better reflect the language and views of patients to demonstrate their involvement and contribution.

Weekly MDT reviews took place consistently, with patients, advocates and external professionals invited as appropriate. These meetings demonstrated strong multidisciplinary involvement and provided regular opportunities to monitor progress, review risks and plan future care.

Quality of Management and Leadership

Staff Feedback

Staff responses to the HIW questionnaires were generally positive.

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

Most respondents agreed that they would recommend the service as a place to work (11/12) and all agreed they would be happy with the standard of care provided by the service for themselves, friends or family (11/11).

Governance and accountability framework

We found that effective policies and procedures were in place to support the delivery of safe and effective care. Staff used appropriate electronic systems for reporting incidents and complaints, completing audits and managing HR functions, which supported visibility and oversight across the service. Suitable local governance arrangements were in place, including morning safety huddles, MDT reviews and clinical governance meetings where incidents, themes and operational issues were discussed.

During the inspection we saw that CCTV was being used in multiple areas across the hospital site, including in both Brenig and Alwen wards. Independent in-patient mental health settings in Wales wishing to use CCTV must first apply to HIW, who will then determine whether to grant this aspect of registration and set out the agreed protocol for how CCTV is to be used appropriately and securely within that setting. In this instance, HIW has not received any application from the hospital or from Elysium Healthcare Ltd to use CCTV in in-patient areas at Ty Grosvenor.

We were told that CCTV was being reviewed in an ad-hoc manner, including to check whether enhanced observations were being carried out correctly. This raised concerns that the current use and monitoring of CCTV at the hospital was not being conducted in a way that protects and respects the privacy and dignity of patients.

Further information on our concerns and the immediate improvements and remedial action required by the service are provided in Appendix B.

Dealing with concerns and managing incidents
The service had clear processes in place for managing concerns and complaints. Patients could raise issues verbally, in writing or anonymously via suggestion boxes. Both wards used an “issue book” to record informal concerns, which were expected to be addressed within 24 hours or escalated where required. The receptionist reviewed these entries weekly and monitored patterns through a central log. Formal complaints followed a structured process, and feedback was provided directly to patients. Outcomes from concerns and complaints were also shared through governance meetings to support learning.

Electronic systems were in place for reporting incidents, with oversight provided through daily huddles and governance forums. Staff were aware of how to escalate concerns and described receiving support from senior managers when involved in complaints or incident investigations.

Workforce recruitment and employment practices
All staff were permanent employees of the hospital, and the service did not use agency staff, which supported continuity of care. Staff described the culture as positive and stated they felt able to raise concerns, including through the designated “Speak Up” champion.

Staff confirmed that recruitment checks, mandatory training and professional registrations were up to date. Regular supervision and annual appraisals were in place, and staff reported that managers were accessible and supportive.

Workforce planning, training and organisational development
There was suitable oversight of mandatory training and appraisal compliance, and we saw high completion rates across the workforce. Staff had access to induction programmes, ongoing supervision and opportunities for further development. Training relevant to the patient group was provided, including Mental Health Act, physical intervention, and restrictive practice training.

Staff reported feeling competent and well supported in their roles, with adequate time to deliver safe care. The multidisciplinary team appeared to work collaboratively throughout the inspection. Although the wards were not at full occupancy, staffing levels appeared appropriate at the time of inspection. However, the service must be mindful of our previous recommendation to ensure staffing levels are such that patients can take their granted Section 17 leave.

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 first night of the inspection, the fire door at the end of the bedroom corridor on Brenig ward was found to be locked, and one of its locks could not be opened. This meant the door could not be used as an exit in an emergency.	The fire door at the end of the corridor was the only exit point, which created a potential risk of entrapment should a fire have occurred in that area of the ward.	We raised the issue immediately with ward staff during the night inspection, alerting them that the fire door could not be opened. The concern was escalated to senior managers on site as an urgent safety matter.	Staff were able to locate a key and unlocked the fire door the same night. The incident and ward procedures were reviewed and amended the following morning to prevent a recurrence.

