Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Heatherwood Court

Inspection date: 26, 27 and 28 January 2026
Publication date: 11 May 2026

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

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1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at Heatherwood Court on 26, 27 and 28 January 2026.

The following hospital wards were reviewed during this inspection:

- Chepstow - a low secure unit with 12 single gender beds
- Cardigan - a low secure unit with 12 single gender beds
- Caerphilly - a low secure unit with 12 single gender beds
- Caernarfon – a rehabilitation unit with 11 single gender beds.

Our team, for the inspection comprised of four 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 or their carers to hear 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 32 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:
Patients generally experienced compassionate, respectful and person-centred care. We found strong evidence that patients' physical and mental health needs were assessed, monitored and reviewed regularly, with good access to both internal and external healthcare services. Staff interactions with patients were mostly kind and respectful, and care planning reflected a holistic and rights-based approach aligned with the Mental Health (Wales) Measure.

Patients were supported to understand their care, rights and how to raise concerns, with advocacy visibly embedded within the service. There was also evidence that patient feedback was routinely sought through multiple routes and used to inform service improvements.

The activities hub was recognised as a valuable and well-resourced facility, with recent investment described by the service. However, access was not consistently achievable for all patients at the time of inspection due to limitations in staffing availability and patient suitability, meaning some were unable to benefit from its facilities.

Access to patient information was not consistent across all wards, with patients on one ward having noticeably less information available to support their understanding of care, rights and how to raise concerns.

We observed occasions where staff undertaking enhanced observations appeared passive, with limited meaningful interaction, representing missed opportunities for therapeutic engagement. We also noted that on one occasion the service was unable to fully meet a patient's specified observation plan in relation to required gender mix, which indicated a need for more proactive planning to ensure individual observation requirements can be met consistently.

This is what we recommend the service can improve:

- Ensure consistent access to clear patient information across all wards
- Strengthen the quality of therapeutic engagement during enhanced observations, ensuring staff actively interact with patients rather than providing passive supervision
- Improve proactive staffing planning to ensure specific observation requirements, including gender mix, can be met consistently.

This is what the service did well:

- The service demonstrated good practice in promoting equality, dignity and human rights, including inclusive policies, reasonable adjustments, strong advocacy provision and meaningful patient involvement in feedback and service development.

Delivery of Safe and Effective Care

Overall summary:
The service had systems in place to support the delivery of safe and clinically effective care. Risk management arrangements were well established, with regular environmental and ligature risk assessments undertaken, appropriate fire safety measures and staff awareness of escalation processes. Safeguarding arrangements were embedded, with staff demonstrating a clear understanding of their responsibilities and appropriate oversight of referrals and concerns.

Medicines management arrangements were generally safe, supported by electronic prescribing, pharmacy oversight and robust storage and administration processes. Clinical records were well maintained, and Mental Health Act documentation was compliant and easy to access.

We found that parts of the physical environment appeared tired at the time of inspection, with some variation in cleanliness observed on one ward. The service advised that a phased refurbishment programme was underway to address these issues.

While pharmacy audits identified actions for improvement, implementation and follow-up were inconsistent. There were also weaknesses in how learning from medication and clinical incidents was documented and shared. Despite established review mechanisms, the number of physical intervention incidents remained high, and elements of the physical environment and levels of patient engagement may have contributed to this. Further assurance was required on how the service would strengthen preventative approaches and reduce restrictive interventions.

This is what we recommend the service can improve:

- Continue with refurbishment work to make sustained improvements to the environment
- Ensure that governance around implementing pharmacy recommendations is strengthened so that issues are resolved in a timelier manner
- Strengthen its approach to prevention, engagement and environmental considerations to reduce the number of physical intervention incidents with patients.

This is what the service did well:

- Care and Treatment Plans were individualised, regularly reviewed and aligned with the Mental Health (Wales) Measure, demonstrating continued improvement since previous inspections
- Electronic prescribing, pharmacy oversight and controlled drug management were well embedded, supporting safe prescribing and administration practices across the hospital.

Quality of Management and Leadership

Overall summary:
The service had governance, leadership and accountability arrangements in place to support the oversight of quality, safety and regulatory compliance. Systems for monitoring, complaints, performance and risk were established, and there was evidence of regular audits, unannounced visits and senior leadership oversight.

Robust recruitment processes were in place, and staff demonstrated commitment to delivering compassionate, person-centred care in a complex and high-acuity environment.

