Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Tŷ Llidiard

Cwm Taf Morgannwg 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 Tŷ Llidiard, Princess of Wales Hospital, Cwm Taf Morgannwg University Health Board on 12, 13 and 14 January 2026.

Tŷ Llidiard provides specialist inpatient child and adolescent mental health services for young people aged 11 to 18. The unit has two wards:

- Enfys Ward – This is the main inpatient ward providing routine, ongoing and multidisciplinary care
- Seren Ward – This is an acute or extra-care ward providing short-term, intensive support for young people needing higher levels of observation or crisis intervention.

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 to patients and their families to find out about their experiences 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 four 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:
We observed staff interacting with young people in a kind, compassionate manner, and the young people told us they felt respected and able to access support when needed. The service demonstrated person-centred and respectful care, with staff promoting healthy lifestyles as part of daily support. Care and treatment plans outlined individual goals around nutrition, exercise and wellbeing, and staff used structured resources to support body image, self-esteem and wider health needs.

Occupational therapy provision had strengthened since the previous inspection, with a broad range of therapeutic and activity-based opportunities available. Privacy was upheld through individual en-suite bedrooms, the option to personalise rooms within risk assessments, and staff practices such as knocking before entering. Quiet and sensory spaces offered additional support when young people needed time away from others. Independence was encouraged through daily-living tasks, cooking activities and preparation for discharge, supported further by access to a transition flat.

Young people described timely access to help, supported by daily multidisciplinary huddles and responsive administration of medication, including as required (PRN). Communication was accessible and jargon-free, with adaptations such as communication cards and a traffic-light system for emotions. Visiting arrangements and digital communication with families were also supported appropriately.

This is what we recommend the service can improve:

- Ensure all observation panels are functioning correctly so staff can carry out safe and appropriate observations.

This is what the service did well:

- Equality, diversity and inclusion were embedded in practice, with advocacy involvement clearly visible and staff actively discussing how to deliver appropriate support for transgender young people.

Delivery of Safe and Effective Care

Overall summary:
The service demonstrated safe and effective care with well-embedded risk-management processes that supported the safety of the young people, staff and visitors. Staff carried personal alarms, call bells were accessible, and fire

procedures were clearly understood and practised. Ligature risks were monitored through regular audits and daily checks. The environment was bright and generally functional, although some areas required maintenance, including damaged outdoor furniture and peeling décor.

Infection prevention and control arrangements were suitable, with clear governance, completed training, daily cleaning of bedrooms and appropriate decontamination of shared equipment. Some wards used tape to secure notices, which hindered effective cleaning. Safeguarding practices were strong, supported by a dedicated social worker, clear escalation routes and routine sharing of learning. The young people reported feeling safe, and risks were managed proactively through observations and separation of individuals when necessary.

Medicines and medical devices were being managed safely, with secure storage, consistent temperature monitoring and good pharmacy oversight. MDT working was collaborative and supported timely care, while restrictive practices were proportionate and used as a last resort. Care and treatment plans were person-centred and up to date, though some domains of the Mental Health (Wales) Measure were not fully explored or translated into clear actions. Patient records remained paper-based, which limited efficiency and navigation.

This is what we recommend the service can improve:

- Adopt a consistent approach to affixing signage and remove the use of tape that prevents effective cleaning
- Ensure all key risk-management information is consistently documented across WARRN assessments, care and treatment plans and MySafety Plans
- Ensure enhanced observation records are completed in full.

This is what the service did well:

- Care and treatment plans were person-centred, outcome-focused and reflected young people's involvement through signed contributions and structured tools supporting participation
- Medicines, medical devices and emergency equipment were managed safely and consistently, with strong oversight and good practice in controlled-drug procedures.

Quality of Management and Leadership

Overall summary:
Staff feedback indicated a largely positive workplace culture, with most staff reporting satisfaction with the quality of care they provided, feeling able to meet the demands of their role, and believing that patients were involved in decisions

and treated with dignity. One staff member, however, expressed contrasting views.

Governance and leadership arrangements appeared appropriate, with senior managers visible, approachable and supportive. Information flowed effectively through daily huddles, weekly meetings and wider governance structures, ensuring lessons learned, incident trends and audit outcomes were shared consistently.

Staffing levels and skill mix were generally appropriate, supported by daily bed-management processes and responsive rostering. The workforce benefited from stability, established supervision arrangements, high levels of mandatory training and a structured induction for new staff. Staff highlighted a positive MDT culture, describing collaborative working and accessible support.

