Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Seren Gobaith Hospital, Ty Melyn LTD

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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 Seren Gobaith Hospital, on 2, 3 and 4 March 2026.

The following hospital wards were reviewed during this inspection:

- Ash Ward - 16 bedded female open rehabilitation ward
- Beech Ward – 8 bedded male low secure ward.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of three questionnaires were completed by patients or their carers and none were completed by staff. Feedback and some of the comments we received appear throughout the report. We also spoke to patients and several staff working at the service during our inspection. 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 told us they felt well cared for, listened to, and treated with kindness. Throughout our visit, we saw positive and respectful interactions between staff and patients, and it was clear that staff worked hard to promote people's independence, wellbeing, and involvement in their care. Patients had access to health information, activities and support that helped them look after both their physical and emotional health.

There are, however, some areas where the service could strengthen its approach to ensure all patients receive consistent information and feel fully included in how the service develops. Information about raising concerns was not always displayed on all wards, Welsh-language materials were not consistently available, and patients did not always see how their feedback was used to make improvements.

The outdoor spaces were also limited, and enhancing these would help create a more calming and therapeutic environment.

Overall, the service has a number of positive foundations in place, particularly in the way staff support patients.

This is what we recommend the service can improve:

- Improve and develop the outdoor garden areas to provide a more therapeutic and welcoming space
- Make sure information about how to raise concerns, including Welsh-language materials, is displayed consistently across all wards
- Ensure staff know how to access translation and interpreting services to support patients with communication needs
- Make sure patients can clearly see how their feedback has been listened to and acted upon, for example through visible "You said, we did" information.

This is what the service did well:

- Staff consistently treated patients with warmth, dignity, and respect, including during more challenging or sensitive moments
- Patients were encouraged to be independent and could take part in meaningful activities that supported their wellbeing
- Care plans reflected individual needs and preferences, and patients were actively involved in discussions about their care.

Delivery of Safe and Effective Care

Overall summary:
Overall, the service has a number of positive foundations in place to support the safe and effective delivery of care. Staff were knowledgeable about patients' needs, and there was evidence of good multidisciplinary working, regular reviews, and well-organised clinical records. Risk assessments were detailed and updated when patient presentation changed, and daily morning meetings ensured that risks, incidents, and priorities were discussed and communicated clearly across teams.

Medication management processes were mostly robust, with clear records, regular audits and good oversight of storage and clinic room checks. However, improvements are needed to ensure all emergency medications are consistently available, fridge and room temperature checks are fully completed, and oxygen cylinders are stored safely in line with national guidance.

Care planning was comprehensive and person-centred, although not all care plans included patient signatures and some lacked clearly documented review dates. A small number of gaps were identified in documenting family involvement, where appropriate, and capacity assessments for treatment did not always contain the level of detail required.

The hospital environment was clean, modern, and well maintained. Infection prevention and control arrangements were broadly appropriate, though IPC training compliance needs improvement.

Staffing levels were good, with minimal use of agency staff, and staff reported positive teamwork and visible leadership. However, several key policies were overdue for review.

This is what we recommend the service can improve

- Ensure all emergency medications, oxygen cylinder storage and temperature checks are consistently completed and documented to the required standard
- Improve the quality and detail of capacity assessments for treatment, in line with the Mental Health Act Code of Practice
- Ensure all overdue organisational policies are reviewed and updated within expected timescales
- Strengthen care plan documentation, ensuring review dates, patient signatures and appropriate family involvement are consistently recorded.

This is what the service did well:

- Provided comprehensive and well-organised care records, including detailed assessments and regular MDT reviews
- Ensured the environment was clean, modern, and well maintained, supporting safe and dignified care.

Quality of Management and Leadership

Overall summary:
Overall, the service has developing and strengthening governance arrangements, supported by regular meetings, structured oversight, and visible leadership. Staff described a positive cultural shift since new managers were appointed, and we observed open communication and effective teamwork during morning meetings and clinical discussions. A programme of audits is in place, and these are used to identify actions and track improvements. The service is also developing a governance workbook and matrix to bring together information on incidents, safeguarding, complaints, training, and policy reviews. This will further support consistent monitoring of quality.