Appendix B – Immediate improvement plan

Service: Ty Grosvenor

Date of inspection: 15, 16 and 17 December 2025

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

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	During the inspection we saw that CCTV had been installed and was being used in multiple areas across the hospital site, including in both Brenig and Alwen Wards. We were provided with a CCTV (Provision and Use) Policy issued by Elysium in March 2024 that set out guidance on the accepted use of CCTV equipment and images to ensure	The service must immediately cease using and reviewing the CCTV installed on Brenig and Alwen Wards.	Regulation 25 of the Care Standards Act 2000	We have restricted CCTV operation where its use is essential for patient safety and have limited viewing access strictly to Dean Harries, Regional Service Director. Effective immediately, we have suspended all ad hoc reviews of CCTV footage and ceased using CCTV for the purpose of checking observations, except where required for specific incidents or safeguarding concerns. We are reviewing our procedures to ensure that all use is necessary, proportionate, and fully respects the privacy and dignity of	Lou Burrows – Hospital Director	Immediately

	compliance with relevant data protection and privacy laws. We also saw a CCTV viewing log which set out the CCTV review requirements for each registered premises with CCTV. A review of the viewing log indicated that the CCTV had been reviewed weekly at the hospital since April 2024.			patients, in accordance with the ICO Code of Practice.		
2.	Independent in-patient mental health settings in Wales wishing to use CCTV must first apply to HIW who will determine whether to grant this element to their registration and set out the protocol for how the CCTV is to be used appropriately and securely for each	The service must submit an application to HIW on its use of CCTV at Ty Grosvenor.	Regulation 25 of the Care Standards Act 2000	Whilst Ty Grosvenor has had CCTV in situ since its opening on 25/05/2015 we have immediately commenced the process to submit a formal application to HIW detailing: The purpose and scope of CCTV use. Historical context of CCTV implementation since 2015. Evidence of previous HIW notifications and investigations referencing CCTV.	Lou Burrows – Hospital Director	28 days

	setting. In this instance, HIW has not received any application by hospital or Elysium Healthcare Ltd employees to use CCTV in in-patient areas at Ty Grosvenor.			Ensure compliance with HIW requirements and address any concerns raised in the recent non-compliance notice.		
3.	Following the inspection, we reviewed the CCTV viewing log being maintained by staff at the hospital. The viewing log stipulated that at least 50% of the required monitoring time must be ad hoc reviews and not for any other purpose. The log showed that an ad hoc review of the CCTV had been undertaken 75 times since April 2024. We were not assured that each ad hoc review was	The service must provide assurance that CCTV is not being used in other inpatient areas of mental health hospitals in Wales.	Regulation 25 of the Care Standards Act 2000	We have restricted CCTV operation to clinically critical areas in all other inpatient areas of Elysium Healthcare Hospitals in Wales where its use is essential for patient safety and have limited viewing access strictly to Dean Harries, Regional Service Director.	Dean Harries - Regional Service Director	Immediately

necessary or justified or preserved the privacy and dignity expectations of patients at the hospital. In addition, the viewing log stipulated that a purpose of using the CCTV was to check observations are being carried out correctly. The log showed 23 instances since April 2024 of observations being reviewed to determine whether they had been carried out correctly. We were not assured that the use of CCTV to review observations was justifiable in accordance with the Information Commissioner's Office					

Data Protection Code of Practice.					

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): **Lou Burrows**

Job role: **Hospital Director**

Date: **29 December 2025**

Appendix C - Improvement plan

Service: Ty Grosvenor

Date of inspection: 15, 16 and 17 December 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.	We noted that CTPs did not always fully reflect all the domains of the Mental Health (Wales) Measure 2010.	The service must ensure that all Care and Treatment Plans clearly document each domain of the Mental Health (Wales) Measure 2010 so that all patient needs are fully identified and appropriately planned for.	Care planning and provision	A full audit of Care and Treatment Plans to be completed, identifying gaps related to domain completion. Targeted training sessions will be delivered to all clinical staff, including nurses and MDT members, focusing on accurate, domain-specific documentation and care planning.	Deputy Hospital Director	On going
2.	The hospital did not have equipment such as a hoist to help patients requiring physical	The service should ensure that bathroom facilities include suitable equipment and adjustments so that patients with mobility difficulties are able to	Environment	Ty Grosvenor's Statement of Purpose outlines that the service are unable to support patients who require intensive support through specialist aids, equipment, major facility modifications, or intensive nursing input. However, the service recognises that patients may	Lou Burrows	Completed