While systems to review incidents and identify learning were in place, improvements were required to ensure incident records were complete and that learning was consistently informed by comprehensive staff accounts, clearly documented and effectively communicated.

Feedback from staff during the inspection and through HIW questionnaires highlighted areas where leadership approach, communication and workforce arrangements were perceived to be inconsistent. Staff raised concerns relating to leadership visibility, confidence in responsiveness, workforce planning, wellbeing and the ability to raise concerns openly. While internal assurance activity had been undertaken by the service, the difference between those findings and the feedback received by HIW indicated a need for further reflection and assurance.

This is what we recommend the service can improve:

- Review staff feedback and provide assurance on how concerns will be explored, addressed and fed back to staff in a sustainable way
- Review workforce planning, including the use of agency staff, to ensure staffing arrangements support continuity, effective communication and therapeutic engagement, particularly during periods of increased acuity.

3. What we found

Quality of Patient Experience

Health promotion, protection and improvement
We found that the physical healthcare needs of patients were being routinely assessed and monitored. All Care and Treatment Plans we reviewed showed that patients had received full physical healthcare assessments on admission, followed by regular monitoring through weekly GP reviews, weight checks and ongoing physical observations. Patients also had access to physical-health clinics run by the onsite physical health nurse, as well as referrals to external healthcare services when required.

A range of condition-specific assessments had been completed where appropriate, including mobility, nutrition, skin integrity, moving and handling and mouth-care assessments. Some patients had specialist dietary assessments, with any dietary requirements were clearly documented and met by the service.

Patients were able to access wider primary and secondary healthcare services, including opticians and dentists, with timely escalation to specialists where needed. They were also encouraged to engage in exercise and health-improvement activities, such as gym sessions and walking groups.

Dignity and respect
Staff were observed interacting with patients across all wards in a kind, respectful and compassionate manner, and patients confirmed that they felt well-treated by staff.

Patients had access to private bedrooms, quiet rooms and other spaces that supported privacy, and staff were seen following expected practices such as knocking before entering rooms. Bedrooms were personalised, with patients able to keep belongings and display items subject to risk assessment. Some patients had keys to their rooms when assessed as safe to do so. All wards were single-sex, and patients had access to appropriate bathroom and shower facilities.

Observation windows and viewing panels were used proportionately to risk, with clear signage reminding staff to knock before using them. Confidential information was stored securely within staff offices, with boards covered or located out of patient view.

Staffing was generally appropriate with a suitable gender mix observed; however, on the final day of the inspection, the service had been unable to provide the required number of male staff to meet a patient's 3:1 observation plan, which specified two male and one female staff member.

The service must ensure staffing rotas meet the required gender mix for individual observation needs through proactive planning and timely rota adjustments.

Patient information and consent

We found that patients generally had access to clear and relevant information to support their understanding of their care, rights and treatment. Most wards displayed a broad range of written materials, including details on advocacy services, HIW, legal rights under the Mental Health Act, how to raise concerns or complaints and visiting arrangements. Patients also received a handbook on admission outlining what to expect during their stay. However, we noted that patient information on Cardigan Unit was noticeably sparse, meaning patients there did not have the same level of access to essential material as those on other wards.

The service must review and strengthen the availability of patient information on Cardigan Ward, bringing it in line with the standard achieved across the rest of the hospital.

Information was available bilingually, and staff were aware of the Active Offer for Welsh-speaking patients. We were told that additional languages could be produced if needed. Staff had completed information governance training, and confidential discussions were held in private rooms to protect privacy. Staff supported patients to use digital systems safely, with individualised Wi-Fi access and monitoring in place.

Communicating effectively

Communication between staff and patients was warm, with staff observed speaking in a way that supported understanding and avoided jargon. Many staff members demonstrated strong knowledge of individual patient needs. However, we also observed periods during the inspection where staff on enhanced observations appeared passive and potentially disengaged, seated in lounges without interacting meaningfully with the patient. We felt this represented a missed opportunity to strengthen therapeutic engagement with the patients.

The service must ensure that staff undertaking observations actively engage with patients wherever appropriate, maximising opportunities for purposeful interaction and reducing passive supervision.

Digital tools were used to support contact with professionals and families, and patients could view parts of their care plan on a device under staff supervision.

Care planning and provision

During the inspection we reviewed the care and treatment plans (CTPs) of four patients at the hospital. We saw strong evidence that individual needs were clearly documented and that care plans were aligned to the Mental Health (Wales) Measure. The CTPs reflected a holistic approach, covering mental health needs, physical health, risks, and social or cultural factors. Patients had identified Care Coordinators, and documentation showed regular review dates and evidence that plans were being monitored and updated.