Processes for reporting and reviewing incidents are functioning well. Staff complete incident forms which are discussed each morning, with multidisciplinary input and clear allocation of actions. Safeguarding concerns are reviewed daily with the involvement of the safeguarding lead, and recent referrals had been managed appropriately. Staff demonstrated good awareness of escalation routes, whistleblowing, and their duty to report concerns.

Recruitment processes are safe and managed, with appropriate checks completed before staff begin work. Staffing levels are stable, reliance on agency staff is low, and staff reported feeling safe and supported. However, supervision compliance was low at 61%, and improvement is required to ensure consistent support and oversight for all staff. Mandatory training compliance also varied, particularly in areas such as safeguarding and infection prevention and control.

While induction processes were strong and staff described a positive and supportive culture, improvements in supervision and training compliance would strengthen overall workforce assurance.

This is what we recommend the service can improve:

- Improve supervision compliance to ensure all staff receive regular, recorded supervision.
- Increase mandatory training completion, particularly safeguarding and infection control.

This is what the service did well:

- Senior leaders were visible and engaged positively with staff, contributing to a developing open culture
- A structured daily governance rhythm was in place, including morning meetings and regular oversight visits
- The service is proactively developing a governance workbook and matrix to improve monitoring and accountability.

3. What we found

Quality of Patient Experience

Health promotion, protection and improvement
Patients had access to information and activities that helped them look after their health and wellbeing. Health promotion materials were visible on the wards, including advice on smoking cessation and contact details for support services. Staff worked proactively with local health services. Patients attended GP appointments, health checks, and blood monitoring.

Patients also had opportunities to take part in activities that supported their physical and emotional wellbeing, such as quizzes, board games, and light exercise. A gym was available, although patients told us they rarely used it.

Patients were encouraged to be independent with everyday living tasks such as laundry and personal organisation. They also had access to outdoor spaces. However, the garden areas were sparse, and improving these would provide a more therapeutic space for patients.

The registered provider must ensure that improvements are made to the garden areas.

Dignity and respect
We found that staff treated patients with kindness, respect, and patience. Across both wards, staff demonstrated warm and supportive interactions, including when patients were anxious or distressed. Patients we spoke with said staff treated them with dignity, and they felt comfortable raising any personal needs.

Patients had their own en-suite bedrooms, which they could personalise. Patients described staff would knock before entering bedrooms, and this was reflected in our observations, where staff routinely knocked and waited before entering. Observation panels were fitted with appropriate screening to protect privacy during checks.

Confidential information was stored out of sight, and private rooms were available for conversations. Staff supported patients to make choices and stay independent, including having private phone calls, keeping personal items, and taking part in activities. The wards provided single-sex accommodation and an appropriate mix of male and female staff.

Patient information and consent
Patients received a welcome guide on admission. This included information about the hospital, daily routines, safety procedures and how to access support. A Statement of Purpose was available and up to date. Information about advocacy services, visiting times and raising concerns was visible on Ash ward, although less consistently displayed on Beech ward.

Patients told us they understood their care and could ask staff for more information at any time. Staff used clear language, avoided jargon, and supported patients to take part in decisions.

Digital communication was supported safely, with individual risk assessments for personal devices and private areas available for confidential conversations.

Communicating effectively
Staff communicated well with patients and adapted their approach to meet individual needs. We observed staff speaking clearly, respectfully and at a pace that allowed patients to understand what was being explained. Patients said they felt listened to and were able to raise questions about their care.

Information for patients and families was available throughout the wards. Translation services were available when needed. However, information about raising concerns was not consistently displayed on both wards, and Welsh-language materials were not visible on every ward. Some staff stated they did not know how they would access translation services, indicating there may be inconsistencies in staff awareness. Others referred to the use of language-line or online tools.