The young people, families and carers had clear routes to provide feedback, with concerns escalated, reviewed and shared through governance processes. Duty of Candour responsibilities were well understood by staff. Information governance arrangements were robust, with secure systems for storing and sharing information. However, electronic patient information boards were not always kept up to date, which posed a potential safety risk.

This is what we recommend the service can improve:

- Review and update the health and safety policy
- Ensure electronic patient information boards are consistently updated to reflect real-time clinical information and observation levels.

This is what the service did well:

- The workforce demonstrated high mandatory-training compliance, stable staffing, and positive multidisciplinary teamwork, contributing to a safe and collaborative culture.

3. What we found

Quality of Patient Experience

Person-centred

Health promotion
We found consideration of health needs for the young people was well embedded in everyday care. The young people are supported to develop knowledge and skills around healthy lifestyles, including nutrition, exercise, substance misuse and personal care. We saw care plans set out nutrition, weight management and lifestyle goals. Staff used resources such as Hunger for Understanding workbooks and provided regular support around body image and self-esteem.

The young people were encouraged to be physically active through access to the hospital sports hall, garden areas and short walks. Staff shared positive examples of supporting individual interests, including helping a young person explore boxing. Personal hygiene was promoted in a sensitive way through one-to-one support and activities such as pamper evenings.

We saw good progress in the occupational therapy provision available, which had strengthened since our previous inspection in 2023. A wide range of therapeutic and activity-based sessions were available, both internally and within the local community as appropriate.

Dignified and respectful care
We observed staff interacting with the young people in a kind, compassionate manner and with dignity and respect throughout the inspection. The young people consistently told us they felt respected and happy with the support provided.

Each young person had their own bedroom with en-suite facilities, which supported privacy. Rooms could be locked from the inside and could be personalised in line with individual risk assessments. Observation panels were in place on the bedroom doors, although we noted one faulty observation panel in an unoccupied bedroom.

The health board must ensure all observation panels work as intended to support safe and appropriate observations.

Staff appeared mindful of protecting privacy, by knocking before entering bedrooms and storing confidential information securely. The mixed-gender communal areas were used appropriately, and staff supported young people to

access alternative spaces if they wished to avoid a particular gender. Quiet rooms and sensory rooms were available when young people needed time away from others. There was an appropriate mix of male and female staff, and efforts were made to allocate same-gender support for enhanced observations when preferred.

Individualised care
We saw good evidence that the young people were supported to make independent choices about their daily routines and care. They had access to aids that promoted independence, including support with meal planning and appropriate access to the internet.

The young people were encouraged to complete everyday tasks such as maintaining personal hygiene, cleaning their rooms and taking part in cooking activities with staff or occupational therapy support. They were able to make decisions about clothing, activities and food choices, with additional guidance where needed for those under 16. A multi-faith room was available, supported by chaplaincy information, and a transition flat was accessible upstairs to help young people prepare for discharge. There was also positive work underway to support post-16 young people with educational opportunities.

Care was respectful of personal preferences, and information about self-referral support services was available on notice boards and in leaflets.

Timely

Timely care
The young people told us they felt well supported and able to access help when needed, describing staff as responsive to their needs. Each morning, the multidisciplinary team held a “huddle” to review every young person’s mood, recent events and care needs, enabling timely decision-making and coordinated actions. Medication was also delivered in a timely manner, with young people reporting no delays when requesting PRN medication.

Equitable

Communication and language
The young people had access to clear and accessible written information through induction packs, electronic screens, posters, notice boards and bilingual signage. Information available included advocacy services, HIW, complaints processes, Mental Health Act rights, visiting arrangements and general information about the service.

We observed staff communicating with the young people in an appropriate, jargon-free manner. Adjustments were being made for those young people who experienced communication difficulties, including communication cards and a traffic-light system to help express emotions.

Digital communication was supported effectively, with young people able to use their personal devices to contact families and professionals where appropriate. Two private visiting rooms were available, and arrangements ensured that children under 18 were appropriately supervised during visits.

Rights and equality

The service demonstrated awareness of equality, diversity and inclusion in their day-to-day practices. Staff had completed equality and diversity training, and relevant policies were available.

Advocacy Support Cymru was clearly promoted, and we saw advocacy involvement during the inspection, with advocates supporting young people in meetings about their care. We saw evidence that staff discussed young people requiring adjustments in case study meetings and adapted their care accordingly. We were told that regular meetings are held with staff to ensure correct pronouns and approaches are used when supporting transgender young people.