	assistance in the communal bathrooms.	bathe safely and with appropriate support.		become temporarily disabled during their admission, and additional support may be required to ensure their safety and dignity. In line with this, the service has a clear process for accessing suitable equipment when a patient develops temporary mobility difficulties. Where such needs arise, appropriate bathing aids, such as shower chairs, grab rails, or other mobility-related equipment, are hired promptly to ensure the patient is able to bathe safely with the appropriate level of support. This process has been used effectively in previous cases and enables the service to maintain safe patient care without breaching the scope of its Statement of Purpose. This approach ensures that patients with temporary mobility difficulties can bathe safely and comfortably. Staff are aware of the procedure for sourcing equipment, and senior management oversight ensures all adjustments remain proportionate, clinically appropriate, and time limited.		
3.	An oxygen cylinder had been left in the	The service should ensure oxygen cylinders are always stored in their	Medical devices, equipment	The service will ensure that all oxygen cylinders are stored in the designated medical gas storage area in line with	Lou Burrows	Completed

	clinic room on Alwyn ward during the first night of the inspection.	appropriate designated area and that staff are clear on the correct storage arrangements.	and diagnostic systems	organisational policy and safety standards. Staff will be reminded of correct storage procedures, and routine checks will be completed to ensure compliance. Issue a reminder email to all staff regarding correct oxygen cylinder storage. Ward and clinic room checks to be incorporated into daily safety walkarounds. Any non-compliance identified will be addressed immediately and escalated where necessary.		
4.	Both staff and patients reported that staffing levels did not always allow patients to take their full periods of Section 17 escorted leave.	The service must ensure staffing levels support all patients to access the Section 17 leave they have been granted as part of their care and recovery.	Safe and clinically effective care	Some patients have not consistently attended planning meetings where leave arrangements are discussed. When planning meetings are missed, staff are unable to organise leave safely and efficiently. In addition, short-notice staff sickness can impact the availability of staffing required to facilitate all planned leave. All patients are expected to attend the daily planning meeting to discuss their leave requirements so that these can be arranged in a safe and structured manner. If a patient does not attend the planning meeting, this may result in their leave not	Lou Burrows	Completed

				being arranged due to insufficient information or lack of opportunity for staff to plan appropriately. Ty Grosvenor operates under safe staffing principles. Where staff report sick at short notice, it can be challenging to secure immediate cover. In these circumstances, all planned leave will be reviewed and prioritised to ensure equitable access. Patients will still have leave facilitated; however, on occasion this may need to be shortened to ensure all patients can access their agreed leave safely. Management will continue to make every reasonable effort to cover staff absences to minimise the impact on patient leave and maintain safe, consistent service delivery.		
5.	The care plans we reviewed contained limited evidence of patient views, preferences or aspirations, so the "patient voice" was not	The service must ensure that care plans better reflect the language and views of patients to demonstrate their involvement and contribution.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	The Hospital Director will ensure all care plans are reviewed to confirm they accurately reflect each patient's views, preferences, and language wherever possible. Staff will receive guidance and refresher training on person-centred documentation, including the use of direct quotes and clear evidence of patient involvement.	Lou Burrows	Ongoing

consistently visible.			On the acute ward, patients are often too unwell to contribute to their care plans at the point of admission. In these cases, care plans will be formally reviewed at each weekly ward round, and staff will ensure they go through and update the care plans with the patient as soon as the patient is clinically able to participate. A monthly care-plan audit will be implemented to monitor compliance, with individual feedback provided and themes reviewed at MDT meetings to ensure sustained 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): Lou Burrows

Job role: Hospital Director

Date: 26 February 2026