The registered provider must ensure that information about raising concerns and Welsh-language materials is consistently displayed on all wards.

The registered provider must ensure that all staff understand how to access translation and interpreting services.

Care planning and provision
Care plans were individualised and reflected patients' needs, risks, and goals. Records showed patient involvement in discussions about their care. Staff supported patients to develop independence by encouraging them to take part in daily activities and make decisions about meals, routines and leave arrangements.

Daily morning meetings, along with monthly community meetings gave patients opportunities to express their preferences and request activities. Staff responded well to these requests and supported patients to access the community when

appropriate. The small patient cohort has enabled staff to spend more time with individuals and develop meaningful therapeutic relationships.

The service worked in partnership with external agencies, including primary care, dietetics, and third-sector organisations.

Equality, diversity and human rights

The service had structures in place to promote equality and protect patients' rights. Staff received Equality, Diversity and Inclusion training (EDI), and an EDI policy was available.

The hospital environment was accessible, with lifts available for patients with mobility needs. Staff made reasonable adjustments, such as providing private areas for family visits and accessing advocacy services.

Patients told us they felt respected and treated fairly, regardless of background.

Citizen engagement and feedback

Patients were encouraged to share their views through daily morning meetings and community meetings. These meetings allowed patients to request activities, raise issues and comment on their experiences. Staff recorded these discussions and acted on requests where possible.

A suggestion box was available, and the service had undertaken at least one patient survey. Patients said they felt comfortable giving feedback. However, we did not see clear evidence of how feedback was shared back with patients. There were no visible "You said, we did" boards, and information on how to provide feedback was not consistently displayed on both wards.

The registered provider must make sure patients can clearly see how their feedback has been listened to and acted on.

Delivery of Safe and Effective Care

Safe Care

Environment

The environment was clean, bright, and well maintained. Staff told us the building is new and designed to support patient privacy, dignity, and independence. Bedrooms were tidy and in good condition, with appropriate furniture and en-suite facilities. Communal areas were comfortable and provided enough space for patients to spend time together or speak to staff in private.

Outside space was available; however, it lacked any meaningful therapeutic features. Staff described the courtyard as bare and not beneficial for rehabilitation. Adding seating, greenery or activities would make the area more welcoming and useful to patients. It was positive to note that the hospital has plans in place to improve the garden area.

The registered provider must ensure that the outdoor space is improved so it offers a more therapeutic and engaging environment for patients.

Managing risk and health and safety

Staff understood how to manage risks on the wards. They were aware of observation levels and how to respond if a patient's risks increased. Ligature cutters were accessible, and staff knew where these were kept. Call bells were in every bedroom and communal area, and staff felt confident that support would arrive quickly if needed.

Fire safety arrangements were appropriate. Fire equipment was maintained, fire drills were completed regularly, and risk assessments were reviewed and up to date. Environmental risks were discussed daily at handovers and reviewed during routine audits. Staff were aware of processes for escalating environmental issues.

Infection prevention and control (IPC) and decontamination

The wards were visibly clean, tidy, and free from clutter. Bedrooms, bathrooms, floors, and furniture were well maintained and suitable for effective cleaning. Staff said PPE was available and that cleaning routines were followed, and cleaning schedules were in place and completed consistently. Handwashing facilities and signage were visible, and patients were encouraged to wash their hands before meals or during activities.

Isolation could be managed safely if needed, and the layout of the building supported good IPC practice.

Nutrition
Patients were supported to eat and drink regularly. Patients told us they were generally satisfied with the food provided. Staff encouraged healthy choices and promoted independence by involving patients in mealtime routines.

Snacks and drinks were available throughout the day, and patients could prepare their own food with support in the occupational therapy kitchen.

Medicines management
Medicines were stored securely, and staff understood their responsibilities. Nurses had access to relevant policies and training, including safe administration and rapid-tranquillisation training where appropriate. Staff said they felt supported by managers and that medication-related concerns were discussed openly through multi-disciplinary team (MDT) meetings and incident reviews.

