Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Ward 21, Ward 22, and the Psychiatric Intensive Care Unit, Royal Glamorgan Hospital, Cwm Taf Morgannwg University Health Board

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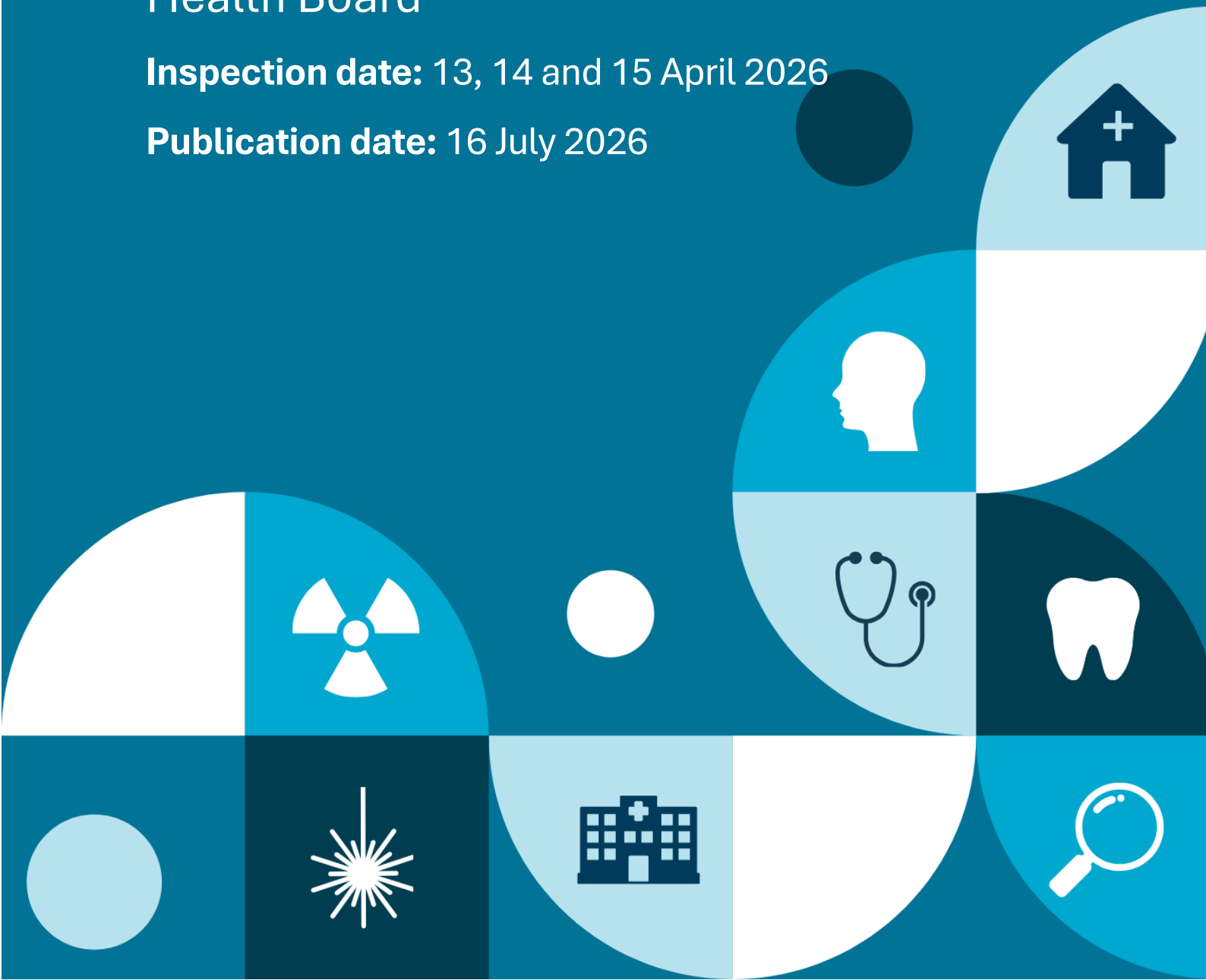

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

Our Purpose

We check the safety and quality of healthcare across Wales.

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 Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

Our Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued, and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Royal Glamorgan Hospital, Cwm Taf Morgannwg University Health Board, on 13, 14 and 15 April 2026. The following hospital wards were reviewed during this inspection:

- Ward 21 - 14 beds providing Delayed Transfer of Care (DTOC) services
- Ward 22 – 14 bed admission and treatment ward
- Psychiatric Intensive Care Unit (PICU) - 6 beds providing short-term, intensive and secure care for people experiencing severe acute mental health crises.

Our team, for the inspection comprised of two HIW healthcare inspectors, four 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 seven questionnaires were completed by patients, and four 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:
Our patient engagement highlighted generally positive experiences of care, with most questionnaire respondents rating the care and service as good or very good. Throughout our inspection, we observed staff treating patients with kindness, respect and compassion, and responding in a timely and appropriate manner. Care was provided in line with clinical need, and staff demonstrated a strong understanding of the patients in their care. Effective processes were in place to support patients' physical and mental health, including thorough assessments and timely access to healthcare services. Regular meetings were held to review patient wellbeing and care requirements, supporting continuity and coordination of care. We also found appropriate arrangements to support patients' rights, advocacy and access to care in their preferred language.

However, these strengths were undermined by several concerns affecting the overall quality of patient experience. Patients reported inconsistent access to outdoor space, limited therapeutic activity and difficulties accessing basic facilities and equipment, compromising dignity, wellbeing and equitable access. We also identified gaps in therapeutic provision, including the absence of a structured activities programme, a vacant activities co-ordinator post, and no dedicated occupational therapy provision for the PICU.

Environmental safety, dignity and privacy issues limited the service's ability to consistently deliver dignified and respectful care. Wards 21 and 22 continued to provide mixed gender accommodation, shared bedrooms and a lack of segregated communal areas, which did not reflect current mental healthcare standards and impacted patients' safety, privacy, and wellbeing.

Patient confidentiality was not consistently maintained, with patient information visible from outside a nursing office. In addition, patient information across the wards was limited, inconsistent and, in some areas, absent, reducing access to information about rights, support and the service.

Overall, while staff demonstrated a clear commitment to delivering compassionate and person-centred care, improvements were required to address environmental concerns, strengthen therapeutic and occupational provision, improve access to facilities and

information, and ensure care is delivered consistently in a way that promotes patients' dignity, safety and wellbeing.

This is what we recommend the service can improve:

- Implement a structured programme of therapeutic activities and ensure consistent delivery across all wards
- Continue robust recruitment to the vacant Activities Coordinator post
- Review OT provision for the PICU to ensure equitable access to therapeutic input
- Review shared bedrooms and mixed-gender accommodation to ensure patients' safety, privacy and dignity are protected
- Ensure clear, accessible and up-to-date patient information is consistently available and clearly displayed
- Provide appropriate facilities, equipment and support to ensure equitable access to care.

This is what the service did well:

- Consistently positive interactions observed between staff and patients
- Patients were supported to make decisions about their own care, promoting independence
- Good processes in place to monitor and support patients' physical health
- A new garden was being developed for the PICU
- Welsh-speaking staff wore embroidered uniforms and badges to clearly indicate their ability to speak Welsh
- Patient records evidenced that their social, cultural, spiritual and religious needs were considered.

Delivery of Safe and Effective Care

Overall summary:
A range of established policies, processes and procedures were in place and operating effectively. This included effective multidisciplinary working, safeguarding arrangements, patient record keeping, Mental Health Act compliance and discharge planning. Existing governance arrangements enabled discussion of incidents, risks and concerns, including use of the Datix system to record and monitor incidents, with regular reports produced to identify trends and share learning.

Patient-level risk management was supported through individual safety plans and effective therapeutic observations. Care and Treatment Plans (CTPs) were comprehensive, well maintained and regularly reviewed. Medication management arrangements were generally robust and effective; however, emergency medication storage arrangements on Ward 21 required review to ensure safe and timely access.

While we found examples of effective clinical practice and dedicated staff, these strengths were compromised by significant concerns relating to the ward environment, infection prevention and control (IPC), patient privacy and dignity, access to essential facilities, and overall safety governance. We identified widespread environmental deterioration, unresolved estates issues and weaknesses in the oversight of safety-critical risks, reducing assurance that risks were being identified, escalated and addressed in a timely way. Low staff compliance with essential mandatory training further limited assurance that staff were consistently equipped to respond safely in high-risk situations.

Immediate assurance action was required in relation to these concerns, and substantial improvement is required to strengthen governance, address environmental and IPC risks, improve training compliance, and ensure the consistent delivery of safe, effective care across all wards.

Immediate assurance:

- We identified significant, widespread and longstanding environmental safety, IPC, privacy and dignity risks across all wards. These included damaged furniture, fixtures and fittings; non-functioning lighting; unresolved ligature risks; water damage and mould; and unsecured or unsuitable toilet and bathroom facilities. Additional safety hazards, including damaged door handles and locks, and unsecured areas, compromised patient safety, privacy, dignity and wellbeing
- Many estates risks remained unresolved for prolonged periods due to capacity constraints, indicating ineffective prioritisation and reducing assurance that environmental risks were being effectively managed
- We found persistently low compliance with high-risk, safety-critical mandatory training, including Immediate Life Support (ILS), Basic Life Support (BLS), rapid tranquillisation, moving and handling and fire safety. We also found that no staff had received training in the safe use of portable British Oxygen Company (BOC) oxygen cylinders. In addition, low Prevention and Management of Violence and Aggression (PMVA) training compliance and limitations in restraint data undermined assurance around the safe use of restraint and physical intervention.

- Our concerns reflected issues identified during our previous inspection in 2023, indicating that previously escalated risks had not been effectively mitigated or sustained over time.

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

This is what we recommend the service can improve:

- Strengthen governance oversight of environmental and IPC risks, including consistent audits, clear responsibilities, access to equipment, and mandatory IPC training compliance
- Review patient laundry arrangements to support IPC, timely access to clean clothing and patient dignity
- Review emergency medication storage arrangements to ensure timely access
- Review Ward 21 configuration and access arrangements to support safe, uninterrupted care delivery.

This is what the service did well:

- Clear safeguarding processes and reporting arrangements
- Individual safety plans in place for all patients
- The hospital was supported by a dedicated and experienced MHA administration team
- Good-quality care and treatment plans, reflecting patients' needs and risks
- Restrictive practices used as a last resort, with effective de-escalation of challenging patient behaviours
- Effective admission and discharge arrangements

Quality of Management and Leadership

Overall summary:
We found a committed ward-level workforce and some effective systems to support care delivery, including positive multidisciplinary working, clear local management support, and constructive partnership working to support care planning and discharge. Established governance, incident reporting and escalation processes were also in place; however, these did not consistently demonstrate effective oversight or sustained improvement. Our inspection findings reduced assurance that risks were identified and addressed in a timely way, with some recurring issues indicating that learning was not sustained.

A clear organisational structure provided defined lines of management and accountability. Staff described a supportive ward-level culture and effective team collaboration and reported feeling able to raise concerns within their teams. However, some staff highlighted limited visibility and engagement from senior managers.

At the time of inspection, the service was undergoing significant change, including ward reconfiguration affecting ward function, staffing establishments and service delivery. Senior staff described a range of completed and ongoing quality improvement activities intended to reshape the unit during this period of transition.

Staffing levels were generally aligned with core requirements; however, workforce pressures were evident, including vacancies, reliance on temporary staff, and variation in access to psychology and occupational therapy support. Weaknesses were also identified in training compliance, appraisal completion and policy review processes, with several policies overdue or in draft.

We found limited evidence to demonstrate that feedback, learning and improvement processes were embedded across the service. While staff generally felt able to raise concerns, arrangements for staff and patient meetings were not consistent across all wards, and there was limited evidence that feedback was routinely captured, acted upon and used to drive improvement.

Overall, stronger leadership visibility, workforce planning, governance oversight and follow-through on improvement actions are required to ensure the consistent delivery of safe, responsive and well-led care.