Delivery of Safe and Effective Care

Safe

Risk management
We found effective risk management arrangements in place to support the safety of young people, staff and visitors. Staff carried personal alarms, and call bells were accessible throughout the unit. Fire procedures were clearly defined and consistently applied, with weekly alarm tests taking place and staff able to describe the evacuation routes and their roles during an emergency.

Ligature risks were monitored through regular audits and daily checks. The most recent ligature audit had been completed in 2024, with the next scheduled for early 2026. Staff were trained in the use of ligature equipment, and cutters were stored in accessible locations throughout both wards. A recent incident involving the use of ligature scissors had resulted in a young person sustaining three minor cuts to their hand after placing it between the blades. The health board may wish to consider whether using fish-knife style ligature cutters, rather than scissors, would reduce the risk of similar injuries during future interventions.

The environment was accessible, with functional spaces that supported therapeutic activity. The wards were bright, with engaging decor evident, particularly the murals on Enfys, however, some of these appeared to be peeling. While furniture was generally in good repair, several areas required maintenance. On Enfys ward, a ripped sofa was noted, and the outdoor benches and tables were rotten in places and required replacement. Minor wall damage and peeling paint was seen in places on Seren ward. The staff we spoke with told us that Seren would benefit from wider environmental improvement.

The health board must ensure timely environmental repairs and replacement of damaged furnishings and outdoor equipment to maintain a safe and therapeutic environment.

Infection, prevention and control and decontamination
Overall, we found suitable IPC processes in place at the unit. Governance arrangements were clear, with an identified IPC lead, accessible policies, and an established escalation process. Staff had completed appropriate IPC training.

Routine environmental checks were carried out by staff, and each bedroom was cleaned daily. We noted that one bedroom contained carpet but were told this would be replaced during an upcoming refurbishment. Cleaning schedules for communal areas were well documented, and we saw evidence that shared

equipment was being decontaminated appropriately. Suitable hand-hygiene facilities and signage were visible, and patients were routinely prompted to wash their hands. Sharps were being disposed of safely on both wards.

Personal protective equipment was available for staff, and isolation facilities were used appropriately, including a recent example of the safe management of a young person with C. diff followed by ultraviolet deep cleaning.

Both wards were generally clean, tidy and free from clutter. However, we saw frequent use of Sellotape and Micropore to secure notices on bins, walls and doors, along with areas of damaged paint. These hindered the ability to ensure effective cleaning.

The health board must ensure all wards adopt a consistent approach to affixing signage and information without using tape that compromises cleaning.

Safeguarding of children and adults
We found safeguarding arrangements were well embedded across the service. A social worker was available on the unit who provided day-to-day guidance and support. Senior oversight was maintained through daily huddles, and learning from safeguarding matters was shared through handovers, meetings and supervision, with risk management plans updated when required.

A safeguarding log was being maintained and showed that referrals were made appropriately by a range of professionals, including nurses, therapists, doctors and the social worker. Staff demonstrated good awareness of safeguarding procedures and their responsibilities, supported by mandatory training, induction, and access to policies on the intranet. They were confident about escalating concerns to the social worker or the Multi-Agency Safeguarding Hub (MASH) and knew how to seek advice out of hours through the emergency duty team. Staff also told us they were aware of whistleblowing arrangements.

The young people generally reported feeling safe on the ward and were clear about who they could speak to if they had concerns. Risks between young people were managed through enhanced observations, staff presence in communal areas, or by separating individuals across the two units when necessary to maintain safety. We also saw examples where family visits had been paused following safeguarding concerns.

Management of medical devices and equipment
We found that medical devices and emergency equipment were managed safely and consistently across the unit. Daily checks were carried out on emergency drugs and equipment, with all items examined found to be in date and stored

appropriately, including oxygen cylinders secured upright on the wall. Staff told us the crash bag was easily accessible, and any items nearing expiry were routinely replaced.

Staff were trained to use oxygen cylinders through Immediate Life Support training, and any concerns or incidents were escalated via Datix and discussed in team meetings. Weekly checks ensured sufficient oxygen supplies were available, and regular maintenance arrangements were in place. Clear processes were described for responding to adverse reactions or equipment-related issues, including informing the medic on call and escalating to the ward manager.

Medicines management

We found that medicines were being managed safely and to a good standard. The clinic room was clean, well-organised and free from clutter. Medicines, including controlled drugs, were stored securely in locked rooms, cupboards and trolleys. Staff were maintaining fridge and room-temperature records consistently, with no gaps identified over the previous six months, which is commendable. Weekly pharmacy oversight was in place, and arrangements for managing and disposing of controlled drugs were working well, supported by a two-nurse system and daily stock checks.