Medication charts were complete, and staff documented administration accurately. Patients were supported to understand their medicines during one-to-one discussions, and clinical audits monitored safe practice.

There were a small number of gaps in the fridge and room temperature records, showing that checks were not completed consistently.

The registered provider must ensure that fridge and clinic room temperature checks are completed and recorded consistently, so there is clear assurance that medicines are always stored within safe temperature ranges.

Safeguarding children and safeguarding vulnerable adults
Appropriate processes were in place to ensure staff safeguarded vulnerable adults and children, with referrals made to external agencies when required. Ward staff had access safeguarding processes and policies, supported by the Wales Safeguarding Procedures via the intranet.

Staff had a clear understanding of safeguarding procedures. They knew who the safeguarding lead was and said they would feel comfortable raising a concern. Safeguarding was discussed daily in morning MDT meetings, and staff knew how to contact local authority teams for urgent advice.

Staff felt supported by managers and said safeguarding issues would be taken seriously and responded to promptly.

Medical devices, equipment and diagnostic systems

Clinical equipment used on the wards was appropriate and safely maintained. Staff conducted routine checks of medical devices, including resuscitation equipment, and documented these checks to ensure readiness and compliance. However, it was identified that the emergency drugs bag did not contain the full complement of required medicines. The service acknowledged this and immediately ordered the missing medications.

The registered provider must ensure that the emergency drugs bag on all wards always contains the full and correct range of medicines, and that regular documented checks are conducted to confirm all items are present, in date and ready for immediate use.

We also found that oxygen cylinders were not always stored safely; some cylinders were not secured in an upright, designated area.

The registered provider must ensure that oxygen cylinders are always stored safely, secured in an upright and designated area.

Staff were trained to use diagnostic equipment safely and appropriately. Equipment observed during the inspection was clean, accessible and in good working order. Fire alarms, extinguishers and safety systems were serviced regularly.

Safe and clinically effective care
Staff told us they had enough time to deliver safe care, update records, and support patients. The skill mix on both wards was appropriate, and the small patient numbers allowed staff to build strong therapeutic relationships.

Escalation processes were in place when additional support was required. The MDT worked well together. Morning meetings offered a clear structure for reviewing risks, incidents, changes to care and patient progress.

Staff explained that learning from incidents was discussed regularly, especially during morning MDT meetings. Debriefs took place after incidents.

Participating in quality improvement activities
The service participated in a range of quality improvement activities, including clinical audits, governance meetings, and patient satisfaction surveys. Findings from audits were used to inform action plans, and there was evidence of learning being shared with staff. In addition, the governance workbook demonstrated that the service is developing a structured approach to monitoring quality, with plans to use a comprehensive governance matrix to track key areas such as safeguarding,

incidents, complaints, medication audits, and policy reviews. This shows a commitment to strengthening oversight and supporting continuous improvement.

Information management and communications technology
Staff used secure electronic systems to access policies, procedures, and patient information. They felt confident using the hospital's computer systems and understood their responsibilities around confidentiality.

Electronic records were password-protected, and paper documents were stored securely in locked areas. Staff used secure NHS email to share information appropriately with external partners.

Digital tools were used to support communication, including supervised use of devices for video calls and online meetings. Staff demonstrated awareness of data protection responsibilities, and regular audits monitored compliance.

Records management
Patient records were well maintained, securely stored, updated regularly, and compliant with GDPR requirements. Regular record-keeping audits and dip sampling reinforced governance standards.

Mental Health Act monitoring
During our review of the Mental Health Act (MHA) documentation, we found that statutory detention papers for the patients sampled were well completed and compliant with the legal requirements of the Mental Health Act 1983 and Code of Practice for Wales (2016). Detention documents were stored securely, easy to navigate and clearly organised.

Patients had been informed of their rights under the Act, and there was evidence that these rights were explained regularly and recorded. Advocacy services were available onsite through CADMHAS, and information on how to access advocacy and legal advice was clearly displayed. Patients were routinely offered support to appeal their detention.