This is what we recommend the service can improve:

- Improve senior management visibility and engagement, in response to staff feedback
- Continue robust recruitment to vacant posts to improve staffing stability
- Review the impact of ward reconfiguration on staffing levels and support arrangements
- Ensure all staff receive an annual appraisal
- Ensure timely completion and effective monitoring of mandatory training
- Ensure policies and procedures are reviewed and updated in a timely manner
- Strengthen patient and staff feedback arrangements to inform service improvement.

This is what the service did well:

- Supportive ward cultures with good team collaboration

- Effective MDT and wider system partnership working
- A range of improvement initiatives completed and ongoing
- Staff were receptive and responsive to our inspection findings.

3. What we found

Quality of Patient Experience

Patient feedback

We invited patients, families and carers to complete HIW questionnaires and spoke with patients on the wards where appropriate. Seven questionnaires were completed from the 34 patients receiving care at the time of inspection. While this sample size was too small to draw robust conclusions or identify themes, some patient responses reflected our inspection findings.

Most respondents (6/7) rated the care and service provided at the hospital as good or very good and reported that staff treated them with kindness and respect. They felt encouraged to be involved in decisions about their care (6/7) and agreed they could access the right healthcare at the right time (5/7). Most (6/7) confirmed they were aware of their CTP, were involved in its development, and were able to attend meetings or ward rounds to discuss their care. All stated that information about their care was provided in a format they could understand.

However, the questionnaire responses showed mixed experiences in relation to access to ward facilities, activities and outdoor space. Fewer than half (3/7) reported being able to access facilities important to them at a time that suited their needs, and patient satisfaction with activities and access to outdoor space was variable.

Patient comments also raised concerns about staffing levels, access to washing facilities and the availability of basic equipment. Feedback regarding the ward environment and cleanliness was mixed; while some patients felt the environment was clean (4/7), others reported that it was only sometimes clean or not clean.

While most respondents reported feeling safe on the wards (5/7), one felt unsafe and one was unsure. Those who expressed concerns linked these feelings to changes and instability within the ward environment, including security issues such as problems with ward doors.

Patient comments included:

> *"Brilliant place to live. Needs are provided straight away."*

> *"All nurses and HCSW give as much as they can. Very good care."*

“Cannot use shower in room – flooding…tea machine broken.”

“Definitely needs more staff they have dropped the NA's (Nursing Associate) to one a shift in the morning this is dangerous and endangers the staff and patients…There is no washing facilities for clothes so we have to pay the wash shop £25 a bag of washing which is unaffordable…The tea trolley is broken and with shortage of stuff unavailable to provide basic needs as a cup of tea or coffee especially if you’re thirsty.”

“Not a lot of activities. Yard is not usable at present.”

“My settings keep changing, sometimes I feel safe and sometimes I feel in danger and I get spooked really easily.”

“I don't always feel safe in the mental health hospital ward 22, there are lots of changes and I don't like that.”

“I would like to go further than the patio…I can’t freely go out and in as I please and I don't like that.”

“Please can you keep the door to the patio open or unlocked so I can go out and get fresh air/ go outside as often as I need? Thanks.”

The health board must review the patient experience feedback highlighted in this report and take action to address identified issues and ensure timely and sustained improvements.

Person-Centred

Health promotion

There were processes in place to help promote and maintain the physical and mental health needs of patients. We reviewed nine patient records across the three wards and found that patients received appropriate physical assessments on admission, with regular review of their care plans and progress. Where long-term physical health conditions were identified, these were suitably monitored within the care and treatment plans.

Patients had access to their bedrooms and communal ward areas, and access to outside space was available. Wards 21 and 22 had outdoor patio areas for patient use; however, the Psychiatric Intensive Care Unit (PICU) garden was undergoing renovation

at the time of inspection and was not in use. Staff advised that PICU patients were supported to access other outdoor areas during this period, with additional staffing in place, and that the PICU garden was expected to be completed imminently. Staff and patients reported that access to outside space was sometimes limited by staffing pressures and workload.

The health board must ensure consistent access to outdoor space for all patients, supported by appropriate staffing and timely completion of environmental works.

A range of self-directed therapeutic activities was available on the wards, including access to televisions, games and puzzles. However, there was no structured programme of therapeutic activities in place across the three wards. Patients told us that the range and frequency of activities were limited and impacted by staffing pressures.

The health board must implement a structured programme of therapeutic activities and ensure consistent delivery across all wards.

An activities coordinator role was in place; however, the post was vacant at the time of inspection, despite repeated recruitment attempts. Staff advised that this vacancy affected the consistency and availability of structured therapeutic activities for patients across the wards.

The health board must continue robust recruitment to the vacant activities coordinator post to support the planning and delivery of therapeutic activities.

Occupational Therapy (OT) provision was in place for Wards 21 and 22, with patients receiving individualised assessment and intervention to support recovery and engagement in therapeutic activity. However, there was no dedicated OT provision for the PICU, which staff recognised as a gap in provision.

The health board must review the Occupational Therapy provision for the PICU to ensure that all patients have equitable access to therapeutic interventions consistent with recovery-focused care.

Dignified and respectful care

Throughout our inspection, we observed staff engaging with patients appropriately and treating them with dignity and respect. Interactions between staff and patients were consistently positive and demonstrated staff attentiveness to individual needs. While the wards' staffing establishment was predominantly female, staff worked flexibly to ensure patient needs were met across the wards.
Patients were able to store personal belongings in their bedrooms. Observation

windows were present on bedroom doors to support privacy during observations. Patients were able to lock their bedroom doors from the inside, though staff could override the locks if necessary. Staff were observed to knock before entering bedrooms and to respect patients' privacy.

Confidential patient information was stored within Patient Status at a Glance (PSAG) boards located in ward nursing offices. During our evening tour of the wards, the Ward 22 PSAG board was observed to be open and visible from outside the nursing office, creating a risk that confidential patient information could be viewed by patients or visitors.

The health board must ensure Patient Status at a Glance boards are consistently kept closed when not in use, to protect patient confidentiality.

During the inspection, we identified significant environmental and privacy-related issues that undermined the service's ability to consistently deliver dignified and respectful care. As identified during previous inspections, where recommendations were made to address these concerns, Wards 21 and 22 continued to provide mixed-gender care and a mix of single and shared bedrooms, with no dedicated segregated communal spaces available. These arrangements negatively impacted patients' privacy and dignity and did not reflect modern mental health care provision.

The health board must review shared bedrooms and mixed-gender accommodation on Wards 21 and 22 to ensure patients' privacy and dignity are supported and aligned with modern mental health care provision.

We identified several additional issues impacting patient safety, dignity, comfort and wellbeing. These concerns were escalated through our Immediate Assurance process and are detailed in Appendix B. Further information on these findings is set out in the Risk Management and Infection Prevention and Control sections of this report.

Patient information

Each ward had dedicated patient information leaflets, and some limited health promotion information was displayed on the wards. However, we found an overall lack of accessible and clearly displayed patient information across the wards to support and inform patients about their care. Ward 21 had no information boards, and the information displayed on Ward 22 and the PICU was limited, inconsistent and in some cases outdated.

We found no information displayed regarding:

- The Mental Health Act

- Advocacy services
- Legal representatives for detained patients
- How to raise a concern or complaint
- Information about the role of HIW and how patients can contact HIW (Ward 21)
- Staff pictorial identification boards
- Information about the service
- Visiting times.

The health board must ensure that clear, accessible and up-to-date patient information is consistently available and clearly displayed across all wards.

Individualised care

Staff demonstrated a good understanding of patients' individual needs and described how care was tailored to support personal preferences, abilities and levels of independence.

We saw evidence that patients were supported to make their own decisions about how to care for themselves wherever possible, promoting independence and quality of life. Patients had access to the internet and were permitted to use personal mobile devices, subject to individual risk assessment. Staff reported that patients were encouraged to make choices about their daily routines, aspects of personal care, and engagement in activities. We observed staff supporting patients with self-care activities during the inspection.

Patients had individualised, person-centred Care and Treatment Plans (CTPs), which documented their involvement in decisions about care. More findings on care planning are detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Timely

Timely care

We observed staff responding to patients in a compassionate, timely and appropriate manner and adapting care delivery to meet individual needs where possible. Suitable arrangements were in place to ensure that patients with urgent care and treatment needs were prioritised.

Established meeting processes supported the timely delivery of patient care, including daily huddle meetings to discuss bed occupancy, patient needs and staffing levels. We attended a daily huddle and observed that staff demonstrated a strong understanding

of the individuals in their care, with discussions focused on patient wellbeing and care requirements.

Staff described a range of additional ward-level, multidisciplinary, and governance meetings, which supported communication, oversight and timely care delivery. We also observed a ward round meeting, which was well structured and demonstrated a clear pace to support patient flow.

We were informed that concerns and incidents were routinely discussed during monthly Quality, Safety and Experience (QSE) meetings, enabling the identification of trends and opportunities for wider organisational learning.

Equitable

Communicating and language

Staff were observed communicating with patients in a clear, respectful and supportive manner. Patients appeared comfortable approaching staff, and staff were responsive and attentive when patients raised concerns or requests.

Patients were supported to communicate using digital technology, including access to ward telephones and personal devices, which enabled contact with family members and others outside the service. An information technology policy was in place to support the safe use of devices.

The ward used electronic and paper patient record-keeping systems to document and communicate patient care. Staff were also able to participate in online meetings, conduct audit processes and share information electronically.

Each ward had rooms where patients could speak to staff privately. We observed patients being invited to attend meetings in private spaces, ensuring conversations could not be overheard.

Staff demonstrated an understanding of the importance of speaking with patients in their preferred language. Welsh language training was available to staff, and Welsh-speaking staff wore embroidered uniforms and badges to clearly indicate their ability to speak Welsh. We were told that language requirements formed part of recruitment and workforce planning, with English identified as essential and Welsh as desirable.

Rights and equality

We reviewed the records of five patients who were detained under the Mental Health

Act. The documentation was compliant with relevant legislation and followed the guidance of the Mental Health Act Code of Practice for Wales (2016). Further information on our findings is detailed in the Mental Health Act Monitoring section of this report.

All patients had access to an independent mental health advocate, who provided information and support regarding any concerns about their care. The involvement of advocacy services was clearly evidenced within the patient records we reviewed.

We generally found appropriate arrangements in place to promote and protect patient rights, supported by high staff compliance with mandatory Equality and Diversity training. Policies were in place to support equitable access to opportunities and fair treatment. Patient records evidenced that their social, cultural, spiritual and religious needs were considered as part of care and treatment planning.

During our staff discussions, they demonstrated a clear commitment to upholding patient rights and respecting individual preferences. Regular meetings were held to review practices and minimise restrictions based on individual risk, to support care being delivered in line with patients' needs.

Some reasonable adjustments were in place to support equitable access to services. The wards were accessible to wheelchair users, and some additional specialist equipment was available to support individual patient needs. However, on Ward 21, patients who required a hoist for bathing could not be supported on the ward and were required to use bathing facilities on another ward.

The health board must provide appropriate facilities, equipment and support to ensure equitable access to care for patients with mobility difficulties.

Delivery of Safe and Effective Care

Safe

Risk management

There were established policies, processes and audits in place to support the management of risk, enabling staff to provide safe and clinically effective care. We reviewed the processes in place to manage risks and maintain the health and safety of patients, staff and visitors, and found the following suitable measures in place:

- A policy was in place to guide staff regarding the management of restricted and prohibited items
- Personal safety alarms were available for all staff to use in an emergency, and we observed staff carrying them throughout the inspection
- Staff demonstrated awareness of individual patient risks and were able to describe how these were managed
- Patient-level risk management was supported by individual safety plans in place for all patients
- Patient therapeutic observation records were being appropriately and contemporaneously completed
- Up-to-date ligature audits were in place, and ligature cutters were readily available, with staff able to clearly describe their location
- Regular audits were conducted to ensure emergency resuscitation equipment was present and in date.