Most CTPs identified a range of interventions, including therapeutic, social, and rehabilitative, with clear allocation of responsibility. The activities hub was recognised as a valuable and well-resourced facility, with the service describing recent investment in its development. However, we noted that its use was not consistently achievable for all patients due to staffing availability at certain times and by which patients were safe or suitable to attend. With a full OT team and activity co-ordinators in post, it will be important for activity timetables to balance hub-based sessions with ward-based activities, ensuring meaningful engagement is available to all patients, including those unable to access the hub.

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

The service demonstrated a commitment to recognising and meeting the diverse needs of patients, with systems in place to promote equality, uphold rights and challenge discrimination. Staff had completed equality and diversity training, and equality impact statements were included within policies. A transgender policy had recently been implemented, with preferred pronouns displayed sensitively on patient information boards to support inclusive practice.

Patients and staff were protected from discrimination through established processes, including staff-led group discussion sessions, accessible safeguarding information across the hospital and access to a Speak Up Guardian.

Reasonable adjustments were available to ensure equitable access to services, such as a lift, widened doorways, profiling beds for those with medical needs and specialist respiratory equipment where required.

Patients had access to their own mobile phones subject to risk assessment, although one patient highlighted issues with Wi-Fi reliability. Private visitor rooms were available and appropriately maintained. Advocacy involvement was visibly embedded within the service, with posters displayed across the hospital and fortnightly advocate visits. Patients confirmed they were aware of the advocacy support available and felt able to use it when needed.

Citizen engagement and feedback

The service used a wide range of methods to gather patient feedback. Patients were able to share their views through weekly ward meetings and monthly Listening Lounge sessions or could complete a huddle request form if they wished an issue to be raised during the daily morning huddle attended by senior management. Opportunities for anonymous or supported feedback were also available, and patients could contact the Speak Up Guardian if they wished to raise concerns privately.

Information on how patients could provide feedback was clearly displayed on ward noticeboards, within the patient handbook and in visitor areas. There was evidence that feedback was acted upon, with “You said, we did” boards in place across most wards, although the board on Cardigan Unit was empty at the time of the inspection. Quarterly satisfaction surveys were completed by patients and reviewed in MDT meetings to inform service improvements. Patients had also been involved in specific consultation activities, including contributing to the development of the 2026 food menu, which was noted as good practice.

Delivery of Safe and Effective Care

Safe Care

Environment
The environment across the service was generally accessible, with lift access available in the main building for people with mobility difficulties. Patients could move throughout the wards without obstruction. Outdoor space was available, although patients had to request staff support to access it.

Several areas across the hospital appeared tired and in need of cosmetic improvement at the time of inspection, including worn furniture, dated décor and minor maintenance issues. The service advised that it was in the middle of a phased refurbishment programme and provided assurance during the inspection that these environmental issues would be addressed as part of this work.

The service must provide an update on refurbishment work completed since the inspection to evidence how it is addressing the cosmetic improvement and outstanding maintenance issues across the hospital.

Managing risk and health and safety
Risk management processes were well established across the service. Environmental and ligature risk assessments were completed monthly, with earlier reviews undertaken if incidents occurred. Staff escalated identified risks through governance and multidisciplinary meetings to ensure timely oversight.

There were up-to-date ligature point risk assessments in place, and several ligature cutters were located throughout each ward for use in the event of a self-harm emergency. Staff were observed wearing personal alarms throughout the inspection.

Suitable fire safety measures and precautions were also in place to protect patients and staff in the event of a fire.

Infection prevention and control (IPC) and decontamination
There was generally good oversight of infection prevention and control procedures across the hospital. Policies were up to date, an IPC lead was in place, and cleaning schedules were available and being completed. Staff had undertaken the required IPC training, and those we spoke with demonstrated a clear understanding of their responsibilities.

Staff had access to appropriate equipment, PPE was available and used correctly, and shared equipment was cleaned between use. Sharps were stored and disposed of safely. Hand hygiene facilities, including sinks, soap and sanitiser stations, were available throughout the hospital and supported by suitable signage. Daily housekeeping and environmental audits provided regular oversight.

However, during the inspection, Cardigan ward appeared noticeably more unkempt during the evening visit, with the lounge floor dirty and requiring a general clean and vacuum. This improved as the inspection progressed, but the service should continue to monitor cleaning standards to ensure that areas are cleaned in a timely and consistent manner.