Section 17 leave authorisations had been completed and signed by the Responsible Clinician. Leave was risk assessed, and photographs were present in-patient records. However, we noted that copies of Section 17 leave forms were not routinely provided to patients, despite the Code of Practice (paragraph 27.18) stating that patients should receive these. This limits patients' understanding of their conditions of leave.

The registered provider must ensure that patients are routinely given a copy of their Section 17 leave form, so they fully understand the conditions of their leave, in line with paragraph 27.18 of the Mental Health Act Code of Practice for Wales.

The quality and detail of capacity assessments for treatment varied. Although capacity was considered in some MDT discussions and documented for financial decisions, completed treatment capacity assessment forms lacked the level of detail required under paragraph 13.8 of the Code of Practice. These forms did not clearly record the decision being assessed, what information was given to the patient, the patient's understanding, or the rationale for determining capacity.

The registered provider must ensure that capacity assessments for treatment are completed in full and in line with paragraph 13.8 of the Mental Health Act Code of Practice, clearly recording the specific decision being assessed, the information given to the patient, the patient's understanding, and the reasons for determining whether the patient has capacity.

Hospital Managers' hearing documentation reviewed during the inspection included written outcomes. Although these referenced the relevant Mental Health Act criteria, the level of detail demonstrating how decisions had been reached was inconsistent across the records reviewed.

The registered provider must ensure that Hospital Managers' Hearing records include clear and detailed reasons for how the decision was made.

Overall, patients were supported to understand their rights, and the administrative processes for managing legal documentation were effective.

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

We reviewed a sample of Care and Treatment Plans (CTPs) and found that care planning was detailed, person-centred and aligned to the domains of the Mental Health (Wales) Measure 2010. Care plans reflected the patient's assessed needs and included a range of therapeutic, psychological and social interventions delivered by the multidisciplinary team.

Records showed evidence of comprehensive assessments at admission, including physical health screening and risk assessments. Risk assessments were reviewed regularly and supported by clear risk management plans. MDT meetings took place frequently with good attendance, and minutes showed active involvement in planning and reviewing care.

Care plans demonstrated a recovery-focused approach, outlining rehabilitation goals and the responsibilities of both staff and patients. Patients' strengths, preferences, and aspirations were included, and there was evidence that advocacy was offered to support involvement in decision-making.

However, some areas require improvement. Not all care plans included patient signatures, making it unclear whether patients had formally agreed to their care

plan. In some cases, review dates were not clearly recorded, and it was difficult to determine whether a care plan was still current or had been replaced. Evidence of family involvement was limited in several records, where this would have been appropriate.

The registered provider must ensure that care plans consistently include evidence of patient involvement, with signatures or clear documentation where a signature cannot be obtained, that review dates are recorded so it is clear whether a care plan is current or has been replaced, and that family involvement is documented where appropriate to support personalised and collaborative care planning.

Overall, the service has strong foundations in place for effective care planning. Care plans are individualised, clinically relevant and updated regularly through MDT processes. Clearer documentation of patient involvement, consistent recording of review dates and improved inclusion of family views (where appropriate) would further strengthen compliance with the Mental Health (Wales) Measure.

Quality of Management and Leadership

Governance and accountability framework

There are clear governance arrangements in place within the service, supported by regular meetings, audits and oversight mechanisms. Senior leaders are visible, approachable and engage well with staff across wards.

Staff told us there has been a positive cultural shift since the current management team was appointed, and we observed effective communication between teams during morning meetings and clinical discussions.

A programme of scheduled audits is in place, covering areas such as medicines management, care plans, infection control, and health and safety. Audit outcomes are discussed at governance meetings, with actions allocated and monitored.

The governance lead is introducing a more structured governance matrix to strengthen the monitoring of key indicators, including incidents, complaints, compliments, training compliance, and policy reviews. However, several clinical and organisational policies were noted to be past their review dates, including medicines management, restrictive practice, complaints, recruitment, and infection control. Although a policy review day has been arranged, these policies must be brought up to date to ensure compliance with relevant regulations and best practice.