However, our inspection identified significant, widespread and longstanding environmental safety and IPC risks across all wards. Examples included extensive damage to furniture, fixtures and fittings; non-functioning lighting; unresolved ligature risks; water damage; and safety hazards such as damaged or unlocked doors. More findings relating to the IPC issues identified during the inspection are outlined in the Infection Prevention and Control section of this report.

While processes were in place for reporting and escalating estates issues, many risks had been logged on estates systems for prolonged periods without resolution, indicating ineffective prioritisation and timely mitigation. Staff reported that estates capacity constraints prevented timely resolution of safety-related issues, further limiting assurance that environmental risks were being effectively managed.

In addition, we found persistently low compliance with high-risk, safety-critical mandatory training, including Immediate Life Support (ILS), Basic Life Support (BLS), rapid tranquillisation, moving and handling, and fire safety. We also found that no staff had received training on the safe use of portable British Oxygen Company (BOC) oxygen cylinders. Moreover, we identified low compliance with Prevention and Management of Violence and Aggression (PMVA) training and found that restraint data could not be analysed to determine whether untrained or non-compliant staff were involved in restraint incidents.

As a result of these findings, we were not assured that risks relating to environmental safety, medical emergencies, and physical intervention were being effectively managed, presenting an immediate risk to patient and staff safety. These findings reflected issues identified during our 2023 inspection, indicating that previously escalated risks had not been sufficiently mitigated or sustained. Our concerns were addressed as part of our Immediate Assurance Process and are detailed in Appendix B.

All three wards operated a twice-daily environmental checklist process intended to provide assurance that ward environments were safe and well maintained. The checklists covered key ward areas and safety-critical features, including bedrooms, communal areas, bathrooms, kitchens, fire exits, doors and locks, blinds and curtains, ligature risks, cleanliness and fire safety.

Our review of the environmental checklists found that the checks were not undertaken and recorded daily. Notable gaps were identified, with missing checklists for multiple dates during the three months prior to our inspection, and many available checklists entirely or partially incomplete. The templates did not include dedicated areas to record issues identified, escalation or follow up actions, resulting in reliance on free text handwritten entries. We saw similar issues repeated across multiple days, with no clear evidence of action taken or confirmation of resolution.

In addition, we identified inconsistencies between checklist records and the ward environments we observed during inspection, including blinds and curtains recorded as present and correct, but found to be missing or outdated. These recording failures, alongside unresolved issues, limited assurance in the reliability of the environmental checks.

Staff reported that there was no formal process for senior managers to conduct quality walk-rounds of the environment at the time of inspection. This process was only initiated during the inspection period following our discussions with staff.

The health board must:

- **Strengthen governance oversight and quality assurance processes to ensure environmental checklists are fully, accurately and consistently completed on all wards**
- **Implement clear processes to ensure issues identified through the checklists are escalated and addressed**
- **Implement and maintain a formal, embedded senior manager quality walk-round process to provide regular oversight and assurance of environmental safety.**

During the inspection, we found that the ward configuration did not support a therapeutic environment and posed both environmental and patient safety risks. Ward 21 operated in part as a through-route to access other wards, resulting in increased footfall through patient areas and requiring staff to regularly manage access. This limited staff ability to provide uninterrupted care and adversely affected patient privacy, dignity and safety, while placing additional pressure on staff. As a result, we were not assured that risks associated with increased access, observation and supervision demands were being effectively mitigated.

The health board must review the ward configuration to ensure that access arrangements minimise through-traffic and mitigate the impact on patient privacy, dignity and safety, supporting a safe and therapeutic ward environment.

Infection prevention and control (IPC) and decontamination

Infection Prevention and Control (IPC) policies and procedures were in place to support the safety of staff, patients and visitors. Each ward had an identified IPC lead, and personal protective equipment (PPE) was readily available. Cleaning schedules and audits were in place across the wards to support routine cleaning and IPC, with audit results indicating generally suitable scores across all three wards.

However, we identified significant and widespread environmental and IPC risks across the wards, which compromised patient safety, dignity and wellbeing and limited assurance that IPC risks were being effectively managed in practice. These included:

- Extensive damage and deterioration to ward environments, furniture, fixtures and fittings
- Structural damage within patient areas, including damaged walls, flooring and bedroom fixtures
- Unresolved maintenance issues that prevented effective cleaning and decontamination
- Longstanding safety-critical estates issues, including missing or water-damaged ceiling tiles and evidence of damp and mould presenting ongoing IPC and health risks

- Faulty or non-functioning equipment, including:
    - Non-functioning lighting in clinical kitchens, bedrooms and bathrooms
    - Ward 21 and 22 charging stations out of use
    - Ward 21 and 22 tea trolleys/hot water dispensers out of use
    - Damaged doors and door handles
    - Damaged furniture and cupboards
    - A smashed nursing office window (Ward 21)
- Communal male bathrooms on Wards 21 and 22 out of use for prolonged periods
- Cleanliness and dignity concerns in communal and patient areas
- Ward 22 patients sharing a single bar of soap in communal bathrooms whilst awaiting anti-ligature soap dispensers- addressed by staff during the inspection
- Missing or outdated privacy and IPC curtains or blinds on Wards 21 and 22, demonstrating inconsistencies between documented safe systems of work and the ward environments observed.

The persistence and scale of these environmental and IPC risks limited assurance that these issues were being effectively identified, prioritised and managed. These concerns were addressed through our Immediate Assurance Process and are detailed in Appendix B of this report.

During the inspection, the PICU and Ward 21 were observed to be generally clean and tidy; however, Ward 22 required cleaning in several areas, which were addressed during the inspection. While cleaning schedules were in place across the wards, the supporting documentation did not clearly define the respective roles and responsibilities of housekeeping and nursing staff in maintaining ward cleanliness. This limited assurance that cleaning arrangements were being consistently implemented, monitored and sustained.

The health board must strengthen leadership and governance arrangements to ensure all ward areas are effectively cleaned and monitored. This must include providing clear guidance to nursing and housekeeping staff to ensure a shared understanding of roles, responsibilities and accountability for maintaining IPC standards.

During the inspection, we were not assured that staff had consistent access to appropriate decontamination and housekeeping equipment to support effective cleaning outside of normal housekeeping hours. While equipment was available within the service, some staff reported bringing cleaning equipment or products from home for use out of hours.

The health board must ensure that staff have consistent access to suitable

cleaning and decontamination equipment to support safe and effective cleaning of the wards.

We found no evidence that shared equipment and facilities were consistently decontaminated between uses in line with IPC standards, and there was no clear labelling to indicate when equipment had last been cleaned or confirmed safe for use.

The health board must ensure clear arrangements for the decontamination of shared equipment and facilities, including appropriate labelling to indicate when items are clean and safe for use.

We were provided with annual IPC audits for all three wards dated 2024; however, staff reported that no further annual IPC audit had been completed since. This limited assurance that IPC risks were being routinely reviewed and addressed through established governance processes.

The health board must ensure annual IPC audits are completed at the required frequency and used to monitor, review and improve IPC practice across all wards.

Staff compliance with mandatory IPC training was generally low, at 68% on Ward 21, 79% on Ward 22 and 80% on the PICU. This limited assurance that all staff had up-to-date IPC knowledge and competencies.

The health board must ensure all staff complete and remain compliant with mandatory IPC training to support consistent practice across all wards.

Laundry arrangements varied across the wards. On the PICU, a washer and dryer were available, with nursing staff completing patients' laundry. However, on Wards 21 and 22, patients relied on a weekly external laundry service, with charges applied per bag. Staff reported that ward pressures sometimes delayed laundry collection, resulting in waits of up to a further week and additional costs to patients. These arrangements did not consistently support timely access to clean clothing or patient dignity.

The health board must review the laundry arrangements on Wards 21 and 22 to support IPC, facilitate timely access to clean clothing and uphold patient dignity.

Safeguarding of children and adults

Appropriate safeguarding policies and procedures were in place to protect vulnerable adults, and staff could access the health board's safeguarding policy and Wales Safeguarding Procedures via the intranet.

Staff demonstrated high compliance with mandatory training for safeguarding adults

and children across all three wards. Our discussions with staff highlighted a strong knowledge and understanding of safeguarding procedures and reporting arrangements.

Safeguarding incidents and concerns were recorded on the Datix electronic incident reporting system and monitored by the senior management team. Staff confirmed that safeguarding concerns were regularly reviewed to identify themes and lessons learned.

Management of medical devices and equipment

We found appropriate resuscitation equipment in place across the wards, with regular checks completed to ensure items were present and in date. Staff we spoke with demonstrated a clear understanding of how to escalate faulty or non-functioning equipment.

Medicines management

Our review of the wards' clinic arrangements generally found robust procedures in place for the safe management of medicines. Relevant policies were in place and were accessible to staff, such as medicines management and rapid tranquilisation.

Medicines were stored securely in locked cupboards and refrigerators, with medication trolleys appropriately secured, and fridge temperatures monitored in line with local procedures. The records evidenced that medication stock was accounted for when administered, and that stock checks were being undertaken as required. We found effective internal auditing arrangements, supported by good pharmacy involvement, which helped to promote the safe administration of medicines.

However, during the inspection, we noted that some clinic room cupboards required repair or replacement doors, which staff had already reported to the estates team. We also noted that emergency medication on Ward 21 was stored in a high cupboard, which could delay staff access during emergency situations.

The health board must review the emergency medication storage arrangements on ward 21 to ensure emergency drugs are readily accessible and can be accessed without delay.

We reviewed patient Medication Administration Records (MAR charts) and found that they were maintained to a good standard. The charts were consistently signed and dated when medication was prescribed and administered, and a reason was recorded when medication was not administered. Patients' consent to treatment certificates were appropriately completed and stored alongside MAR charts, and patients' current Mental Health Act legal status was clearly recorded.

We observed safe and appropriate prescribing practices, with medications prescribed in line with individual patient needs and reviewed regularly to ensure continued appropriateness. We were told that patients or their family/carers were involved in decisions about their medications wherever possible. Patient medications were routinely discussed during ward rounds, and any updates or changes to their medication were recorded.

Staff we spoke with demonstrated appropriate knowledge and understanding of medicines management procedures. We found effective systems in place to ensure medication errors were appropriately reported, investigated and addressed, with learning shared with staff to support ongoing improvement.

Effective

Effective care

Staff demonstrated a strong commitment to delivering high-quality, person-centred care. However, they reported that pressures relating to staffing capacity, access to training and the physical ward environments limited the consistency with which safe and effective care could be delivered.

We found some suitable processes in place to support the delivery of safe and effective care, aligned with relevant policies, professional standards and guidance. The multidisciplinary team (MDT) was well established, and clinical decisions were made through a multidisciplinary approach. MDT working supported the review of patients' needs, risks and treatment plans through regular ward rounds and safety briefings.

Care and treatment planning arrangements supported continuity of care, including a team-nursing approach, which enabled another member of the care team to update assessments when the primary nurse was unavailable. Staff reported effective collaborative working, positive professional relationships and an open culture in which clinical concerns could be discussed and escalated.

Staff used the Datix system to record, manage and monitor incidents. A clear incident sign-off structure was in place, with regular reviews to identify themes and trends. We reviewed a sample of incidents and found they were appropriately recorded, investigated and monitored, with discussion through governance meetings to support learning. Senior staff confirmed that learning from incidents was shared with teams.

Staff demonstrated a clear understanding of their responsibilities in undertaking therapeutic patient observations. Observation levels were regularly reviewed to ensure they remained appropriate. We observed safe and supportive observations in practice,

and records confirmed that observation frequency increased when patients required closer monitoring.

While we found immediate assurance concerns in relation to staff compliance with PMVA training, staff demonstrated a good understanding of restrictive practices, including preventative approaches to reduce the need for restrictive interventions. The wards used distraction, verbal de-escalation and early recognition of distress techniques, with restrictive practices used only as a last resort, supported by appropriate risk assessment and review. The PICU had an Extra Care Area (ECA) available, which could be used as a last resort for patient segregation in line with local policy, and we witnessed calm and effective staff responses to challenging patient behaviour during the inspection.