Staff described clear escalation processes for medication-related concerns, including the use of Datix and notifying medical staff. Two recent medication errors had been identified by nurses themselves, reflecting positive safety awareness. PRN medicines were being used appropriately, and regular medicines were monitored by the medical team. Patients were routinely involved in discussions about their medicines during ward rounds, pharmacist visits and daily MDT reviews.

Medication Administration Record (MAR) charts were generally maintained to a high standard. We saw no blank administration boxes, omission codes were used appropriately, and prescribing practices aligned with least-restrictive principles. One MAR chart required correction where the Section 3 start date and CO2/CO3 information had not been documented, meaning nurses could not easily confirm the patient's legal authority for treatment. This was resolved promptly during the inspection, but the health board should remind staff to ensure all legal-status information is recorded clearly at the point of prescribing.

Policies for medicines management, controlled drugs and rapid tranquillisation were available; however, some out-of-date versions were being stored alongside current policies. We discussed this with the service who arranged for the old versions to be removed to avoid confusion or error amongst staff.

Effective

Effective care

Staff reported that they generally had sufficient time and staffing capacity to provide safe and effective care. They described a professional and collaborative MDT environment supported by daily handovers, regular case reviews and weekly case or group supervision sessions, which helped maintain oversight of patient needs and team wellbeing. Staff said they could access clinical policies, NICE guidance and the Code of Practice through the intranet.

Restrictive practices appeared proportionate and used as a last resort. We saw that Prevention and Management of Violence and Aggression (PMVA) trained staff were available on each shift with the option to request additional support if required. Staff described physical interventions as infrequent, and none of the incidents we reviewed appeared excessively prolonged. This aligned with positive accounts of de-escalation strategies, personalised triggers and supportive safety planning. There was evidence that families were routinely informed following such incidents.

There were several documents in use to support the management of risks and challenging behaviour. The Wales Applied Risk Research Network (WARRN) assessments were detailed, current and clearly identified triggers, risks and appropriate interventions. Care and treatment plans also highlighted “my possible triggers” and outlined relevant strategies for staff to follow. Each young person had a MySafety Plan in place, and we noted positive progress since the previous inspection, including a detailed plan for one young person that set out the specific PMVA arrangements required to support NG feeding. However, another young person’s MySafety Plan did not include any reference to PMVA interventions despite clear evidence elsewhere in the documentation of risks relating to violence and aggression towards others. This meant that essential risk-management information was not always explicitly reflected across all documents, creating the potential for key details to be overlooked if staff only referred to one part of the care record.

The health board must ensure that key risk-management information is clearly and consistently reflected across all relevant documents, including MySafety Plans, to reduce the risk of important details being missed and to support safe, consistent care delivery.

Staff told us that they felt they had enough time to complete enhanced observations. However, we identified gaps within several observation records. Gaps reduce assurance that young people were safely observed at the required

frequency and mean that important information about any changes in risk or presentation may not be captured.

The health board must ensure that enhanced observation records are completed in full to provide an accurate account of each young person's presentation, and to ensure that no safeguarding concerns or changes in risk are missed.

Nutrition and hydration

We found that the nutritional and hydration needs of the young people were being regularly assessed and monitored to ensure they were being met. Food and fluid charts were used routinely. Patients were generally able to choose what, when and where they ate unless care plans required a more structured approach. Where eating disorders were present, intake was supported through structured meal planning and food diaries. Staff told us that suitable diets, including vegetarian and halal options, could be arranged through housekeeping when required.

The menu offered healthy options, and the onsite dietician provided tailored guidance. Set mealtimes and snack times were in place due to some patients' clinical needs. Patients could access snacks and drinks throughout the day using a dedicated young persons' kitchen, with some cooking activities supported by occupational therapy. Dining areas were staffed to ensure mealtimes were safe and supportive.

Specialist support was available where required, with same-day access to Speech and Language Therapy and regular dietetic input. Modified diets were provided when swallowing difficulties were identified.

Patient records

Patient records were kept in paper format and stored securely throughout the inspection. Records were available when requested, though locating specific information was sometimes difficult due to multiple volumes and sections that were not always easy to navigate. Some documents, such as consent forms, required staff assistance to find.

Although files used coloured dividers, the absence of a contents page meant navigation was slower and triangulating incidents and clinical information could be challenging. Several young people had two volumes, which added to the complexity of reviewing the records.

From discussions with staff, it was clear that the paper-based system limited efficiency.