The registered provider must ensure that all organisational and clinical policies are reviewed and updated in line with their scheduled review dates.

Unannounced visits by the Responsible Individual have taken place in line with requirements, with findings shared with the hospital management team. There is also clear evidence that senior managers undertake night visits and environmental walk-arounds to maintain oversight of practice across both wards.

Dealing with concerns and managing incidents

The service has processes in place to record, review and act on incidents. Staff complete incident forms (IR1s), which are reviewed at daily morning meetings, where multidisciplinary discussion and action planning takes place. The clinical manager oversees incident reporting, ensures forms are completed correctly, and provides feedback to staff where improvements are needed. Themes and patterns are monitored, and learning is shared through clinical governance, staff meetings, handovers, and email updates.

Safeguarding concerns are reviewed daily by the MDT, with input from the hospital's safeguarding lead. There was evidence that recent safeguarding referrals had been managed appropriately, with correct notifications made to statutory bodies. Staff demonstrated good awareness of how to escalate concerns, the whistleblowing process, and their duty to report.

Overall, systems to report, track and learn from concerns and incidents are in place and operating effectively.

Workforce recruitment and employment practices
We found effective recruitment processes in place, including completion of pre-employment checks such as DBS clearance, reference verification, and professional registration checks. Staff information is held on electronic and paper systems, and managers maintain spreadsheets to track expiry dates for PIN numbers and DBS renewals.

Staff told us they felt safe and supported at work, and no concerns were raised in relation to staff conduct or the safety of patients. There is no significant reliance on agency staff, with the service using bank staff and overtime where needed to maintain safe staffing levels. This supports continuity and familiarity for patients.

Supervision arrangements are in place; however, compliance is variable. Supervision levels were reported as 61%, and improvement is required to ensure that all staff receive regular and consistent supervision in line with organisational policy.

The registered provider must ensure that supervision compliance is improved and maintained, ensuring all staff receive regular, recorded supervision in line with organisational policy.

The service has clear policies relating to recruitment, staffing and professional standards.

Workforce planning, training and organisational development
The service has a workforce plan in place that ensures adequate staffing levels across the wards, with safe skill mix, gender balance, and high levels of permanent staff. Staff reported that there were enough staff on shift and that they had enough time to provide safe and effective care.

Induction arrangements for new staff, including agency or bank workers, are comprehensive. New staff complete shadow shifts and are introduced to key policies, procedures, and ward routines.

Mandatory training compliance varied, and some modules including safeguarding, basic life support and infection prevention and control need improvement. Overall compliance with mandatory training was 70%.

The registered provider must ensure that mandatory training compliance figures are improved.

Staff described positive working relationships, regular MDT and handover discussions, and a supportive workplace culture. However, some staff reported the need for improvements to the annual leave system.

The registered provider should engage with staff to understand their views on the annual leave system and identify how it can be improved to better meet their needs.

Overall, the workforce is stable, well-trained and supported, with clear structures for communication and development. Strengthening training compliance and ensuring regular supervision will further enhance workforce capability and resilience.

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
The emergency drug bag did not contain the full complement of required medicines.	In an emergency, staff may not have immediate access to life-saving medicines	Immediately escalated to clinical manager and hospital manager.	This issue was resolved during the inspection, as the missing medicines were identified and ordered before the visit concluded.

Appendix B - Immediate improvement plan

Service: Seren Gobaith

Date of inspection: 2 - 4 March 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
2.						
3.						