Nutrition and hydration

We found that patients' nutritional and hydration needs were assessed, recorded and monitored appropriately. A Malnutrition Universal Screening Tool (MUST) nutritional risk assessment was completed on admission, and clinical records evidenced ongoing physical health and weight monitoring. Staff described good access to dietetic services and Speech and Language Therapy (SALT) when required, and identified dietary needs were clearly reflected in patient care plans.

Patients were provided with appropriate diets in accordance with their medical and nutritional needs. Menus offered a variety of options to meet individual preferences, cultural and dietary requirements. Each ward had a dedicated dining room, and patients told us they were supported to make individual food choices. We observed the food provided to be varied, appropriate and of good quality.

Hot and cold drinks were available throughout the day; however, equipment for serving hot drinks, including the tea trolley on Ward 21 and the hot-water dispenser on Ward 22, was out of order. Staff reported that preparing drinks for patients increased their workload alongside clinical duties, and patients also reported this as an issue affecting their care.

The health board must ensure all ward food and drink equipment is fit for purpose to support patients' nutritional and hydration needs and reduce avoidable pressure on staff.

Patient records

Clinical records were maintained electronically and in paper format. Paper records were stored securely, and the electronic system was password protected to prevent unauthorised access. Clinical details were recorded contemporaneously and comprehensively, providing a detailed overview of the patients and their care. Further

information on our findings regarding patient records and care plans is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Mental Health Act monitoring

We reviewed five patient records across the three wards to assess compliance with the Mental Health Act (MHA). All patients reviewed were detained under the MHA, and we found that detention was lawful and in line with the legislation and the Code of Practice.

We found robust auditing and monitoring arrangements in place to support compliance with the MHA. The hospital was supported by a dedicated and experienced MHA administration team, with a centralised database used to monitor statutory timescales, referrals and key due dates.

The MHA documentation reviewed during our inspection was well organised, complete and easy to navigate, supporting effective oversight and review. We found good processes in place to support patients' rights, including the provision of suitable information about detention, regular review of detention status and access to safeguards. Patients were supported to access independent advocacy services, and staff demonstrated a good understanding of their responsibilities in supporting patients to exercise their rights under the MHA.

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

Alongside our review of statutory detention documentation, we considered the application of the Mental Health (Wales) Measure 2010. During the inspection, we reviewed nine patient records across all three wards and found a high standard of clinical record keeping. The records were well organised, easy to navigate and reflected patients' identified needs and risks.

Patient Care and Treatment Plans (CTPs) were aligned with the required domains of the Mental Health (Wales) Measure, providing a comprehensive account of patients' presentation and the interventions being offered. Records demonstrated that CTPs were regularly reviewed, with evidence of strong MDT involvement informing care planning and decision making.

All patients had individualised, person-centred CTPs supplemented by individualised intervention plans, including plans relating to physical health care, observation levels and the prevention and management of violence and aggression (PMVA). An extensive range of assessments supported care planning, including comprehensive risk

assessments that clearly identified risks and the measures in place to mitigate and manage them. The Wales Applied Risk Research Network (WARRN) process was fully implemented across all wards and was used consistently to support structured risk assessment and management.

We saw evidence that patients were involved in the development of their care planning wherever possible. Regular MDT reviews supported more formal review of care, with involvement of patients, family members, carers, external agencies and community professionals where appropriate.

Efficient

Efficient

We found good arrangements in place for admission to, and discharge from, services, with clear discharge and aftercare plans documented for all relevant patients. The records evidenced effective ward staff liaison with Community Mental Health Teams (CMHTs) and other relevant services, to support continuity of care and appropriate discussions regarding future placements.

Staff reported that ward re-admission rates were low, with relevant data held and monitored centrally to support governance oversight. We observed that staff worked effectively across services to coordinate involvement with families and carers, including access to a weekly carers' group, which supported communication, engagement and positive outcomes for patients.

Quality of Management and Leadership

Staff Feedback

We engaged with staff throughout the inspection and received four responses to our staff questionnaire; however, the small sample size limited the ability to draw wider conclusions about staff experience.

The four questionnaire responses were generally mixed, with some areas of concern. While most (3/4) reported being satisfied with the quality of care they provided to patients, only half (2/4) said they would recommend the hospital as a place to work. Additionally, most (3/4) reported that they would not be happy with the standard of care provided to their friends or family and stated they were not content with the health board's efforts to keep staff and patients safe. Additionally, only half agreed that patient care was the health board's top priority, and most disagreed that the health board takes swift action to improve when necessary.

All respondents reported that their current working pattern allowed for a good work-life balance. However, one felt that their job was detrimental to their health. All respondents confirmed they were aware of Occupational Health support, though only half agreed that the health board took positive action to support staff health and wellbeing.

Staff comments included:

> *"The unit is heavily used by patient all over RCT and surrounding areas …. But it is badly in need of repair and refurbishing…. A small number of repairs would make a huge difference to the unit and patients who use it."*

> *"Communication is vital in looking after mental health patients and building relationships in their recovery …. Some staff have no idea how to demonstrate empathic understanding or good listening skills."*

> *"My managers … are approachable and helpful and are always there should I wish to seek support or guidance."*

The health board must reflect on the staff feedback outlined in this report and implement improvements to support the staff experience and sustain high-quality patient care.

Leadership

Governance and leadership

At the time of inspection, the service was undergoing significant change, including structural and service reconfiguration across the mental health wards, affecting ward function, staffing models and service delivery arrangements.

There was a clear organisational structure in place, with defined lines of management and accountability. Established governance arrangements included a range of formal oversight and assurance processes, including governance meetings, multidisciplinary team (MDT) meetings, escalation processes and incident review systems. These arrangements generally provided oversight of service delivery and supported the identification, monitoring and escalation of risks and concerns. However, we found that governance oversight required strengthening in key areas, particularly in relation to patient safety, the management of environmental and operational risks, and staff training compliance.

Staff consistently demonstrated a strong commitment to delivering safe, person-centred care, and described positive MDT working. They provided positive feedback about their colleagues and immediate line managers, reporting that they felt supported in their roles. Senior managers described a range of support arrangements, including drop-in sessions and wellbeing support such as Occupational Health and reflective practice.

However, our staff engagement indicated low confidence in senior manager visibility, communication and responsiveness. All survey respondents and some staff we spoke with during the inspection reported that senior managers were not visible on the wards, and that communication between senior management and staff was ineffective.

The health board must consider the feedback regarding senior management visibility and communication and implement improvements to foster a more collaborative approach to patient care.

Workforce

Skilled and enabled workforce

Staffing levels were generally sufficient to meet patients' assessed needs during the inspection, and most staff felt able to deliver safe and effective care. Staffing levels were adjusted in response to patient acuity, levels of observation and challenging behaviour, with escalation to senior staff where additional staffing was required.

However, during our staff discussions, they described environmental challenges, ongoing workforce pressures and recent changes to ward staffing establishments. We

found high nursing staff vacancies across the service, with bank and agency staff routinely used to maintain safe staffing levels. Recruitment activity was ongoing, and wards sought to book temporary staff familiar with the service and patient group where possible. Staff reported that the reliance on temporary staff increased workload and pressure, particularly during periods of higher patient acuity.

The health board must continue robust recruitment to vacant posts to strengthen staffing stability, reduce workforce pressures and support safe, effective patient care.

Staff described the impact of the recent service reconfiguration, including the change of Ward 21 from a treatment ward to a Delayed Transfer of Care (DTOC) ward, with a corresponding reduction in staffing levels. They told us that these changes had resulted in an increased workload, staffing challenges and a negative impact on staff morale.

The health board must engage with staff to review the impact of service reconfiguration and ensure staffing levels and support arrangements meet patient needs and promote staff wellbeing, team cohesion and the consistent delivery of effective care.

Some staff felt that staffing levels on the mental health wards at Royal Glamorgan Hospital were lower than those on equivalent wards within the health board. Staff also described variation in access to psychology services and occupational therapy, which they felt impacted on the consistency of therapeutic input available to patients.

The health board must review staffing levels and access to psychology and occupational therapy services across mental health wards to ensure the consistent delivery of effective, person-centred care.

Suitable pre-employment checks, employment records and induction processes were in place for all staff. Staff described regular supervision arrangements, and we found that most staff had received an annual appraisal, with completion rates of 82% on Ward 21 and 86% on Ward 22. However, appraisal completion on the PICU was lower at 75% and required improvement.

The health board must ensure that all staff receive an annual appraisal to ensure they are appropriately supported, developed and enabled to deliver safe and effective patient care.

Processes were in place for senior staff to monitor mandatory training compliance; however, in addition to our Immediate Assurance concerns regarding low compliance

with safety-critical training, we found further gaps in mandatory training compliance across all three wards.

These included:

- Information Governance- Ward 21 - 57%, Ward 22 - 69%, PICU - 70%
- Mental Health (Wales) Measure – Care and Treatment Planning - Ward 21- 62%, Ward 22 - 75%, PICU - 75%
- Duty of Candour - Ward 21 - 57%, Ward 22 - 73%, PICU - 70%
- Mental Capacity Act (MCA), including consent and Deprivation of Liberty Safeguards (DoLS):
  Ward 21 -28% (Level 3)
  Ward 22 -70% (Level 2), 40% (Level 3)
  PICU: 70% - (Levels 2 and 3).

We also found low compliance with Mental Health Act Code of Practice for Wales (2016) training on Ward 22 (79%), and Mental Health Act (MHA) training on the PICU (75%).

The health board must implement robust measures to ensure that all outstanding mandatory training is completed, regularly monitored, and that staff receive appropriate support to complete training in a timely manner.

During the inspection, we reviewed a range of policies and procedures and found that several were overdue for review or remained in draft, including:

- Personal Protective Equipment – review date March 2021
- Business Continuity – review date June 2019
- Extra Care Area Seclusion and Long-Term Segregation – draft
- Maintenance of Mental Health Premises - draft
- Recruitment of Ex-Offenders – review date March 2013
- Recruitment and Retention of Transgender Staff – review date September 2021
- Recruitment and Selection– review date December 2020
- Recognition, Prevention and Therapeutic Management of Violence and Behaviours – review date January 2026.

The health board must ensure that policies and procedures are reviewed and updated in a timely manner to provide clear, current and reliable guidance for staff.

Culture

People engagement, feedback and learning

Staff described a positive ward-level culture, with teams working collaboratively and supporting one another in day-to-day practice. Staff told us they felt able to raise concerns and described an environment where issues could be discussed and escalated appropriately within ward teams.

An established process was in place for patients, families and carers to escalate concerns through the Listening to People process. Formal complaints were recorded on the Datix system and monitored by senior managers throughout the investigation. Our staff discussions indicated that both informal and formal complaints were appropriately recorded and investigated, and most staff reported feeling supported to raise concerns about patient care or other issues. However, we found low compliance with mandatory Duty of Candour training to support staff in their roles, as referenced earlier in this report.

A dedicated staff meeting process was in place to encourage regular staff engagement and feedback. We generally found evidence of regular meetings on Ward 21 and Ward 22. However, we found limited evidence of staff meetings taking place on the PICU.

The health board must ensure that staff meetings are regularly held on the PICU and that records are maintained to evidence regular staff engagement and communication.

Staff told us that they routinely engaged with patients to discuss issues, resolve concerns and understand their needs and wishes, and described holding patient meetings to discuss day-to-day issues affecting care. However, we did not see consistent evidence to demonstrate that regular patient meetings were taking place across all three wards.

Staff told us that a carers' café had been introduced to engage with carers and gather feedback on their experience of the patient journey. However, information on how patients, families and carers could raise concerns or provide feedback was not clearly displayed, and patients we spoke with were not aware of how to provide feedback or be involved in service development. We did not see consistent evidence that feedback was routinely captured, reviewed, or that actions taken were effectively communicated to support learning and improvement.