The health board must:

- **Review the current paper record system and implement improvements to ensure information is easy to navigate and in a timely manner**
- **Consider moving to an electronic patient record system to improve accessibility, enhance consistency and reduce the challenges experienced when reviewing and cross-checking information.**

Mental Health Act monitoring

We reviewed three detained young people's records and found them compliant with the Mental Health Act and Code of Practice. Statutory forms, medical recommendations and Approved Mental Health Professional (AMHP) reports were completed correctly and signed as required. These documents had been appropriately scrutinised, and the records clearly supported the legal basis for detention.

Capacity assessments were documented regularly, and consent to treatment certificates were held with the medication charts. Section 17 leave was authorised appropriately, with risk assessments in place and clear conditions recorded to guide staff and young people. Rights information was provided verbally and in writing, re-presented regularly, and supported by visible posters and leaflets.

The Mental Health Act documentation was organised, secure and easy to navigate. Processes overseen by the Mental Health Act administrator appeared robust, with only one missed statutory tribunal referral identified during the review; this was promptly actioned, and we were assured this was an isolated oversight.

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

During the inspection we reviewed the care and treatment plans of four young people at the unit. We saw that the young people had up-to-date, individualised care and treatment plans that reflected their assessed needs and helped maintain their safety. Plans were person-centred, outcome-focused and written in accessible language, with clear goals and planned review dates. Young people contributed actively to their plans through signed documents, first-person statements and completed templates. Staff also made good use of structured tools to capture young people's views ahead of ward rounds, enabling their meaningful involvement in care planning.

However, the care and treatment plans we reviewed did not fully reflect all domains of the Mental Health (Wales) Measure. Certain areas, such as social, cultural factors or spiritual needs, were not routinely developed into clear actions. For example, one young person identified religion as important to them, but this was not explored further in their plan. We also noted that language needs were

not consistently captured on admission. This was an improvement that had been identified during our 2023 inspection, so it was disappointing to see no progress in relation to this.

The health board must ensure that all care and treatment plans fully address the relevant domains of the Mental Health (Wales) Measure, and that these are routinely explored, recorded and translated into clear, measurable actions.

Efficient

Efficient

We found that arrangements for admission and discharge were generally efficient. Staff told us that discharge processes were sometimes slow using paper records, as documents had to be manually emailed to community teams, but overall coordination was effective. There was good evidence of services working together, with one young person's care and treatment plan showing clear collaboration between hospital staff and external agencies.

Staff reported having enough time and capacity to deliver care safely, attend meetings, and complete assessments. They described staffing levels as appropriate and said they were able to request additional support when needed. Senior nurses told us they felt able to prioritise clinical work effectively and that daily routines, such as one-to-one sessions and care plan updates, were achievable within existing staffing arrangements.

Teams reported positive multidisciplinary working, with regular attendance at handovers and case discussions. Staff described a collaborative environment where professional views were respected, and where weekly group supervision supported shared learning. They highlighted that established staff and newer team members were well integrated, contributing to a consistent approach to care.

Quality of Management and Leadership

Staff feedback

The responses to the HIW staff questionnaires were generally positive, however, one staff member provided less positive feedback. All staff who completed a questionnaire said that they were satisfied with the quality of care and support they gave to patients and that they were able to meet the conflicting demands on their time at work. All staff also felt that patients were informed and involved in decisions about their care and that patients' privacy and dignity is maintained.

Three out of the four staff who completed a questionnaire agreed that care of patients was their organisation's top priority and that they were content with the efforts of their organisation to keep them and patients safe. Three out of the four staff also agreed that they would recommend the unit as a place to work and would be happy with the standard of care provided by the organisation for themselves or friends and family. However, one staff member disagreed with all four of these statements.

Leadership

Governance and leadership

The governance and leadership arrangements for the unit appeared appropriate. Senior managers were described by staff as approachable and regularly present on the ward, and staff told us they felt supported and able to raise concerns. Information flowed through several established processes, including daily huddles and a weekly Wednesday meeting, where lessons learned, case studies and immediate updates were discussed and shared among the team.

Wider governance structures supported the sharing of information across the health board, with senior staff attending clinical governance forums and quality and safety meetings. These covered incident trends, environment updates and audit outcomes, with ward managers cascading key messages through handovers, staff meetings and routine communication. Staff were clear about their roles, reporting lines and responsibilities.

However, we noted that the health and safety policy was out-of-date and required review.

The health board must review and update all out-of-date policies and procedures to ensure staff have access to accurate and up-to-date guidance.

All staff who completed a questionnaire felt senior managers were committed to patient care and that senior managers were visible. All staff also felt that their manager could be counted on to help with difficult tasks at work and provides clear feedback on their work.