Nutrition
We found that nutritional and hydration needs had been consistently assessed and addressed across the service. Physical health assessments routinely included nutrition, and screening processes identified any specific dietary requirements. Cultural and religious needs had been catered for appropriately; for example, halal meals had been provided where required. Weight monitoring had taken place regularly, and patients had access to dietetic support and SALT input when needed.

Patients were offered choice and flexibility regarding food and drink. Meals were cooked on site, with set times for lunch and dinner, while breakfast, snacks and drinks could be accessed more freely, subject to risk assessments. Individuals were able to contribute views on menus through regular meetings, and healthy-eating initiatives were visible throughout the environment. Drinks and snacks remained available throughout the day, and safe storage arrangements supported those preparing or keeping personal food items.

Medicines management
The arrangements for medicines management appeared safe and effective. Key policies relating to medicines management, controlled drugs and rapid tranquilisation were up to date and easily accessible to staff.

The clinic rooms were small but clean, tidy and well maintained. We were advised that refurbishment of the clinic rooms formed part of ongoing development work, including the removal of the hatches on clinic room doors, which we considered to be a positive step.

Medicines storage and administration processes were robust. Medication trolleys, cupboards and fridges were locked, and temperature checks were well maintained. Controlled drugs were administered safely, with appropriate double-signing and regular stock checks supported by weekly pharmacy oversight.

The electronic prescribing system was well embedded, with staff increasingly confident in its use. The system displayed key safety information clearly, including Mental Health Act legal status and patient photographs. We also noted that photographs were placed on individual medication boxes to further reduce the risk of error.

However, compliance with implementing actions identified during pharmacy audits required improvement. The December 2025 clinical governance meeting minutes showed that none of the 12 issues identified in November 2025 for Caerphilly Unit were addressed, and Chepstow Unit achieved only 40% compliance for the same period.

The service must ensure that governance around implementing pharmacy recommendations is strengthened so that issues are resolved in a timelier manner.

Safeguarding children and safeguarding vulnerable adults
Appropriate safeguarding arrangements were embedded across the service. Staff were able to describe their responsibilities clearly and were confident in how to recognise, report and escalate concerns, and were aware of the whistleblowing process.

Patients generally reported feeling safe and knew who they could speak to if they had a concern. Clear information was displayed on noticeboards, and opportunities to raise concerns were available through weekly meetings, the Listening Lounge and regular visits from advocacy services. Safeguarding arrangements for child or family visits were overseen by the safeguarding lead and supported by risk assessment processes.

We saw evidence that referrals were completed using the appropriate documentation and were discussed in daily morning huddles and clinical governance meetings. A high number of patient-to-patient incidents had been reported in some months, many of which did not meet statutory thresholds, which demonstrated an open approach by the service to reporting and monitoring concerns.

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

Safe and clinically effective care
We found systems in place to support safe and effective care. Staff understood clinical policies, NICE guidance and the Code of Practice, and they regularly accessed audits and updates. All patients had My Safety and Support Plans, and the Recovery in Supported Environments (RISE) framework supported daily goal setting to encourage engagement in recovery. Restrictive Practice Reviews and the Restrictive Practice Forum were noteworthy areas of good practice, providing structured opportunities to review incidents and reduce restrictive practices, helping to create greater consistency across the hospital.

However, the number of physical intervention incidents remained high, with 211 recorded in the previous three months. We considered whether environmental factors may have been contributing to escalation. For example, Cardigan Unit offered limited communal space, with patients largely confined to a corridor and lounge area due to supervised or restricted access to dining and quiet rooms. This created potential for boredom and peer-to-peer tensions. Continuous alarms from the unit's paging and bedroom systems were also a source of frustration for both staff and patients. These issues may have contributed to escalation and the continued high number of physical intervention incidents.

The service must provide assurance on how it will strengthen its approach to prevention, engagement and environmental considerations to reduce the number of physical intervention incidents with patients.

Participating in quality improvement activities
We were told that various quality improvement initiatives were taking place. Quarterly audits had been used to identify development needs and assess compliance with clinical and environmental standards. Improvement work had progressed in several areas, including patient pathway development and physical environment changes such as the new Cardiff block. The service had also embedded patient involvement through the listening lounge, opportunities to participate in local governance meetings, and workshops considering restrictive practice from the patient perspective.