The health board must:

- **Display clear information about how patients can provide feedback and raise concerns**
- **Ensure regular patient meetings are held on all wards and are consistently**

documented

- **Strengthen systems to record, address and provide feedback about actions taken in response to issues raised**
- **Provide governance oversight to assure patient and family/carer feedback is used to inform service improvement.**

Information

Information governance and digital technology

We considered the arrangements for maintaining patient confidentiality and adherence to information governance requirements, including the General Data Protection Regulation (GDPR) within the wards.

Paper records and data were securely stored in locked areas, ensuring confidentiality and protection. Information recorded on the hospital's electronic health record system was password-protected, with access restricted to relevant staff. Established processes were in place to ensure safe and secure information sharing with partner agencies.

While staff generally demonstrated a clear understanding of their role and responsibilities in managing personal and sensitive information, compliance with mandatory information governance training was low across all three wards, as highlighted earlier in this report.

Learning, improvement and research

Quality improvement activities

Senior staff described an ongoing programme of work intended to reshape the unit and drive quality improvement during a period of significant change and restructuring. This included a range of improvement initiatives, including trauma-informed approaches to care, the use of the Cognitive Analytic Therapy (CAT) model to better understand and respond to episodes of violence and aggression, and MDT huddles and situation reports to support shared oversight.

Staff reported that the health board was the first in Wales to report weekend bed-state information to Welsh Government. They also described plans to introduce a dedicated bed manager role to improve patient flow and operational oversight. In addition, staff described external improvement activity, including reinstated Royal College of Psychiatrists' Quality Network (CCQI) membership for the PICU.

Processes were in place to record, investigate and escalate incidents, and staff described a range of audit and improvement activity, including the introduction of the AMaT electronic audit system to monitor quality. However, incomplete and inconsistent documentation limited assurance that audit systems were reliably escalating risks or driving improvement, and the persistence of risks identified during previous inspections indicated that learning from earlier findings had not resulted in sustained improvements.

Throughout the inspection, staff were receptive and responsive to our findings and recommendations. While some improvements were addressed during the inspection, the health board must take further action to implement the recommendations set out in this report and ensure that improvements are embedded and sustained.

The health board must take robust action to implement the recommendations set out in this report and ensure that improvements are embedded and sustained.

Whole-systems approach

Partnership working and development

Staff described a range of partnership working arrangements to support patient care and service delivery across the wider system. We saw evidence of effective MDT working, including good liaison with Community Mental Health Teams (CMHTs) to support care planning, discharge arrangements and continuity of care. Records demonstrated MDT involvement in care and treatment planning, with appropriate engagement with patients and, where appropriate, carers.

Staff also described effective engagement with a range of wider system partners to support patient care and discharge planning. This included regular liaison with the crisis team, third-sector organisations and wider support services, including housing services and Mind, to support patients' broader needs and continuity of care.

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 Ward 22 kitchen door handle was damaged, and the door was found unlocked on two occasions during the inspection.	This posed a risk to staff and patient safety.	Concerns were raised with ward staff during the inspection.	The kitchen door was repaired and secured during the inspection.
Ward 22 patients were sharing a single bar of soap in communal bathrooms whilst awaiting anti-ligature soap dispensers.	This posed an IPC risk to staff and patient safety.	Concerns were raised with ward staff during the inspection.	Suitable alternative provisions were put in place during the inspection.

Appendix B – Immediate improvement plan

Service: **Royal Glamorgan Hospital**
Wards: **Ward 21, Ward 22, and Psychiatric Intensive Care Unit.**
Date of inspection: **13 – 15 April 2026**

Findings	We reviewed staff training compliance for Prevention and Management of Violence and Aggression (PMVA), Basic Life Support (BLS), Immediate Life Support (ILS), Moving and Handling, Rapid Tranquillisation and Fire Safety across the three wards and found examples of very low levels of compliance relating to these high-risk, safety-critical training requirements. Ward 21: • Immediate Life Support: 24% • Basic Life Support: 77% • Manual Handling: 94%, modules B,C,E - 44% • Rapid Tranquillisation: 50% Ward 22 • Immediate Life Support: 50% • Basic Life Support: 35% • Manual Handling: 64%, modules B,C,E - 53% • PMVA: 39% • Rapid Tranquillisation: 57% PICU • Immediate Life Support: 10% • Basic Life Support: 50%

	• Manual Handling: 58% - modules B,C,E 58% • Fire Safety – 44% In addition, we were informed that 38 patient restraints had taken place within the Mental Health Unit in the last twelve months. During the inspection, staff were unable to confirm whether any untrained or non-compliant staff had undertaken patient restraints during this period. As result of these findings, HIW is not assured that sufficient numbers of staff on these wards have the required up-to-date skills and competencies to respond safely and effectively to medical emergencies, to undertake physical intervention or rapid tranquillisation, or to support patients using safe moving and handling techniques. Our findings relating to low levels of training compliance were also identified during our previous inspection on 20–22 November 2023 and were raised at that time as an immediate concern regarding patient safety. This demonstrates a failure to implement the improvements identified within the previous Immediate Improvement Plan and to carry out the actions agreed by health board management.

	Improvement needed	Standard / Regulation
1.	The health board must: • Ensure that all staff complete and remain compliant with ILS, BLS, PMVA, safe moving and handling and fire safety training to support patient and staff safety • Ensure restraint data can be promptly reviewed, analysed and monitored to determine whether any non-compliant or untrained staff were involved in restraint incidents.	Safe and Effective Care

Service Action:	Responsible officer	Timescale
ILS - Ward 21, Ward 22 and PICU are on a trajectory of 85% ILS compliance by 26/05/2026. Training dates have been arranged, and staff have been booked. **BLS** - Ward 21, Ward 22 and PICU are on a trajectory of 85% BLS compliance by 26/05/2026. All training has been booked.	Ward Manager and Senior Nurse Ward Manager and Senior Nurse	In Progress See Evidence 1 Estimated Date for Completion 26/05/2026.
PMVA - Ward 21, Ward 22 and PICU are on a trajectory of 85% PMVA compliance by 11/05/2026. All training has been booked.	Ward Manager and Senior Nurse	In Progress See Evidence 1A Estimated Date for Completion 11/05/2026
MANUAL HANDLING - Ward 21, Ward 22 and PICU are on a trajectory of 85% Manual Handling compliance by 30/07/2026. Training dates have been arranged, and staff have been booked.	Ward Manager and Senior Nurse	In Progress See Evidence 1B Estimated Date for Completion 30/07/2026
FIRE TRAINING - Ward 21, Ward 22 and PICU are on a trajectory of 85% Fire training compliance by 24/06/2026. Training dates have been arranged, and staff have been booked.	Ward Manager and Senior Nurse	In Progress See Evidence 1C Estimated Date for Completion 24/06/2026

RAPID TRANQ - Ward 21, Ward 22 and PICU are on a trajectory of 85% Rapid Tranq compliance by 26/04/2026 Training dates have been arranged, and staff have been booked.	Ward Manager and Senior Nurse	Completed See Evidence 1D 26/04/2026
The ongoing training compliance will be monitored on a weekly basis, the Ward Manager and Senior Nurse will scrutinise the rosters weekly to ensure suitably trained numbers of staff are on duty, this will be subject to a six-month review. This will be shared and overseen in Directorate and Care Group Quality, Safety and Experience (QSE) meetings.	Ward Manager and Senior Nurse	In Progress Estimated Date for Completion 23/10/2026
Ward Managers review all incidents reported on the Datix system daily. Incidents involving restraint are reviewed within the DATIX system and subsequently investigated by the Ward Manager and Senior Nurse. This investigation includes the training compliance of the staff involved. The MHLD Care Group has Datix dashboards that enable staff to easily review themes and trends in Datix incident reporting. Any identified themes, concerns, or issues are escalated through the Directorate QSE meeting to the Care Group QSE to ensure appropriate governance, oversight, and assurance (examples of the reports are included in Evidence 1F and 1G)	Ward Manager and Senior Nurse	Complete 23/04/26 See Evidence 1F See Evidence 1G
Training compliance for all staff is monitored through Directorate and Care Group Integrated Performance Meetings (IPM). Following a review of current processes, the Directorate has implemented amendments to strengthen	Ward Manager and Senior Nurse	Complete 23/04/26 See Evidence 1H

the quality of information around staff trained in PMVA captured during the daily Safe to Start huddle, so any identified risks or gaps are addressed, and appropriate mitigations implemented to ensure both staff and patient safety. This ensures the collection of more robust information capture that aligns with the DATIX system, enabling reliable and effective audit processes to be undertaken.		See Evidence 1I
A sample audit of 20 restraint incidents over a four-month period will be undertaken to ensure that mitigation measures align with the information collected within the daily huddle. Should any shortfalls be identified through the audit process, a repeat audit will be conducted to provide assurance and monitor improvement.	Ward Manager and Senior Nurse	In Progress Estimated Date for Completion 24/05/26

Findings	We found that staff were not aware of the recent Regulation 28 report and Patient Safety Notice 041 reminder issued by the Welsh Government on 30 August 2024 in relation to the correct operation of oxygen. In addition, no staff had received training on the safe use of portable British Oxygen Company (BOC) cylinders. This meant that we could not be assured that the risks of harm to patients were being appropriately managed.

	Improvement needed	**Standard / Regulation**
2.	The health board must ensure that all staff who use portable BOC oxygen cylinders receive competency-based training on their safe use across all health board services.	Safe and Effective Care

Service Action:	**Responsible officer**	**Timescale**
The Health Board has urgently reviewed options to rapidly increase staff compliance in Medical Gas Training which includes BOC oxygen competencies.	Ward Manager and Senior Nurse	Complete 23/04/26

An email has been cascaded to all staff on the wards to remind them of the medical gases policy for awareness. The Policy has also been added to the agenda of all upcoming Ward Meetings.		See Evidence 2
The Adult Unscheduled Care Directorate will rapidly improve staff compliance with Medical Gas Safety Training delivered via the ESR module, strengthening Care Group assurance and reducing risk related to the safe use, storage, and set-up of medical gases and cylinders with a trajectory to complete by 09/05/2026.	Ward Manager and Senior Nurse	In Progress Estimated Date for Completion 09/05/2026 See Evidence 2A
This will be monitored through the Directorate Quality, Safety and Experience (QSE) meeting. Any identified themes, concerns, or issues are escalated to the CARE Group QSE to ensure appropriate governance, oversight, and assurance.	Ward Manager and Senior Nurse	In Progress Estimated Date for Completion 04/06/2026

Findings	During the inspection, we identified significant and widespread environmental and infection prevention and control (IPC) risks to patient and staff safety across Ward 21, Ward 22 and the Psychiatric Intensive Care Unit. The following concerns were identified through direct observation, staff feedback and review of estates and maintenance records: Ward 21: • Damage and deterioration to fixtures and fittings, including faulty equipment and doors, damaged walls, flooring, chairs and furniture, and a smashed nursing office window • Long-standing safety-critical estates issues, including ligature risks in patient bedrooms (logged 20 July 2025) • Missing and water-damaged ceiling tiles, logged on 19 March 2025, indicating a prolonged IPC risk • Non-functioning lighting in areas of the ward, including the kitchen and Bedroom 4; staff reported using mobile phone torches to provide care

- The communal male bathroom out of use for a prolonged period, resulting in male patients using female facilities and raising safety and dignity concerns
- IPC and dignity concerns, including missing or outdated privacy/IPC curtains or blinds, demonstrating inconsistencies between the documented safe system of work and the environment observed during inspection.