Workforce

Skilled and enabled workforce
Staffing levels and skill mix appeared appropriate to meet the needs of the young people. Daily bed-management meetings and use of the health roster system helped ensure staffing was adjusted promptly in response to acuity and observation requirements.

Staff told us that vacancies had been filled, and although the ward was two staff members short on the first night of the inspection, this was managed safely due to the low number of young people on the ward. It will be important for the health board to continue monitoring staffing levels to ensure they remain appropriate as occupancy or acuity increases.

There was good evidence of staffing stability within the unit, with several long-standing staff members contributing to consistency of care and a positive culture. Processes for pre-employment checks, supervision and staff meetings were well established, and employment records were stored securely.

Mandatory training compliance was high, with clear oversight through governance and quality forums. Staff confirmed access to a broad range of training relevant to the patient group, including Mental Health Act, Mental Capacity Act, safeguarding, restrictive practices and resuscitation. New staff also completed a structured induction with shadowing and competency assessments.

Three out of the four staff members who completed a questionnaire told us that they have had appropriate training to undertake their role. The other staff member said they would benefit from additional training in learning disability in mental health and in understanding eating disorders.

The health board must ensure that a training needs analysis is completed to ensure the educational needs of all staff are considered as part of staff annual appraisals.

Culture

People engagement, feedback and learning

There were clear processes in place to support the young people, families and carers to provide feedback, and to ensure that any learning from concerns or complaints was shared across the team. Discharge satisfaction questionnaires and community meeting feedback to gather ongoing views from young people. Formal complaints were reviewed by the senior nurse, with an emphasis on resolving issues informally with young people and families wherever possible.

Information on how to make a complaint was displayed on the ward, and the PALS team reviewed concerns and provided themed data into clinical governance meetings. This helped ensure learning was routinely fed back into practice, with updates shared through handovers, staff meetings and established governance forums. Duty of Candour principles were embedded, with staff able to describe their responsibilities and the ward manager outlining their role in incident investigations and how Duty of Candour is considered as part of this process.

Staff described a consistent approach to supporting colleagues when complaints were raised, with the ward manager and HR maintaining regular communication and following established procedures.

Information

Information governance and digital technology

We found that the service had appropriate systems in place to manage information safely and securely. Staff received annual GDPR training, and the health board had policies to support compliance. Documents shared externally were password-protected and sent through secure NHS systems, and access to patient records was restricted to relevant staff.

Electronic systems supported incident reporting, clinical audits and HR processes, helping ensure that information was available to staff and could be shared with partners in a safe and structured way. These arrangements contributed to the effective running of the ward and supported wider governance oversight.

However, we noted that the electronic patient information boards on both wards were not being consistently updated. For example, during the inspection, one young person who was on 1:1 enhanced observation was shown on the board as requiring 15-minute observations. Although observation levels were correctly discussed during handovers and recorded in the handover folder, an inaccurate board could present a safety risk if staff relied on it when undertaking observations.

The health board must ensure that the electronic patient information boards are consistently maintained and accurately reflects real-time clinical information.

Learning, improvement and research

Quality improvement activities

There was clear evidence of a wide range of audit activities taking place both centrally and at ward level. An Audit Management and Tracking tool was being used to schedule, complete and monitor audits, ensuring actions were followed up. We were told that learning from audits was shared through supervision, staff meetings and handovers.

Incidents were being reported through Datix, reviewed by ward management and discussed during handovers, MDT meetings and governance forums. However, improvements were required in the recording and administration of incidents. Of the nine incidents we reviewed, only three had been reported on the same day, with some not entered until several days later. Datix records also showed missing information, including the duration of restraint, staff positions, clarity on post-incident physical observations, and details of who administered medication during incidents. 29 incidents remained open at the time of our inspection, despite having been investigated and awaiting update or closure.

The health board must strengthen incident-reporting processes and ensure the remaining open incidents are addressed promptly. Additionally, ensure all future incidents are logged in a timely manner, that Datix entries contain accurate and complete information, and that incidents are reviewed and closed promptly to improve oversight and support learning.

Whole-systems approach

Partnership working and development

Staff reported good partnership working between community-based teams and crisis teams to support young people during admission and at discharge.

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
No immediate concerns were identified on this inspection.			

Appendix B - Immediate improvement plan

Service: Tŷ Llidiard

Date of inspection: 12, 13 and 14 January 2026

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

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate assurance issues were identified on this inspection.					

