Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Hafan Deg Ward, Ty Siriol Unit

Aneurin Bevan University Health Board

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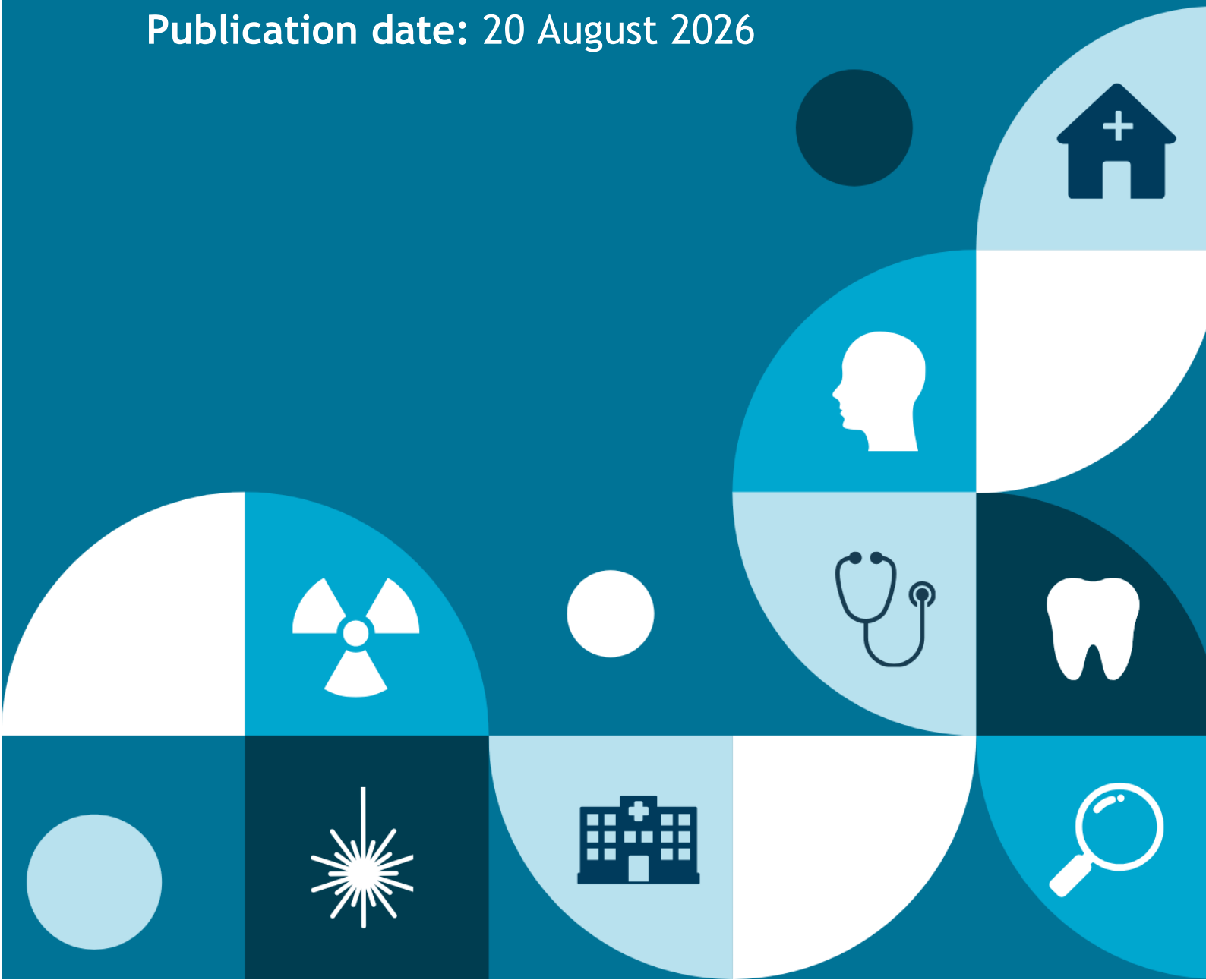

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

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 Hafan Deg Ward on 18, 19 and 20 May 2026. Hafen Deg is a 20 bedded older adult functional mental health assessment ward based in the Ty Siriol Unit within the grounds of County Hospital, Pontypool.