Ward 22:

- Deterioration of the ward and clinical environment, including damaged fixtures and fittings, non-operational equipment, and multiple missing ceiling tiles and damaged cupboards in the clinic room
- Evidence of mould and damp in the ward corridor, escalated as a serious health and IPC risk (logged 3 September 2025)
- Unsafe access and security risks, including a damaged kitchen door found unlocked on two occasions during the night visit, and an urgent unresolved estates issue identifying an unlocked ward area allowing patient access to potential risk items (logged 26 September 2025 and escalated in October, November and December)
- Cleanliness, dignity and patient safety concerns, with communal patient areas requiring cleaning and the communal male bathroom out of use, resulting in male patients using female facilities.

PICU:

- Long-standing ligature risks logged in the estates system, including broken or removed curtain rails and curtain tracks requiring anti-ligature replacement, with multiple entries recorded between June and August 2025
- IPC issues, including mouldy shower tray sealant in all ensuite bedrooms, logged on 29 July 2025
- Missing cupboard door in the sluice room, logged on 5 August 2025.
- Structural damage within patient bedrooms, logged on 5 August 2025.

Our review of estates records from December 2024 onwards identified multiple urgent and high-risk patient safety issues and long-standing maintenance concerns that had not been remedied. Not all environmental risks we identified during inspection were captured within the estates maintenance log. Staff reported that the estates service was severely understaffed and advised that, from autumn 2025, maintenance activity was limited to urgent or mandatory works only.

As a result of these findings, HIW is not assured that current estates and maintenance arrangements are effective in identifying,

	prioritising and addressing environmental patient safety risks in a timely way. The persistence of multiple high-risk issues, alongside reported limitations in estates capacity, limits assurance that patient safety risks are being consistently prioritised and mitigated. In addition, the mental health inpatient care environment has remained on the health board's risk register since 2018, indicating a long-standing and unresolved risk.

	Improvement needed	Standard / Regulation
3.	The health board must: • Undertake a comprehensive review of all mental health inpatient ward environments at Royal Glamorgan Hospital, to ensure all environmental, ligature and infection prevention and control (IPC) risks are identified, recorded, monitored, and escalated until resolved. • Take urgent action to mitigate all high-risk environmental issues identified, ensuring that risks are reduced while permanent remedial works are undertaken. • Ensure the inpatient environment supports patient safety, privacy, and dignity, including access to functioning bathrooms, adequate lighting, clean communal areas and appropriate privacy/IPC curtains or blinds • Strengthen governance and oversight, including clearer assurance reporting, monitoring of long-standing risks and sustained senior management oversight. • Review estates staffing and resourcing and address any capacity or resilience gaps affecting timely risk mitigation. • Review and strengthen controls associated with the inpatient environment's inclusion on the health board risk register since 2018 ensuring actions are sufficient to reduce and close the risk	Safe and Effective Care Leadership

Service Action:	Responsible officer	Timescale
On 16/04/26, inpatient ward managers were issued with estates logs for their respective ward areas and undertook a comprehensive baseline review to confirm that all environmental, ligature and IPC issues were accurately captured. Ward staff remain responsible for promptly identifying and recording hazards or faults.	Service Manager	Complete 16/04/2026 See Evidence 3A (1)
Ongoing monitoring and assurance of estates and environmental risks will be undertaken through directorate Integrated Performance Meeting (IPM), to support shared ownership and visibility. Directorate reporting is supported by a detailed estates risk appendix, detailing risk status, mitigation, escalation points and outstanding actions, supplemented by a concise summary narrative. This ensures oversight extends beyond high-level metrics and supports effective prioritisation and decision-making.	Service Manager	In Progress See Evidence 3A (2) Estimated Date for Completion 27/04/2026
Following receipt of the validated report of outstanding maintenance issues, Estates and Facilities teams commenced immediate remedial action from 17/04/26. A total of 167 maintenance issues were identified across Ward 21, Ward 22 and the PICU.	Service Manager	Complete 23/04/26 See Evidence 3C
To strengthen oversight and ensure that mitigation actions are robust and sufficient, an extraordinary risk register meeting has been scheduled for 27/04/26, specifically focusing on inpatient environmental risks, in direct response to the HIW Immediate Action. The purpose of this meeting is to undertake a detailed review of existing risk register entries, identify any risks not currently captured, and agree a clear and strengthened action plan to mitigate risk pending full resolution.	Service Manager	Complete 23/04/26 See Evidence 3B

Quotes for replacement curtain rails and window blinds for areas without appropriate curtains were obtained, and orders placed 23/04/26.	Service Manager	Complete 23/04/26 See Evidence 3D
Existing curtains have been replaced by the Facilities team where required and a curtain monitoring schedule implemented by Facilities management.	Service Manager	Complete 23/04/26 See Evidence 3E
Hand soap dispensers have been ordered for all patient bedrooms and communal water closets. As an immediate interim measure, the directorate procured hand soap directly and distributed it to these areas to ensure continuity of IPC controls.	Service Manager	Complete 23/04/26 See Evidence 3F
Estates works have progressed, to enable out-of-order bathroom and toilet facilities to be returned to full service, with actions monitored through special estates and clinical governance arrangements. All wards have both female and male bathrooms open.	Service Manager	Complete 23/04/26 See Evidence 3G
The MH&LD Care Group has committed to revise and formally approve the Maintenance of Mental Health Premises policy by the end of May 2026. This revision will specifically reflect enhanced escalation procedures, assurance requirements and clarified responsibilities in relation to the management of environmental and estates risks within mental health inpatient settings.	Service Manager	In Progress Estimated Date for Completion 30/05/26
A safe system of work has been implemented to strengthen governance and oversight. This includes clearer assurance reporting, enhanced monitoring of long-standing and unresolved estates risks and defined senior management oversight through established directorate and Health Board governance routes. Together, these actions strengthen both the immediate operational controls and the longer-term policy	Service Manager	Complete 23/04/26 See Evidence 3H

framework, supporting sustained oversight.		
A meeting was held 23/04/26 attended by the MHLD Senior Leadership team and senior Estates colleagues where it was agreed to instigate a review of estates resources and capacity	Head of operational Estates	In Progress Estimated Date for Completion: 30/07/26 See Evidence 3I
Arrangements have been put in place to review and strengthen controls associated with the mental health inpatient environment risk held on the Health Board risk register since 2018. An extraordinary risk register meeting has been scheduled for 27/04/26 to focus specifically on inpatient environmental risks, in direct response to the HIW Immediate Action. The purpose of this meeting is to undertake a detailed review of existing risk register entries relating to the inpatient environment, to identify any risks that are not currently captured, and to agree a clear and strengthened action plan to mitigate the risk. This will include reviewing the adequacy of current controls, clarifying ownership, and establishing actions and timescales sufficient to support risk reduction and, where appropriate, risk closure. The outcomes of the meeting will be reflected through updated risk register entries and strengthened governance arrangements, ensuring that longstanding environmental risks are subject to sustained senior oversight, clear escalation, and ongoing monitoring until effectively mitigated.	Service Manager	In Progress Estimated Date for Completion: 30/04/26 See Evidence 3B.
This will be shared within the Directorate Quality, Safety and Experience (QSE) meeting. Any identified themes, concerns, or issues are escalated to the CARE Group QSE to ensure appropriate governance, oversight, and assurance.	Lead Nurse	In Progress Estimated Date of Completion 17/06/2026

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): **Clare Yates**

Job role: **Lead Nurse**

Date: **24/04/2026**

Appendix C – Improvement plan

Service: **Royal Glamorgan Hospital**

Wards: **Ward 21, Ward 22, and Psychiatric Intensive Care Unit**

Date of inspection: **13 – 15 April 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 patient feedback highlighted areas requiring improvement, with environmental conditions and access to facilities negatively impacting patient experience.	The health board must ensure the patient experience feedback is reviewed and used to implement timely and sustained improvements.	Patient feedback	The Adult Directorate will review and update the current patient feedback questionnaire, and develop a consistent feedback form and mechanism, incorporating a "You Said, together we" format. This will be shared within the Ward Managers' monthly report and shared within the Directorate Quality, Safety and Experience (QSE) group.	Senior Nurse and Lead Nurse	In Progress Estimated Date of Completion **06/07/2026** Estimated Date of Completion **30/08/2026**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
2.	Staff and patients reported that patient access to outside space was sometimes limited by staffing pressures and workload.	The health board must ensure consistent access to outdoor space for all patients, supported by appropriate staffing and timely completion of environmental works.	Health promotion	Within the Royal Glamorgan Hospital, patients have unrestricted access to outdoor areas between 07:00 and midnight. Access outside of these hours is available upon request, dependent on risk. Patient information notices outlining this access are displayed across all wards. At the time of the HIW inspection, the PICU outside area was unavailable due to ongoing refurbishment and maintenance works, requiring patients to use the outdoor space on Ward 22. These works were completed on 28th May 2026, and unrestricted access to the PICU patio has since been fully reinstated.	Ward Manager and Senior Nurse Ward Manager and Senior Nurse	Complete **15/06/2026** **Appendix 2** **Appendix 2a**
3.	There was no structured programme	The health board must implement a structured	Health promotion	Whilst recruitment to the Activity Worker post is ongoing, interim	Ward Manager and	Complete **22/06/2026**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	of therapeutic activities in place across the three wards.	programme of therapeutic activities and ensure consistent delivery across all wards.		measures have been implemented to ensure patients continue to receive meaningful therapeutic engagement.	Senior Nurse	**Appendix 3**
				These include assigning a named HCA from a ward within the unit for each shift to coordinate and facilitate activities, ensuring consistent delivery.	Ward Manager and Senior Nurse	**Appendix 3a**
				To develop and introduce a structured weekly activity timetable across the acute wards.	Ward Manager and Senior Nurse	**Appendix 3b**
4.	The activities coordinator post was vacant at the time of inspection	The health board must continue robust recruitment to the vacant activities coordinator post to support the planning and delivery of therapeutic activities.	Health promotion	The Mental Health Directorate has re-advertised the post and placed the vacant Activity Coordinator position out for advert Anticipated to recruit by end September 2026	Senior Nurse and Lead Nurse	In Progress Estimated Date of Completion **30/09/2026**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
5.	There was no dedicated OT provision for the PICU which staff recognised as a gap in provision.	The health board must review the Occupational Therapy provision for the PICU to ensure patients have equitable access to therapeutic input in line with recovery-focused care.	Health promotion	The Health Board will undertake a review of Occupational Therapy provision within PICU to determine how equitable access for patients can be achieved. This will include jointly scoping the feasibility of the current 0.6 WTE Band 6 Occupational Therapist post working across both PICUs/sites. It is recommended that this work is jointly led by the Senior Nurse and the Principal Occupational Therapist.	Senior Nurse and Principle Occupational Therapist	In Progress Estimated Date of Completion **13/07/2026**
				Should the scoping exercise determine that it is not feasible for the current part-time PICU Occupational Therapist post to deliver a service across two sites, a broader review of Occupational Therapy provision within Adult Mental Health services will be required. This should be undertaken jointly by the AMH Directorate and	Deputy Head of Occupational Therapy and AMH Directorate	In Progress estimated date for completion **01/12/2026**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				the Occupational Therapy Service to explore opportunities for redistribution of existing posts or consideration of skill mix within current or forthcoming vacancies. Risk currently sitting within the Health Board Risk Register 6297		
6.	The Patient Status 'at a Glance board' on Ward 22 was observed to be open and visible from outside the nursing office	The health board must ensure Patient Status 'at a Glance board' are consistently kept closed when not in use, to protect patient confidentiality.	Dignified and respectful care	All staff at the Royal Glamorgan Hospital have been reminded by the Senior Nurse, via an email of the requirement to ensure that glance boards are appropriately covered to maintain patient privacy and confidentiality. This message will be reinforced through the ward safety briefs at daily handovers for 5 days.	Senior Nurse and Lead Nurse	Complete **13/06/2026** **Appendix 6**
				The Status 'at a Glance board' is now covered when not in use.	Senior Nurse and Lead Nurse	**Appendix 6b**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				In addition, ongoing monitoring will be undertaken through a monthly Senior Nurse spot-check audit, with findings reviewed over a three-month period and reported via the Directorate Quality, Safety and Experience (QSE) meeting.		In Progress Estimated Date of Completion **30/08/2026**
7.	Wards 21 and 22 continued to provide mixed-gender care and a mix of single and shared bedrooms, with no dedicated segregated communal spaces available.	The health board must review shared bedrooms and mixed-gender accommodation on Wards 21 and 22 to ensure patients' privacy and dignity are supported and aligned with modern mental health care provision.	Dignified and respectful care	On Ward 21 and 22 there are multi occupancy bedrooms, but these are never mixed sex. Ward 21 and 22 also have separate male and female toilets A Safe System of work has been implemented across the inpatient service and this process is being adhered to	Ward Manager	Complete **12/06/2026** **Appendix 7**
8.	We found an overall lack of accessible and clearly displayed patient information	The health board must ensure that clear, accessible and up-to-date patient	Patient information	All signage has been reviewed, and notice boards are updated.	Ward Manager and Senior Nurse	In Progress Estimated Date of Completion