Appendix C - Improvement plan

Service: Tŷ Llidiard

Date of inspection: 12, 13 and 14 January 2026

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 one faulty observation panel in an unoccupied bedroom.	The health board must ensure all observation panels work as intended to support safe and appropriate observations.	Dignified and respectful care	Faulty observation panel reported to the door manufacturer.	Locality Manager	21st January 2026 (complete)
				New observation panel to be fitted.	Locality Manager	1st April 2026
				Daily environmental audit in situ. This system supports early identification and reporting of environmental concerns where remedial action maybe required.	Ward Managers	9th March 2026 (Complete)
				A spot check against this audit will be completed on a monthly basis over a six	Senior Nurse	16th September 2026

				month period. This will be reported into Quality, Safety and Experience Group (QSE).		
2.	The environment required maintenance on both wards in places.	The health board must ensure timely environmental repairs and replacement of damaged furnishings and outdoor equipment to maintain a safe and therapeutic environment.	Risk management	Daily environmental audit in situ. This system supports early identification and reporting of environmental concerns where remedial action maybe required.	Ward Managers	9th March 2026 (Complete)
				The CAMHS and Specialised Services Directorate hold quarterly Fire and Estates meetings, that feed into the UHB Corporate Facilities meeting for the escalation of any maintenance.	Locality Manager & Service Manager	9th March 2026 (Complete)
				A spot check against this process will be completed on a monthly basis over a six month period. This will be reported into QSE.	Senior Nurse	16th September 2026
				The phase 2 Capital works to improve the Enhanced Care Area (ECA) is in progress.	CTMUHB (Capital Planning)	31st July 2026
	Frequent use of tape to secure notices and areas	The health board must ensure all wards adopt a consistent approach	Infection, prevention and	Daily environmental audit updated to include:	Senior Nurse/Locality Manager	9th March 2026 (Complete)

3.	of damaged paint hindered effective cleaning.	to affixing signage and information without using tape that compromises cleaning.	control and decontamination	• No tape to be used to secure notices • All notices not stored appropriately (notice board/E-screen) will be moved to the appropriate location.		
4.	Essential risk-management information, including PMVA strategies for young people with known risks of violence or aggression, was not consistently reflected across all documents.	The health board must ensure that key risk-management information is clearly and consistently reflected across all relevant documents, including MySafety Plans, to reduce the risk of important details being missed and to support safe, consistent care delivery.	Effective care	Immediate spot check undertaken on relevant documentation including risk management information.	Senior Nurse / Audit Lead	13th March 2026 (Complete)
				Monthly WARRN and care-plan audit to be implemented and subject to a six month review, to ensure that YP who are identified to require restrictive practice, have	Senior Nurse/ Audit Lead	16th September 2026

				clear risk management actions within the WARRN and a co-produced restraint reduction goal within the care-plan. My Safety Plan is embedded into the care-plan document and specific to what the young person feels best helps them in managing their mental health and any crisis.		
				Audit findings will be reported via Directorate QSE to ensure that the required level of improvement has been met/ agree if the audit needs to be extended for assurance.	Senior Nurse	16th September 2026
5.	We identified gaps within several observation records.	The health board must ensure that enhanced observation records are completed in full to provide an accurate account of each young person's presentation and to ensure that no	Effective care	Monthly Audit of engagement and observation records in situ in order to review completeness and disseminate any learning identified.	Audit Lead/Senior Nurse	13th March 2026 (Complete)
				Nurse In Charge (NIC) checklist to be implemented.	Ward Manager /Senior Nurse	13th March 2026 (Complete)

		safeguarding concerns or changes in risk are missed.		NIC checklist to be audited monthly and subject to six month review to further strengthen improvements in this area. Findings will be reported via Directorate QSE.	Ward Managers/Senior Nurse	16th September 2026
6.	Locating specific information within patient records was sometimes difficult due to multiple paper volumes and sections that were not always easy to navigate.	The health board must: • Review the current paper record system and implement improvements to ensure information is easy to navigate and in a timely manner • Consider moving to an electronic patient record system to improve accessibility, enhance consistency and reduce the challenges experienced when reviewing and	Patient records	'At a glance' Index to be created to assist with navigation through the patient file.	Senior Nurse	1st April 2026
				MHLD to award contract for electronic record.	Service Director MHLD	1st May 2026
				The MHLD Care Group will implement a single electronic record for patient notes.	Service Director MHLD	31st May 2028