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):

Job role:

Date:

Appendix C - Improvement plan

Service: Seren Gobaith

Date of inspection: 2 - 4 March 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.	The garden areas were sparse, with limited greenery and outdoor equipment.	The registered provider must ensure that improvements are made to the garden areas.	Safe Care.	Garden furniture, seating, planters and decorative items have been sourced and installed to enhance the therapeutic environment. All items are risk assessed and appropriate for the setting. Patients have been actively involved in selection and planting activities. Ongoing development of the garden environment is	OE,LH,OTAs	Complete and ongoing.

				planned to ensure continuous improvement.		
2.	Information about raising concerns was not consistently displayed on both wards, and Welsh-language materials were not visible on every ward.	The registered provider must ensure that information about raising concerns and Welsh-language materials are consistently displayed on all wards.	Dignified Care.	Bilingual (Welsh and English) "QR coded Raising Concerns" posters have been standardised and displayed consistently across all wards and high-traffic areas, ensuring visibility and accessibility for all patients and visitors.	LH,OE	Complete
3.	Some staff stated they did not know how they would access translation services, indicating there may be inconsistencies in staff awareness.	The registered provider must ensure that all staff understand how to access translation and interpreting services.	Communication and Information.	Information regarding access to translation services has been disseminated via staff bulletin and posters. This information is also included in patient welcome packs to ensure awareness for both staff and patients.	LH, OE	Complete

4.	We did not see clear evidence of how feedback was shared back with patients.	The registered provider must make sure patients can clearly see how their feedback has been listened to and acted on.	Citizen engagement & Feedback	A structured feedback component has been introduced into OT morning meetings. A "You Said, We Did" system has been implemented across all wards, displayed in poster format and updated monthly to demonstrate responsiveness to patient feedback.	LH, OE	Complete
5.	There were a small number of gaps in the fridge and room temperature records, showing that checks were not completed consistently.	The registered provider must ensure that fridge and clinic room temperature checks are completed and recorded consistently, so there is clear assurance that medicines are stored within safe temperature ranges at all times.	Medicines Management.	Enhanced oversight has been implemented. Senior nursing staff now complete regular temperature and environmental checks, supported by ANP oversight. Any gaps in recording are identified and addressed promptly, ensuring consistent	LH, TH	Complete and ongoing

				compliance and safe practice.		
6.	The resuscitation (resus) bag did not contain the full complement of required medicines.	The registered provider must ensure that the resuscitation bag on all wards contains the full and correct range of medicines at all times, and that regular documented checks are carried out to confirm all items are present, in date and ready for immediate use.	Medicines Management.	Action complete. Resuscitation equipment has been reviewed and includes all required items. Ongoing checks are undertaken by the ANP to ensure compliance, readiness, and safety.	LH, TH	Complete
6.	Oxygen cylinders were not always stored safely; some cylinders were not secured in an upright, designated area.	The registered provider must ensure that oxygen cylinders are stored safely at all times, secured in an upright and designated area.	Safe Care.	Oxygen cylinders are now stored securely in designated areas in an upright position in line with safety requirements.	RC	Complete
7.	Section 17 leave forms were not routinely provided to patients.	The registered provider must ensure that patients are routinely given a copy of their Section 17 leave form, so they fully understand the conditions of their leave.	Mental Health Act Code of Practice for Wales (2016).	Although patients are routinely offered a copy of their Section 17 leave form, this was not consistently documented. A revised SOP has been	DG,LJ	Complete

			implemented to ensure all patients are offered a copy of the form at authorisation, staff document whether it was provided or declined, and conditions of leave are explained and understood, in line with the Mental Health Act Code of Practice 2016. In addition, the monthly MHA audit tool has been updated to include a double-checking process. These measures formalise existing practice and ensure compliance is transparent, consistent, and auditable.		

8.	Completed treatment capacity assessment forms did not clearly record the decision being assessed, what information was given to the patient, the patient's understanding, or the rationale for determining capacity.	The registered provider must ensure that capacity assessments for treatment are completed in full, clearly record the specific decision being assessed, the information given to the patient, the patient's understanding, and the reasons for determining whether the patient has capacity.	Mental Health Act Code of Practice for Wales (2016)	Seren Gobaith recognises the need for robust, decision-specific capacity assessments. In response, the capacity assessment form has been revised to improve clarity and regulatory assurance. The updated form removes reliance on cross-referencing to clinical notes and instead provides structured space beneath each element to clearly record the specific decision being assessed, the information provided to the patient, the patient's understanding and ability to weigh that information, and the rationale for the capacity	DG, LJ	Complete