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	across the wards to support and inform patients about their care.	information is consistently available and clearly displayed across all wards.		This will be monitored via the monthly Ward Manager and Senior Nurse audit which will be reviewed over a 3-month period and be reported via the Directorate Quality, Safety and Experience (QSE) meeting	Ward Manager and Senior Nurse	**06/07/2026** In Progress estimated date for completion **01/10/2026**
9.	On Ward 21, patients requiring a hoist to bathe could not be supported on the ward and were required to use bathing facilities on another ward.	The health board must provide appropriate facilities, equipment and support to ensure equitable access to care for patients with mobility difficulties.	Rights and equality	All acute inpatient wards are equipped with assisted en-suite shower facilities to support patients with mobility needs. Due to the existing footprint and configuration of Ward 21, it is not feasible to provide a designated assisted bathroom within this area. Patients with mobility needs are rarely admitted; however, should such a requirement arise, a risk assessment and appropriate care plan would be completed. The patient would then be transferred to	Ward Manager and Senior Nurse	Complete **22/06/2026** **Appendix 9**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				the most suitable ward to ensure their needs are met safely and effectively.		
10.	Notable environmental checklist gaps were identified, with missing checklists and many checklists entirely or partially incomplete. We identified inconsistencies between checklist records and the ward environments observed during inspection. We were informed that no formal environmental senior manager quality walk-round process	The health board must: • Strengthen governance oversight and quality assurance processes to ensure environmental checklists are fully, accurately and consistently completed on all wards. • Implement clear processes to ensure issues	Risk management	A single checklist proforma will be shared across all the adult inpatient wards. A reminder email has been circulated to all staff to remind them to complete the current checklist proforma. This message will also be reinforced through the ward safety brief during daily handovers and at team meetings to ensure consistent communication and awareness across all staff groups.	Ward Manger, Senior Nurse and Operational Manger	In Progress Estimated Date for Completion date **10/07/2026** Complete **22/06/2026** **Appendix, 10a**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	was in place at the time of inspection.	identified through the checklists are escalated and addressed • Implement and maintain a formal, embedded senior manager quality walk-round process to provide regular oversight and assurance of environmental safety		A clear and structured escalation and assurance process has been implemented in line with the Mental Health Premises SOP. All environmental issues identified through ward checklists are recorded via a standardised process, with defects logged onto the central MH&LD Care Group Estates Log to ensure a single, auditable record of all environmental risks.		**Appendix 10b**
				A formal monthly senior manager environmental walk-round process has been implemented across all adult inpatient wards. These walk-rounds are jointly undertaken by the Senior Nurse and Operational/Support Manager and recorded within the MH Estates log and the Adult Acute H&S, IP&C, FRA Action Log, which is discussed in		Complete **22/06/2026** **Appendix 10c** **Appendix**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				Directorate Quality, Safety & Experience (QSE) Meeting. A defined escalation pathway has been embedded captured within the SOP, to ensure issues are actively progressed and resolved. Where works are not completed within agreed timeframes, these are escalated through a formal route to ensure timely resolution and oversight of risk. These are shared within the Care Group Integrated Performance Meeting (IPM).		**10d** **Appendix 10e** **Appendix 10f**
11.	Ward 21 operated in part as a through-route to other wards, increasing footfall through patient areas and requiring staff to frequently manage	The health board must review the ward configuration to ensure that access arrangements minimise through-traffic and mitigate the impact on	Risk management	This risk is recorded on the Health Board Risk Register **(ID 6611)** and relates to the use of Ward 21 as a through-route to other wards within the inpatient environment. A controlled access system remains in place, with all	Adult MH Directorate	Complete **22/06/2026**

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	access.	patient privacy, dignity and safety, supporting a safe and therapeutic ward environment.		entry and exit managed by staff to maintain oversight of movement through the ward. When risks increase staff deployment has been adapted to ensure a consistent presence within key areas of the ward, supporting patient observation, managing access, and enabling early identification and de-escalation of risk behaviours. Environmental mitigation measures continue to be progressed, including improvements to line of sight (e.g. installation of observation mirrors). Patient flow and access arrangements are actively managed on a day-to-day basis, with use of alternative ward space, escorted movement where appropriate, and clear staff oversight to minimise disruption and maintain a safe and therapeutic environment. This position is supported through ongoing monitoring via the risk register and senior management		

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				oversight to ensure the risk is actively managed and remains under review.		
12.	Cleaning schedules were in place, but supporting documentation did not clearly define the respective roles and responsibilities of housekeeping and nursing staff in maintaining ward cleanliness.	The health board must strengthen leadership and governance arrangements to ensure all ward areas are effectively cleaned and monitored. This must include providing clear guidance to nursing and housekeeping staff to ensure a shared understanding of roles, responsibilities and accountability for maintaining IPC standards.	Infection, prevention control and decontamination	The Facilities Manager within the Royal Glamorgan Hospital has reported that at present the update of The Health Board's Cleanliness Standard Roles, Responsibilities and Audit Tool Procedure is on hold until the publication of the New National Standards for Cleaning in NHS Wales. The current policy is still appropriate at this time based on current funding /standards.	Ward Manager and Facilities	Complete **22/06/2026** **Appendix 12**
				The Cleanliness Standard Roles, Responsibilities and Audit Tool Procedure has been shared with all staff via email and will be reinforced via the ward safety brief at daily handovers and team meetings. A monthly cleaning audit is currently conducted by the Housekeeping	Ward Manager and Facilities	Complete **22/06/2026** **Appendix 12a,12b**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				Supervisor. To enhance this process, the audit will now be carried out jointly with the Ward Manager		**Appendix 12c**
				Audit results will be shared with staff and displayed on the ward for patient/carer information. Planned quarterly interface meeting between housekeeping services and Senior Nurse for Inpatient teams has been agreed.		Complete **22/06/2026** **Appendix 12c** **Appendix 12d**
13.	We were not assured that staff consistently had access to appropriate decontamination and housekeeping equipment to support effective cleaning outside of normal housekeeping hours.	The health board must ensure that staff have consistent access to suitable cleaning and decontamination equipment to support safe and effective cleaning of the wards.	Infection, prevention control and decontamination	Access to out-of-hours housekeeping services is available when required. Details on how to access this service have been communicated to all staff via email. This information will be reinforced during daily safety briefings at handover, as well as in staff meetings.	Ward Manger and Facilities	Complete **22/06/2026** **Appendix 13 and 13a**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				Access to appropriate cleaning and decontamination equipment outside of standard housekeeping hours is now available to staff as required. Guidance on how to access these items has been communicated to all staff via email. This information will be reinforced through the ward safety brief at daily handovers and in team meetings.		
				Out of hours contact numbers are on displayed on the ward.		Complete **22/06/2026** **Appendix 13b**
14.	We found no evidence that shared equipment and facilities were consistently decontaminated between use in line with IPC standards.	The health board must ensure clear arrangements for the decontamination of shared equipment and facilities, including appropriate labelling to indicate when items are clean and safe for	Infection, prevention control and decontamination	An email reminder has been issued to all staff outlining the expected standards. This will be reinforced through the ward safety brief during daily handovers, as well as in team meetings.	Ward Manager and Senior Nurse	Complete **22/06/2026** **Appendix 14, 14a**
				Senior Nurse will complete a monthly audit and report any	Senior Nurse	In Progress Estimated

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
		use.		concerns or issues through Quality, Safety & Experience Meeting (QSE). This will be reviewed within 3 months.		date for completion **30/09/2026**
15.	No further annual IPC audit had been completed since 2024. This limited assurance that IPC risks were being routinely reviewed and addressed.	The health board must ensure annual IPC audits are completed at the required frequency and used to monitor, review and improve IPC practice across all wards.	Infection, prevention control and decontamination	Following discussion with the Infection Prevention and Control (IPC) team within the Health Board, annual audits are not routinely undertaken. Instead, audits are completed in line with AMAT scores as part of the ward manager's monthly schedule, including environmental audits. In addition, spot-check audits are carried out. A date had been scheduled for an IPC audit to be carried out on the Ward 22, following HIW inspection, action plan given to Senior Nurse.	Ward Manager and Senior Nurse	Complete **22/06/2026** **Appendix 15** **Appendix 15a**
16.	Staff compliance with mandatory IPC training was generally low, at	The health board must ensure all staff complete and remain	Infection, prevention control and	Mandatory IPC Training compliance **Ward 21 – 92.8%**	Ward Manager, Infection	Complete **22/06/2026**

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	68% on Ward 21, 79% on Ward 22 and 80% on the PICU.	compliant with mandatory IPC training to support consistent practice across all wards.	decontamination	**Ward 22 – 94.1%** **PICU RGH – 100%** This will be reported via the Directorate Quality, Safety and Experience (QSE) meeting.	Prevention control (IPC Leads) and Senior Nurse	**Appendix 16** **Appendix 16a** **Appendix 16b**
17.	Laundry arrangements did not consistently support timely access to clean clothing or patient dignity on wards 21 and 22.	The health board must review laundry arrangements on Wards 21 and 22 to support IPC, timely access to clean clothing and patient dignity.	Infection, prevention control and decontamination	The Directorate has commissioned the upgrade of laundry facilities for patient use, including the installation of 2 washing machines and 2 tumble dryers. A purchase order has been raised for the required electrical infrastructure works, with Estates progressing installation of the necessary sockets to enable commissioning of the equipment. Installation is dependent on contractor mobilisation, with Estates currently confirming a start	Operational Manger and Estates	Complete **22/06/2026** **Appendix 17**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				date. Once electrical works are complete, the equipment will be installed and brought into use, restoring on-ward laundry provision and improving patient access and dignity. Additionally, mitigation measures are in place where washing facilities are available on alternative area within the MH unit.		
18.	Emergency medication on Ward 21 was stored in a high cupboard, which could delay staff access during urgent or emergency situations.	The health board must review the emergency medication storage arrangements on Ward 21 to ensure emergency drugs are readily accessible and can be accessed without delay.	Medicines management	The storage of emergency medication on Ward 21 has now been lowered and is readily accessible for staff use.	Ward Manager	Complete **15/06/2026** **Appendix 18**
19.	Equipment for serving hot drinks, including the	The health board must ensure ward food and	Nutrition and hydration	Following the HIW inspection the tea trolley on Ward 21 has since	Ward Manager	Complete **22/06/2026**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	tea trolley on Ward 21 and the hot-water dispenser on Ward 22, was out of order.	drink equipment is fit for purpose to support patients' nutritional and hydration needs and reduce avoidable pressure on staff.		been repaired.		**Appendix 19**
				Arrangements are in place for the replacement of the hot water dispenser on Ward 22. Ward 22 have access to a tea trolley which is in use on the ward.	Ward Manager	In Progress Estimated Date of completion **31/07/26** **Appendix 19a**
20.	The responses to the staff questionnaire were generally mixed, with areas of concern.	The health board must reflect on the staff feedback outlined in this report and identify improvements to support staff experience and sustain high-quality patient care.	Staff feedback	The findings from the staff questionnaire will be escalated to the Senior Management Team (SMT) for review and discussion. An action plan will be developed in response to the feedback, focusing on addressing key areas of concern, improving staff experience, and supporting the delivery of high-quality patient care. In addition to this, all furniture has	Lead Nurse, Senior Nurse and Adult SMT	In Progress Estimated Date for Completion date **30/07/2026**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				now been ordered. Compassionate Leadership sessions have been delivered, and Implementing Safe Wards training has been completed across all wards. We have seen significant improvement through staff participation in the Compassionate Leadership sessions, which focus on ensuring all staff feel valued, supported, and understood. This approach promotes empathy and strengthens teamwork, ultimately helping to ensure patients receive exceptional care. Furthermore, Safe Wards training has been implemented. This is an evidence-based model for inpatient settings that aims to reduce conflict between staff and patients, contributing to a safer and more therapeutic environment.		