Information management and communications technology
The service demonstrated that it had effective systems in place to manage information safely and securely. We were told that data was collected, used and retained in line with GDPR requirements, supported by authenticated servers and completed staff training. Information was stored and accessed through secure, password-protected systems, including the use of an authenticated VPN. The service also used recognised secure platforms such as Egress to protect personal and sensitive information, particularly when transferring data externally.

Records management
Records were mainly maintained electronically using the Nourish system, with My Safety and Support Plans held in paper format. Nourish was a secure, password-protected system that prevented unauthorised access and upheld confidentiality. Records were stored securely, were easy to locate, and were clearly organised, allowing staff to navigate relevant sections without difficulty. All members of the multidisciplinary team (MDT) recorded within a single patient record, helping to maintain consistency and continuity.

Mental Health Act monitoring
We reviewed the statutory documentation for four detained patient and found that all were compliant with the Mental Health Act (MHA) and the Code of Practice. This meant that patients were legally detained at the hospital. All MHA paperwork was stored electronically, and the files were well organised, easy to navigate and straightforward for staff to locate.

We saw evidence that capacity assessments had been completed, and consent to treatment certificates were available on the electronic prescribing system for staff to access when needed. Records also showed that management reviews, hospital managers' hearings and tribunal applications had taken place within required timescales, with outcomes clearly recorded.

Section 17 leave forms set out conditions in a clear and understandable way for both staff and patients. Risk assessments underpinning leave were evident, and there was documented involvement of patients in discussions about their leave arrangements.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision
During previous inspections, care documentation had often appeared generic, with limited personalisation and instances where care plans were not updated to reflect changes such as observation levels. At the last inspection, improvements were noted, with documentation becoming more individualised and better aligned with supporting information. This inspection demonstrated further progress, with care plans now presenting as more reflective of individual needs and risks, and supported by clearer, more consistent MDT oversight.

The Nourish electronic patient record contained comprehensive and well-structured information, including pre-admission assessments, MDT referral discussions and detailed physical health assessments completed on admission. Risk assessments were evidence-based and regularly reviewed by the responsible clinician and MDT. Care plans were aligned to the domains of the Mental Health Measure Wales, reflected patient views, and were supported by documented MDT

meetings and Care and Treatment Plan reviews, with patients and their representatives involved where appropriate.

Quality of Management and Leadership

Staff Feedback

Responses to the HIW staff questionnaires were mixed. Many respondents described a strong commitment among nursing and support staff to delivering compassionate, respectful and person-centred care. Staff were reported to work beyond expectations in challenging circumstances to maintain patient dignity and keep patients at the centre of care delivery. Several respondents acknowledged the complexity of the patient group and the challenges of managing risk in line with least-restrictive principles. Positive feedback was also provided regarding ongoing service development, including environmental improvements, bespoke flats and a focus on patient activities.

However, staff responses also raised concerns about leadership and communication. Feedback described variable visibility and approachability of senior management, alongside inconsistent communication between ward teams and senior leaders. Some respondents reported limited confidence in leadership responsiveness and decision-making. Recent organisational changes, including the removal of ward manager roles, were perceived by staff to have reduced clarity, support and accountability at ward level. Senior nurses were described as carrying increased responsibilities, further limiting their capacity for direct patient care and staff support.

Respondents also reported challenges relating to staff wellbeing and psychological safety. Some staff indicated that they did not feel able to raise concerns openly and expressed limited confidence that concerns would be listened to or addressed constructively. This was associated with reports of stress, burnout and reduced morale. Staff identified a need for improved mentoring, more consistent supervision, opportunities for reflection and clearer learning following incidents, particularly to support newer members of staff.

HIW is aware that the service had recently undertaken internal assurance activity to explore staff experience, which did not identify significant concerns. However, this contrasted with the nature and strength of feedback received during this inspection and through the HIW questionnaires, indicating a need for further exploration to understand staff experience and the underlying causes of recurrent concerns raised with HIW.

The service must reflect on the feedback received and provide assurance to HIW about further actions that can be taken to explore staff experience to ensure that concerns raised by staff are understood, addressed and resolved in a sustainable way.

Governance and accountability framework
The service had governance and oversight arrangements in place to support leadership, accountability and the monitoring of quality and safety. Policies and procedures were up to date. Evidence was seen that Regulation 28 unannounced visits were being completed in line with requirements. Daily operational meetings were held, attended by members of the senior leadership team, to review incidents and emerging issues. Staff were informed of changes through a combination of monthly staff meetings and daily huddles, supporting information flow between management and ward teams.