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

During the inspection we gave out questionnaires and spoke to patients or their families/carers to find out about their experiences of using the service. We also spoke with staff members to find out their views on working for the service.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Patients and families provided positive feedback about their experiences on the ward. We observed staff interacting warmly and sensitively, demonstrating a person-centred approach to care.

Patients benefitted from a structured programme of activities, including group sessions, creative work and gardening, which helped support their wellbeing and independence. A volunteer was highly valued for engaging patients and supporting meaningful activity. Patients were also supported to maintain their independence and were encouraged to make day-to-day choices about their care.

We found strong arrangements in place to support patients' physical healthcare needs alongside their mental health care. Comprehensive physical health assessments were undertaken on admission, supported by a range of recognised assessment tools, and there was evidence of ongoing monitoring to support the management of identified risks.

However, we identified some areas where patient experience could be further improved. These included aspects of the ward environment, where some fixtures such as bedroom curtains were not consistently maintained, which could impact privacy and dignity. While staff generally communicated effectively with patients, their awareness of the Welsh Government's 'More than Just Words' framework regarding Welsh language was inconsistent. We also found that not all patients and families were fully aware of available advocacy services or how to access them. In addition, some patients reported limitations in accessing spiritual and religious support during their stay, indicating that these needs were not always consistently met in practice.

This is what we recommend the service can improve:

- Ensure all bedroom curtains are properly fitted and maintained, with curtain rails and hooks kept in good repair to support patient privacy and dignity
- Ensure patients and families are consistently informed about advocacy services and how to access them
- Ensure patients are routinely supported to access spiritual and religious services in line with their needs.

This is what the service did well:

- Patients and families described staff as caring and supportive

- Patients felt safe within the ward environment
- Access to indoor and outdoor spaces, including a garden, enhanced patient experience.

Delivery of Safe and Effective Care

Overall summary:

We found that systems were generally in place to support the delivery of safe and effective care, including governance arrangements for risk management, safeguarding, and multidisciplinary team working. Patients were cared for in a clean and generally well-maintained environment, and staff demonstrated a good understanding of safeguarding processes and emergency procedures. Arrangements to support nutrition and hydration were effective, with appropriate assessment, monitoring and access to specialist input where required.

We found that risk management processes were in place, including the use of structured risk assessments and regular review through ward rounds and multidisciplinary meetings. Staff were able to describe patients' needs, risks and appropriate management strategies. However, this information was not always consistently reflected in care and treatment plans. In some cases, care planning lacked detail, with limited evidence of clearly defined strategies to support the management of behaviours or address identified risks. Opportunities to use structured assessment tools and specialist input, including psychological support, were not always evident, which limited the ability to consistently deliver personalised and therapeutic care.

However, we identified significant concerns that meant we were not assured that key safety systems were consistently effective in practice. These included issues relating to the management of medicines, infection prevention and control, the use of covert medication, and the application of the Mental Health Act. In particular, we identified gaps in statutory documentation and lapses in legal authority for detention and treatment, as well as weaknesses in medicines storage, stock control and oversight. These issues indicated that systems for monitoring and embedding safe practice were not always robust or consistently followed.

Immediate assurances:

- Gaps in Mental Health Act (MHA) documentation were identified, including lapses in detention authority and treatment being administered without valid legal authorisation, indicating weaknesses in systems to track statutory deadlines and safeguard patients' rights
- Covert medication was being administered without evidence of appropriate legal processes, including capacity assessments, best interests decisions,

multidisciplinary input or clear care planning to demonstrate least restrictive practice

- Medicines management systems were not being consistently followed, with unsecured medicines storage, unlocked cupboards and trolleys, and ineffective stock control leading to out-of-date medication being held and not identified through routine checks
- Infection prevention and control arrangements were not consistently implemented, including unclear guidance for staff, inconsistent use and disposal of PPE, and a lack of care planning and oversight for the management of an infectious condition.

More information on the immediate improvements and remedial action taken by the health board are provided in Appendix B.

This is what we recommend the service can improve:

- Ensure minor environmental issues, including damaged fixtures and lighting, are addressed promptly
- Ensure care planning consistently reflects risk management strategies, including behavioural support and therapeutic approaches
- Ensure care and treatment plans are consistently detailed, person-centred and evidence clear patient involvement
- Improve the quality and completeness of medication administration records, including allergy status and signatures.