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				In addition, the CTM Speak Up Safely initiative has been shared through team briefings and the Adult Directorate Staff Newsletter, providing staff with a clear and accessible route to raise queries and concerns.	Lead Nurse, Senior Nurse and Adult SMT	Complete **03/06/26** **Appendix 20**
21.	Our staff engagement indicated low confidence in senior manager visibility, communication and responsiveness.	The health board must consider the feedback regarding senior management visibility and communication and implement improvements to foster a more collaborative approach to patient care.	Governance and leadership	A joint Senior Nurse/ Operational manager visit is undertaken weekly. A Monthly 'Cuppa and a Chat' staff drop-in sessions have been implemented and will be facilitated by the Senior Nurse. In addition, the MHLD Care Group host a monthly Q&A session, which has been circulated within the Care Group via the Business Support Team.	Lead Nurse Senior Nurse	Complete **09/06/2026** Complete **23/06/2026** **Appendix 21** **Appendix 21b**
				A Lead Nurse monthly visiting schedule (rolling programme) has been implemented any concerns and recurring themes will be		Complete **23/06/2026** **Appendix 21a**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				escalated and discussed within the Senior Management Team (SMT)		
22.	We found high nursing staff vacancies across the service, with bank and agency staff routinely used to maintain safe staffing levels.	The health board must continue robust recruitment to vacant posts to strengthen staffing stability, reduce workforce pressures and support safe, effective patient care.	Skilled and enabled workforce	The below are the current vacancies within the inpatient wards of Royal Glamorgan Hospital: **Ward 21** 1 x Band 6. 0.5 Band 5 RMN. 0.4 Band 2 HCA 1 Activity Worker. **Ward 22** 6 x Band 5 RMN. 2 on Trac 4 x Streamlining for September intake. **PICU** No vacancies The Health Board has an agreed arrangement for a streamlining process, with these posts currently		Complete **22/06/2026**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				being progressed for the September intake to support newly qualified staff nurses. All remaining vacancies have been advertised on Trac and are progressing through the recruitment process. It is anticipated that all vacant posts will be filled by October 2026. All vacancies are reported through the Directorate Integrated Performance Meeting.		
23.	Staff reported that recent service reconfiguration had increased workload, contributed to ongoing staffing challenges and negatively affected staff morale.	The health board must engage with staff to review the impact of service reconfiguration and ensure staffing levels and support arrangements meet patient needs and promote staff wellbeing, team	Skilled and enabled workforce	A meeting has been arranged 29/07/2026 with the Senior Nurse and Lead Nurse and Operational Manager to engage with staff and discuss the impact of the service reconfiguration on workload, staffing and morale. In addition, Leadership visibility will be strengthened through regular	Lead Nurse, Senior Nurse and Operational Manager	Complete **23/06/2026** **Appendix 23**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
		cohesion and the consistent delivery of effective care.		Senior Nurse, Operational Manager walkarounds and Lead Nurse visits.		
				Concerns and recurring themes will be escalated and discussed within the Senior Management Team (SMT). Concerns and recurring themes will be escalated and discussed within the Senior Management Team (SMT). Feedback and agreed actions will be communicated through the Acute Senior Leadership Team (SLT), cascaded to Ward Manager forums, and shared with staff through local ward team meetings and staff briefings to ensure visibility of actions taken and ongoing improvements.	Lead Nurse, Senior Nurse and Operational Manager	In Progress estimated date for completion **17/08/2026**
24.	Some staff felt that staffing levels on the mental health wards at	The health board must review staffing levels and access to	Skilled and enabled workforce	A Nursing establishment review was completed and monitored through the Nursing workforce meeting.	Head of Nursing, Senior	Complete **22/06/2026**

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	Royal Glamorgan Hospital were lower than those on equivalent wards within the health board and described inconsistent access to psychology and occupational therapy.	psychology and occupational therapy services across mental health wards to ensure the consistent delivery of effective, person-centred care.		Staffing requirements are determined on a day-by-day basis and when additional staff are required to meet the needs of the patients then additional staffing requests are submitted. All requests since the implementation of the new staffing establishment have been approved.	Nurse, Principal OT and MH Directorate	Complete **24/06/26**
				OT The Senior Nurse and Principal Occupational Therapist will jointly lead a scoping exercise to assess the feasibility of the current 0.6 WTE Band 6 Occupational Therapist post operating across two PICU sites. Should the outcome indicate that it is not feasible for the existing part-time PICU OT role to deliver a service across both sites, a wider review of OT provision within Adult Mental Health services will be		In Progress **01/12/26**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				undertaken. This will be a collaborative review between the AMH Directorate and the OT Service to explore opportunities for redistribution of existing posts or consideration of skill mix adjustments in relation to any vacancies within the Directorate		
				Psychology At present, our service is operating with a reduced establishment, which has impacted our capacity to fully meet demand. We have conducted a review of staffing levels and service needs and have put mitigations in place to support continuity of care and maintain service delivery as safely and effectively as possible. Vacancies for an Art Psychotherapist and maternity cover for a Band 7 CAAPS roles have now been placed on Trac, and we are prioritising these appointments		In Progress **31/08/26**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				to stabilise the workforce and improve resilience within the service going forward. In the interim, we are continuing to utilise available resources flexibly, alongside prioritisation processes, to ensure that risk is managed appropriately and that service users receive the most urgent care required. In addition, training had been provided to frontline acute staff over the last 12 months in regard to a relational model of psychological care, with team formulations and reflective practice utilising this model in place to ensure a safe psychological environment. This will continue to be built on through the next year with the addition training available to acute staff to further develop a psychologically skilled and trauma-informed workforce across acute services in Cwm Taf Morgannwg.		

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
25.	Annual appraisal completion on the PICU was low at 75% and required improvement.	The health board must ensure that all staff receive an annual appraisal to ensure they are appropriately supported, developed and enabled to deliver safe and effective patient care.	Skilled and enabled workforce	Current Annual Appraisal compliance for PICU RGH is 76.1% with an agreed improvement trajectory to achieve 100% by **30/07/2026.** This will be monitored through the Directorate Integrated Performance Meeting (IPM)	Ward Manager and Senior Nurse	In Progress estimated date for completion date **30/07/2026** **Appendix 25**
26.	We found examples of low mandatory training compliance across all three wards.	The health board must implement robust measures to ensure that all outstanding mandatory training is completed, regularly monitored, and that staff receive appropriate support to complete training in a timely manner.	Skilled and enabled workforce	All Ward Managers are responsible for actively monitoring, supporting, and evidencing staff compliance with mandatory training requirements. To support improvement, targeted measures have been implemented, including the provision of protected time to enable staff to complete training and improve access and overall compliance. This is shared within the Ward Managers report following monthly audit	Ward Manager, Senior Nurse and Lead Nurse	Complete **22/06/2026** **Appendix 26, 26a and 26b**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				Additionally, to further strengthen compliance monitoring and governance, an automated reminder system has been implemented for Ward Managers. A bi-weekly reminder is issued via the Adult Mental Health Business Support calendar, prompting Ward Managers to review and update their mandatory training compliance and trajectory data. The communication includes a direct link to the live SharePoint compliance documents, ensuring timely access to the most up-to-date information and supporting accurate reporting and oversight. This automated approach reinforces accountability and promotes consistent updating of compliance records across all wards. Compliance is regularly monitored and reviewed through Care Group Integrated Performance Meetings		**Appendix 26c**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				(IPM) to ensure sustained oversight and accountability.		
27.	Several policies were overdue for review, draft, or did not have a clear review date.	The health board must ensure that policies and procedures are reviewed and updated in a timely manner to provide clear, current and reliable guidance for staff.	Skilled and enabled workforce	All Mental Health policies are monitored by the Mental Health Learning Disability (MHLD) Policy Review Group which has an operational scope to: •Review & RAG of all existing MH Policies to establish priorities rating •Develop a policies plan with trajectories for addressing the backlog •To progress for sign off at Care Group level •Maintenance of a register of policies for review When due for renewal, policies are assigned to an expert group for update, review, and completion, before being sent back to the MHLD Policy Group for ratification.	Chair of Policies Group	In Progress Estimated Date for completion **01/12/26**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				At the time of the HIW inspection, eight policies were identified as out of date or in draft, comprising two Mental Health-specific policies and six Health Board-wide policies.		
				HB wide policies are the responsibility of the policy authors to ensure timely reviews of written control documents within their areas. This is set out in the Policy for the Development, Review and Approval of Organisational Wide Policies. The policy programme is currently under review and aims to introduce an additional step where reminders will be issued to the policy leads ahead of the policy passing its review period.	Assistant Director of Governance and Risk Cooperate Governance	Complete **22/06/26**
28.	We found limited documentary evidence of staff meetings on the PICU.	The health board must ensure that staff meetings are regularly held on the PICU and	People engagement, feedback and learning	Within PICU RGH, monthly staff meetings are now in place. Following every meeting minutes	Ward Manager	Completion **22/06/2026** **Appendix 28**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
		that records are maintained to evidence regular staff engagement and communication.	People engagement, feedback and learning	will be shared with all staff.		
29.	We did not see consistent evidence that patient and family/carer feedback was routinely captured, reviewed, or that actions taken were effectively communicated to support learning and improvement	The health board must: • Display clear information about how patients can provide feedback and raise concerns • Ensure regular patient meetings are held on all wards and are consistently documented • Strengthen systems to record, address		Information has been displayed within our notice boards on how patients can provide feedback and raise concerns.	Ward Manager, Senior Nurse	Complete **22/06/2026** **Appendix 29**
				Weekly patient meetings are in place across the inpatient ward with notices displayed for patient awareness.	Ward Manager, Senior Nurse	**Complete 22/06/2026 Appendix 29a**
				'You said we Did' board will be implemented across the inpatient wards to provide feedback to patient.	Ward Manger, Senior Nurse and OT	In Progress estimated date for Completion **31/08/2026**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
		and provide feedback about actions taken in response to issues raised • Provide governance oversight to assure patient and family/carer feedback is used to inform service improvement.				
				Following feedback from patient meetings, this will be reviewed on a monthly basis, reported within the Ward Manager's report, and used within the 'You Said, We Did' approach to inform service improvement, with outcomes shared at Senior Management Team (SMT) and Quality, Safety and Experience (QSE) meeting.	Ward Manger, Senior Nurse and Lead Nurse	In Progress estimated date for completion **31/08/2026**
30.	While some improvements were addressed during the inspection, the health board must take further action to implement the recommendations set out in this report and to ensure that	The health board must take robust action to implement the recommendations set out in this report and ensure that improvements are embedded and sustained.	Quality improvement activities	The Care Group has developed a governance framework to ensure all recommendations from the inspection are actioned, monitored and sustained. A centralised improvement plan tracker has been established, with named responsible leads, clear	BISC Team	Completed **22/06/2026**

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	improvements are sustained.			timescales and RAG-rated progress updates. Performance against the plan will be reviewed monthly through the Directorate Quality, Safety and Risk Meeting and escalated through Care Group governance structures as required		

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: C. Yates

Name (print): Clare Yates

Job role: Lead Nurse, Unscheduled Care, Adult Mental Health

Date: 24/06/2026