				determination. This ensures assessments are comprehensive, self-contained, and auditable, in line with the Mental Capacity Act and the Mental Health Act Code of Practice for Wales, and provides clear assurance to Healthcare Inspectorate Wales of consistent and compliant practice.		
9.	Hospital Managers' hearing documentation reviewed during the inspection included written outcomes. Although these referenced the relevant Mental Health Act criteria, the level of detail demonstrating how	The registered provider must ensure that Hospital Managers' Hearing records include clear and detailed reasons demonstrating how decisions have been made.	Mental Health Act Code of Practice for Wales (2016)	Seren Gobaith will strengthen the recording of Hospital Managers' Hearing outcomes to ensure decision-making is transparent, clearly reasoned, and open to effective scrutiny. Panel members will be encouraged to explicitly document		Completed 29/04/2026

	decisions had been reached was inconsistent across the records reviewed.			how the Mental Health Act criteria have been applied to individual cases, alongside the key evidence considered. Clear written guidance will be developed to set expectations for the required level of detail, including examples of good practice. Targeted training will be provided to Hospital Managers to reinforce the importance of comprehensive, legally robust documentation, and ongoing monitoring will support sustained improvement. In addition, a memo has been issued today to all panel members outlining these		

				expectations and the actions being taken.		
10	Not all care plans included patient signatures, making it unclear whether patients had formally agreed to their care plan. In some cases, review dates were not clearly recorded, and it was difficult to determine whether a care plan was still current or had been replaced. Evidence of family involvement was limited in several records	The registered provider must ensure that care plans consistently include evidence of patient involvement, with signatures or clear documentation where a signature cannot be obtained, that review dates are recorded so it is clear whether a care plan is current or has been replaced, and that family involvement is documented where appropriate to support personalised and collaborative care planning.	Record Keeping	Care planning processes have been standardised across all wards. Care plans now include patient involvement, signatures (or documented rationale if not obtained), clear review dates, evidence of collaboration, and SMART goals. The ANP provides ongoing oversight to ensure quality, accuracy, and that care plans remain current and recovery-focused.	LH, TH	Complete and ongoing
11.	Several clinical and organisational policies were noted to be past their review dates, including medicines	The registered provider must ensure that all organisational and clinical policies are reviewed and	Quality Safety & Improvement.	All policies have been reviewed and updated by the senior management team. A quarterly review cycle	LH, OE, JW	Complete and ongoing

	management, restrictive practice, complaints, recruitment and infection control.	updated in line with their scheduled review dates.		has been implemented. Policies are now linked to the training platform, requiring staff to review relevant policies alongside training. A “Policy of the Month” initiative has been introduced to promote awareness and engagement.		
12.	Supervision levels were reported as 61%, and improvement is required to ensure that all staff receive regular and consistent supervision1	The registered provider must ensure that supervision compliance is improved and maintained, ensuring all staff receive regular, recorded supervision in line with organisational policy.	Workforce.	Supervision is now recorded and monitored via the governance workbook, enabling accurate oversight and reporting. Compliance has improved to above 80% and continues to be monitored.	LH	Complete and ongoing
13.	Mandatory training compliance varies, with some modules such as safeguarding	The registered provider must ensure that mandatory training compliance figures are improved.	Workforce.	Mandatory training compliance is currently 83.44%, with all modules above 80%	LH	Complete and ongoing

	and IPC requiring improvement.			and improving towards the 90-100% target.		
14.	Some staff reported the need for improvements to the annual leave system.	The registered provider should engage with staff to understand their views on the annual leave system and identify how it can be improved to better meet their needs.	Workforce.	Communication has been issued to staff regarding annual leave, with opportunities provided for individual discussion to address concerns and improve the process.	LH,OE	Complete

Service representative:

Name (print): Leah Hall

Job role: Director of Governance

Date:29/04/2026