This is what the service did well:

- Risk management systems, including incident reporting and ligature risk assessments, were in place
- Staff demonstrated awareness of emergency procedures and access to appropriate equipment
- Ward-based initiatives, including elements of the Safewards model and regular patient meetings, supported a calmer environment and improved communication between patients and staff.

Quality of Management and Leadership

Overall summary:

Clear processes were in place to escalate risks and incidents, supported by daily touchpoint meetings and divisional oversight arrangements, alongside a structured governance framework including quality and safety meetings and incident reporting systems.

We also found evidence of a positive team culture, with staff describing effective multidisciplinary working, good communication through handovers and ward rounds, and strong support for staff development, including high compliance with mandatory training, regular appraisals and well-established preceptorship arrangements.

Quality improvement activity was evident, including audit processes, use of the All Wales Audit Management Tool (AMaT) and participation in the health board's ward accreditation programme. However, we were not assured that the audit and monitoring arrangements were consistently identifying and addressing risks, including those identified during the inspection.

In addition, ward meetings were not always held regularly, limiting opportunities for staff communication and shared learning, and some policies were out of date. Some staff also highlighted that there was a high proportion of newly qualified staff on the ward and described how this, alongside recent changes to 12-hour shift patterns, could impact continuity of care, including staff availability for patient reviews and care planning. The health board should reflect on this feedback as part of its ongoing workforce planning.

This is what we recommend the service can improve:

- Ensure ward meetings are held regularly to support staff engagement and shared learning
- Ensure all policies and procedures are regularly reviewed and kept up to date
- Strengthen the effectiveness of audit, monitoring and quality improvement systems to ensure risks are identified and addressed consistently.

This is what the service did well:

- Staff described leaders as visible, approachable and supportive
- "Top Tip Tuesday" and other communication methods supported sharing of key information
- High levels of compliance with mandatory training and regular staff appraisals
- Evidence of partnership working with community teams and families.

3. What we found

Quality of Patient Experience

Patient feedback

We gathered patient feedback through questionnaires and by speaking directly with patients and their families throughout the inspection. Overall, feedback about the care provided on the ward was very positive. One patient commented:

> *"Outstanding service!"*

While some patients reported feeling a little confused on arrival, they said this improved as they became more familiar with the ward. Patients told us they felt safe and valued the ward environment, particularly the garden facilities, which supported their wellbeing.

We spoke with the families of four patients, all of whom spoke highly of staff and the support provided. Staff were consistently described as compassionate and caring. Families told us staff took time to answer questions and support both patients and relatives. One family member commented:

> *"Not only has my [relative] been receiving the best care, we also have as a family. These guys deserve an award!"*

Person-Centred

Health promotion

We saw evidence that systems were in place to support physical healthcare for patients alongside their mental healthcare needs. Patients had access to a structured programme of activities, with input from occupational therapy, which promoted routine, independence and overall wellbeing. Activities were varied and included group sessions, creative work and gardening. Patients also had access to indoor and outdoor spaces, including a well-maintained garden, which provided a pleasant environment for relaxation, physical activity and social interaction. A volunteer supported activities on the ward, particularly in the garden, and was highly regarded for engaging patients and involving them in decisions about future activities.

The care and treatment plans we reviewed showed that patients received a physical healthcare assessment on admission. A range of recognised assessment tools were used to support the identification and management of individual needs, including Waterlow for pressure damage risk and structured falls and mobility assessments. In some cases, more comprehensive assessments were completed, including mouth care, bladder and bowel care, and foot and nail care.

There was evidence of ongoing monitoring of patients' physical healthcare needs. This included the use of NEWS observations, food and fluid charts, skin monitoring and weight monitoring, which supported the ongoing management of identified risks.

Dignified and respectful care

Feedback from patients and families was consistently positive about the way they were treated on the ward. Families described staff as respectful and approachable, and our observations throughout the inspection supported this feedback. Staff were seen to interact warmly and respectfully with patients, demonstrating a good understanding of individual needs and preferences, contributing to a consistently positive patient and family experience. We observed that patients were supported with personal care needs in a dignified and sensitive way.