Systems were in place to monitor quality and risk, including regular audits undertaken by internal practice and quality leads. Incident reporting processes enabled the identification of themes and trends, and the service undertook thematic reviews where required to support learning and improvement.

Dealing with concerns and managing incidents
The service had systems in place to manage concerns, complaints, incidents and near misses in line with regulatory requirements. Clear complaints processes were accessible to patients, families and carers, including the ability to raise concerns anonymously via the whistleblowing policy. Information explaining how to make a complaint was displayed throughout the hospital and provided on admission, and staff and patients demonstrated awareness of the process.

Complaints were captured formally, including verbal and informal concerns, and were reviewed through internal management meetings to identify actions, themes and learning. Evidence was seen that complaints raised by patients, families and external professionals were investigated appropriately and responded to within required timescales.

The hospital reported a high number of incidents, reflecting the complexity and acuity of the patient group. We saw evidence that incidents were being reported appropriately to HIW and other relevant statutory bodies. Restrictive Practice Reviews were undertaken to analyse themes and trends, with multidisciplinary involvement, patient input and consideration of Positive Behaviour Support plans. These reviews were detailed and represented good practice in supporting incident reduction and learning at organisational level.

However, our review of the circumstances and documentation relating to one recent incident highlighted areas for improvement. We noted that the incident form lacked key contextual details, including the location of IM medication administration. Although a clinical review had been completed, this appeared to have taken place before full and accurate accounts had been obtained from all staff involved, limiting the opportunity to fully understand the context of the

incident. We were informed that, following the review, a decision had been made that staff were no longer permitted to administer medication following verbal consent from the Responsible Clinicians; however, this learning was not clearly documented and did not appear to have been shared with staff in a timely manner.

The service must strengthen its incident review and learning processes to ensure incident records are complete and accurate, clinical reviews are informed by comprehensive staff accounts, and learning is clearly documented and communicated promptly to staff.

Workforce recruitment and employment practices
An up-to-date recruitment policy was in place to support safe recruitment practice. Pre-employment checks, including Disclosure and Barring Service clearance, professional registration and references, were undertaken centrally and were evidenced in staff files held onsite.

The service had reported a downward trend in agency usage over the past six months. However, concerns were raised by staff members during the inspection regarding the use of agency staff. Staff reported that although efforts were made to book familiar agency workers, this was not always achieved, and on some shifts a high proportion of staff were agency workers. Staff also reported communication barriers with some agency staff. This was felt to affect continuity, communication and therapeutic engagement, particularly during periods of increased risk.

The service must review its use of agency staff to ensure an appropriate skill mix is maintained by strengthening induction, communication expectations and engagement requirements so that unfamiliar agency staff do not negatively impact patient experience, therapeutic interaction or continuity of care.

Workforce planning, training and organisational development
Most staff who completed a HIW questionnaire said that they had received appropriate training for their roles, including mandatory and role-specific training. We saw evidence that overall compliance among staff with such training was high. However, some comments from staff highlighted difficulties at times accessing training due to staffing pressures, limited cover and expectations to complete training in personal time.

From discussions with staff during the inspection and feedback received through HIW questionnaires, concerns were also raised about workforce planning and the alignment of staffing arrangements with ward acuity. Staff reported that staffing levels and skill mix did not consistently reflect the complexity of patient need or the requirement for enhanced observations. Staffing was described as reactive, with limited contingency planning for unplanned sickness or fluctuations in acuity.

Staff also reported that senior nurses were routinely included in staffing numbers despite being frequently required off the ward, reducing their availability for direct patient care and leadership.

Staff further reported that staffing pressures affected workload and wellbeing. Some staff described difficulty taking breaks and challenges balancing administrative responsibilities, incident management and patient contact. While care delivery was reported to be manageable during settled periods, staff stated that high acuity and frequent incidents limited opportunities to complete care planning, risk assessments and one-to-one therapeutic work.

The service must consider staff feedback regarding access to training, workload and wellbeing, and provide assurance to HIW on how these perceptions will be explored, addressed and monitored to support staff confidence, engagement and sustainability.