		cross-checking information.				
7.	The care and treatment plans we reviewed did not fully reflect all domains of the Mental Health (Wales) Measure, with social, cultural, spiritual and language needs not consistently explored or recorded.	The health board must ensure that all care and treatment plans fully address the relevant domains of the Mental Health (Wales) Measure, and that these are routinely explored, recorded and translated into clear, measurable actions.	Monitoring the Mental Health (Wales) Measure 2010: care planning and provision	Due to the regional nature of the ward, Ty Llidiard does not act as Care Coordinator under the MHM (2010). This responsibility sits with the Local Authority / Health Boards where the young person resides. Ty Llidiard will adopt the National CTP audit on AMaT bi-monthly to ensure all domains of the MHM are completed. Results will be shared with Care Coordinators to support improvements.	Senior Nurse/CTP Leads	1st May 2026
				A snap shot audit of all CTMUHB patients admitted over the last 12 months will take place to review compliance to the MHM and the results of this audit will be shared widely with the CTMUHB community teams to	Senior Nurse	20th May 2026

				support any learning identified.		
				The findings of the CTMUHB audit and AMAT will be reported into Directorate QSE. This will then form part of regular AMAT audit reporting into QSE.	Senior Nurse	20th May 2026
8.	We identified that the health and safety policy was out of date.	The health board must review and update all out-of-date policies and procedures to ensure staff have access to accurate and up-to-date guidance.	Governance and leadership	The out-of-date policies identified were all health board corporate policies. Email sent to corporate team to highlight the policies that require review. The MHLD Care Group and Policy Review Group is responsible for the monitoring of all MHLD Policies and procedures. It is also responsible for reporting any corporate policies/procedures found to be out of dat.	Senior Nurse/MHLD Policy Lead Corporate Policy Lead	13th March 2026 (Complete)
				The MHLD Care Group will reshare the Terms of	Lead Nurse	13th March 2026 (Complete)

				Reference (TOR) for the MHLD review Group to ensure the process for reporting out of date policies is followed.		
9.	One staff member said in the HIW questionnaires that they would benefit from additional training.	The health board must ensure that a training needs analysis is completed to ensure the educational needs of all staff are considered as part of staff annual appraisals.	Skilled and enabled workforce	The training identified was regarding meal support. Full Day Meal Support Training is presently being rolled out by the regional Eating Disorder Outreach Service, training compliance is presently 35% and will rise to 53% May 2026 and 85% by December 2026. This will remain a training requirement for all substantive and new MDT staff working in Ty Llidiard.	Senior Nurse	31st December 2026
				Compliance will be reported and monitored via Directorate QSE..	Senior Nurse	31st December 2026
				Speciality specific training needs analysis to be completed and considered in line with QNIC standards. Once agreed and embedded, compliance will be reported and monitored via Directorate QSE.	Senior Nurse/Head of Therapies	1st July 2026 completion of analysis Update on progress in QSE 20th May 2026 and

						final report in QSE 15th July 2026
10.	We noted that the electronic patient information boards on both wards were not being consistently updated.	The health board must ensure that the electronic patient information boards are consistently maintained and accurately reflects real-time clinical information.	Information governance and digital technology	Spot check completed to evidence the electronic information / at a glance board has been updated. This is also on the NIC check list.	Senior Nurse	13th March 2026 (complete)
				The electronic whiteboard user guide has been recirculated to all registered nurses, alongside instruction to self-report any requirement for additional training.	Senior Nurse	13th March 2026 (complete)
				Audit to be developed to ensure factual completeness of the electronic patient information board. This will be completed monthly over a 6-month period, learning will be disseminated and reported via Care Group QSE for assurance.	Ward Manager(s)/ Audit Lead	30th September 2026
11.	Improvements were required in	The health board must strengthen		The Incident Management Framework has been	Senior Nurse	10th March 2026 (complete)

	the recording and administration of incidents.	incident-reporting processes and ensure the remaining open incidents are addressed promptly. Additionally, ensure all future incidents are logged in a timely manner, that Datix entries contain accurate and complete information, and that incidents are reviewed and closed promptly to improve oversight and support learning.	Quality improvement activities	cascaded to all staff responsible for reporting, investigating and closing incidents.		
				A weekly check by the Senior Nurse has been implemented to ensure timely investigation and closure of incidents. And a reminder for timely investigation and closure forms part of daily NIC check list.	Senior Nurse	13th March 2026
				The above checks will be implemented in order to review the timeliness of incident reporting with a monthly review for six months into QSE meetings, to monitor the quality. This will also include a review of: • Open Incidents • Incidents under investigation	Senior Nurse	16th September 2026

				• Incidents awaiting closure This will provide assurance around adherence to the Incident Management Framework.		

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): **Rebecca James**

Job role: **Senior Nurse**

Date: **13 March 2026**