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: Heatherwood Court

Date of inspection: 26, 27 and 28 January 2026

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

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

Appendix C - Improvement plan

Service: Heatherwood Court

Date of inspection: 26, 27 and 28 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.	On one occasion during the inspection, the service had been unable to provide the required number of male staff to meet a patient's 3:1 observation plan.	The service must ensure staffing rotas meet the required gender mix for individual observation needs through proactive planning and timely rota adjustments.	Privacy and dignity	Heatherwood Court has a designated Rota Manager who works closely with the Hospital Administrator to meet shift number and gender requirements. This is reviewed both at the rostering stage and during weekly review of the roster in relation to patient/hospital and gender requirements at that specific time as requirements change on a regular basis within the service. Unfortunately, on this one occasion the rostering and allocation had been met, but due to short term sickness on the day the hospital was unable to meet the requirement. Heatherwood Court has had minimal staff vacancies for some months, however, due to annual	General Manager – Lydia Bevan	18/05/2026

				leave, sickness and maternity leave there is a current temporary need for increased short-term cover. Heatherwood are currently working with the local agency providers to block book regular agency staff who have experience of working in the service and who are recommended by the staff teams to temporarily backfill the vacancies. This has previously been very successful as noted in the previous HIW inspection in HWC and the action should be completed by the end of April 2026.		
2.	We noted that patient information on Cardigan Unit was noticeably sparse.	The service must review and strengthen the availability of patient information on Cardigan Ward, bringing it in line with the standard achieved across the rest of the hospital.	Patient information and consent	During the inspection it was highlighted that the patients would regularly pull-down information on display. However, to prevent this taking place moving forward, more secured notice boards have been ordered for the main unit (there are presently notice boards in the hall on entry to the ward). This will also be discussed with the patients in weekly meetings prior to installing to ensure they are in agreement and will be regularly reviewed to ensure they remain in situ.	Hospital Director – Olivia Ferrari	18/05/2026
3.	Several areas required cosmetic improvement, including worn	The service must provide an update on refurbishment work completed	Environment	Chepstow unit is being fully refurbished with all new furniture, fixtures and full en-suiting.	General Manager – Lydia Bevan	18/05/2026

	furniture, a need for deep cleaning and minor maintenance issues, although staff reported that refurbishment was due to begin imminently.	since the inspection to evidence how it is addressing the cosmetic improvement and outstanding maintenance issues across the hospital.		The ensuite schedule was provided to HIW during inspection of timescales for Cardigan and Caernarfon. There are no long-term outstanding maintenance requests in the service, and this is reviewed weekly in an onsite maintenance meeting which is attended by General Manager, Operations Director and Head of Maintenance. However, there are regular maintenance tasks which are required due to the complexity of the service and need for regular decoration. The General Manager completes a weekly walk around the units, and the furniture is recovered / replaced depending on need as soon as it is identified. During the inspection the management team were not made aware of any worn furniture. However, the General Manager maintains the walk arounds and will address immediately. A monthly painting rotation to refresh the unit's paintwork was introduced in February 2026, and the housekeeping team have an ongoing schedule for deep cleaning carpets and floors. The kitchen units are in the process of being repaired / replaced as required.		

4.	Compliance with implementing actions identified during pharmacy audits required improvement.	The service must ensure that governance around implementing pharmacy recommendations is strengthened so that issues are resolved in a timelier manner.	Medicines management	The local governance minutes reflect this area for development and there are weekly and monthly audits to support the Clinical Lead, Hospital Director, Nursing team and Doctors to ensure full compliance in this area. Where there is a compliance issue this will be addressed.	Clinical Lead – Rebecca Parry	01/05/2026
5.	The number of physical intervention incidents occurring at the hospital was high, with 211 recorded in the previous three months.	The service must provide assurance on how it will strengthen its approach to prevention, engagement and environmental considerations to reduce the number of physical intervention incidents with patients.	Safe and clinically effective care	The service uses statistical process control charting month on month to review rates of restrictive intervention use per thousand bed days; this is consistent with the overall approach to the governance of restrictive intervention across the entirety of Iris Care Group. Governance data for the group as a whole shows Heatherwood Court data displays far more variability month on month than other ICG services, which is consistent with the service providing clinical provision for people with highly complex clinical presentation, many of whom have had substantial histories in forensic impatient and PICU services. National data for such services tend to show levels of restrictive intervention at a level similar to that found at Heatherwood Court.	Hospital Director - Olivia Ferrari Clinical Lead – Rebecca Parry	31/07/2026

				In addition, the wards governance focus on accurate recording, means that the service can be more confident that the data collected is accurate. Recent National reports have indicated concerns regarding data capture in relation to restrictive interventions, an issue that given the services long history of extremely diligent management of restrictive interventions, we do not believe we experience at Heatherwood Court. It is important to note that the organisation and Heatherwood Court focus on minimising the use of all forms of restrictive practise and this continues to be a priority and our response here is not to be reflective of disagreement, but when rates of restrictive intervention increase it is imperative that governance and clinical actions are undertaken to reduce them. In January a Reducing Restrictive Practice working group was formed (which was commended by HIW) and within these meetings good practice is noted.		
6.	Staff raised concerns through questionnaires and during the	The service must reflect on the feedback received and provide	Staff feedback	A full site cultural review is being undertaken by Quality Lead for Hospitals and our Ethics and Safeguarding Lead. The scope of the review is based around HIW	Ethics and Quality Lead and Quality	31/07/2026

	inspection which require further consideration and resolution.	assurance to HIW about further actions that can be taken to explore staff experience to ensure that concerns raised by staff are understood, addressed and resolved in a sustainable way.		feedback, our internal annual staff questionnaires and also feedback from staff supervisions and team meetings. The scope will include team feedback in relation to improvements required in the service. In May there are also scheduled staff team development days booked which will focus on service improvement from the staff's perspective as well as organised team building events. Following completion of the culture review and staff development days a 'staff committee' will be formed to oversee the compilation of the action plan and implementation of relevant actions.	Lead for Hospitals Hospital Director and Head of Learning & Development Operations & Hospital Director & HR representative	 12/05/2026 31/08/2026
7.	Our review of the circumstances and documentation relating to one recent incident highlighted areas for improvement in incident recording and learning.	The service must strengthen its incident review and learning processes to ensure incident records are complete and accurate, clinical reviews are informed by comprehensive staff accounts, and	Dealing with concerns and managing incidents	The incident was raised during inspection and immediate action taken to rectify the situation – a further clinical review was undertaken on the 30/01/2026. Heatherwood Court has a robust clinical review process which includes Heatherwood Courts MDT, patients and external care teams in a detailed analysis of the incident and learning that is required which was evidenced during the inspection. This was an isolated incident.	Hospital Director & Clinical Lead	16/04/2026 completed

		learning is clearly documented and communicated promptly to staff.		However, learning from the incident identified by HIW has taken place. The internal Quality Safety, Risk committee reviewing patient safety weekly captures ongoing learning and actions, moving forward all clinical review minutes are now approved by the HD prior to distribution.		
8.	Concerns were raised by staff members during the inspection regarding the use of agency staff.	The service must review its use of agency staff to ensure an appropriate skill mix is maintained by strengthening induction, communication expectations and engagement requirements so that unfamiliar agency staff do not negatively impact patient experience, therapeutic interaction or continuity of care.	Workforce recruitment and employment practices	As in point 1 - Heatherwood are currently working with the local agency providers to block book regular agency staff who have experience of working in the service and who are recommended by the staff teams to temporarily backfill the vacancies. This has previously been very successful as noted in the previous HIW inspection in HWC and the action should be completed by the end of April 2026. This will ensure the staff have the same training and supervision as employed members of Heatherwood court team. Of note the stability index in Heatherwood is 77% with only 1 nurse vacancy (in competitive markets a stability rate of 75-85% is recommended).	General Manager – Lydia Bevan	01/05/2026

9.	Staff feedback raised some concerns that require further review and assurance.	The service must consider staff feedback regarding access to training, workload and wellbeing, and provide assurance to HIW on how these perceptions will be explored, addressed and monitored to support staff confidence, engagement and sustainability.	Workforce planning, training and organisational development	The actions being taken in point 6 and point 1 and 8 in relation to regular agency block bookings will feed into this action. As in point 6 at the point of completion of the cultural reviews the findings will be available for Heatherwood to share with HIW. At this point a staff committee will be formed who will contribute with the management team in collating an action plan based on feedback and once compiled this will also be available to share with HIW. The committee will meet on a 4-weekly basis initially to ensure high level actions are implemented and reviewed with staff in a timely manner and once implemented will continue to meet quarterly to review actions are still appropriate and complete 6-monthly reviews with staff teams to measure the success of the action plan and that it continues to meet staff needs.	General Manager – Lydia Bevan Ethics and Quality Lead and Quality Lead for Hospitals Hospital Director Operations Director Head of HR	01/05/2026 31/07/2026 28/09/2026

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): **Olivia Ferrari**

Job role: **Hospital Director**

Date: **17 April 2026**