Each patient had their own individual bedroom. Staff were observed knocking before entering bedrooms, and doors were closed when care or treatment was being provided. However, we noted that some bedrooms had missing curtain hooks or curtains not properly fitted to the rails.

The health board must ensure that all bedroom curtains are properly fitted and maintained, with curtain rails and hooks kept in good repair to support patients' privacy and dignity.

Patients were able to keep some personal belongings, with additional storage arrangements in place to manage items safely in line with risk. However, bedrooms appeared sparse. Although the ward was intended for short-stay patients, some patients had been on the ward for several months. We advised the healthcare provider to consider allowing patients to personalise their space to improve their experience.

Patients had access to communal areas to socialise, as well as private spaces when needed. Confidential information was stored securely and not displayed in public areas.

Individualised care

Patients were supported to maintain independence through access to appropriate aids, such as walking aids to support mobility, and were encouraged to carry out everyday tasks, including managing their own drinks and clearing plates after meals. Staff were seen to promote patient choice and involvement in day-to-day decisions, reflecting a person-centred approach to care.

Our review of care and treatment plans found that most patients had up-to-date and individualised plans in place that reflected their assessed needs and supported their safety. Care and treatment plans were generally outcome-focused, with evidence of clear goals, identified interventions and named responsibility for delivery. Interventions included a range of therapeutic, physical health and social support, which were appropriate to meet individual needs.

However, this was not consistent across all records. While several care and treatment plans were well structured and clearly linked to assessed needs, others were either incomplete or lacked sufficient detail. In some cases, interventions and outcomes were not clearly defined, and there was limited evidence to demonstrate how patient views had informed care planning.

The health board must ensure that care and treatment plans clearly set out identified needs, outcomes to be achieved and the specific actions required to meet those outcomes, in line with the requirements of the Mental Health (Wales) Measure 2010.

Timely

Timely care

Feedback from patients and family members indicated that patients received timely care and support when needed. Staff were observed providing support throughout the inspection, responding to patients' needs and monitoring their wellbeing, including offering emotional support where required.

There was evidence that medication was offered to patients in a timely way. Staff were observed administering medication and carrying out routine checks, such as monitoring blood pressure and general wellbeing, as part of ongoing care.

Equitable

Communicating and language

We found that staff communicated effectively with patients and demonstrated an understanding of individual communication needs. Patients were supported to express their views and preferences.

Patients were able to maintain contact with family members, advocates and other professionals using ward telephones or personal devices. Arrangements were in place to ensure these were stored securely and used safely. Private spaces were available to support confidential conversations where required.

The care and treatment plans we reviewed showed that patients' language preferences were generally recorded on admission and reflected in care planning. This helped to ensure that communication with patients was appropriate to their individual needs.

Information was generally available in appropriate formats, with translation services accessible when needed. Some bilingual signage was displayed across the ward. While patients' preferred language was recorded, some staff we spoke to showed limited awareness of the 'active offer'. Communicating with patients in their first language, particularly older adults, can support comfort, understanding and overall wellbeing.

The health board must ensure that all are aware of the Welsh Government's 'More than Just Words' framework and the 'Active Offer' and ensure the Health Board's Welsh language leads engage with staff across the mental health service to raise awareness promptly.

Rights and equality

We found that systems and processes were in place to support patients' rights and promote equality on the ward. An equality and diversity policy was available, and staff described a culture where patients were treated fairly. This included training on equality, anti-racism and managing violence and aggression, helping staff to recognise and respond appropriately to potential discrimination.

The ward environment supported equitable access to services. The premises were purpose built, with step-free access and wide corridors to support patients with mobility needs. Staff told us they used preferred names and pronouns, and placement decisions were made based on individual need and risk.

Patients had access to information about their rights and how to raise concerns. Advocacy services were available. However, feedback indicated that not all patients and families were fully aware of how to access them. This suggested there were opportunities to improve how information about advocacy and support services was communicated.

The health board should ensure that patients and their families are consistently informed about available advocacy services and how to access them.

Patient feedback also identified some limitations in meeting patients' spiritual and religious needs. One patient reported limited access to religious services during their stay, including missed opportunities to attend services and infrequent visits from a minister. This indicated that, while needs were recognised, they were not always consistently supported in practice.

The health board must ensure that patients are routinely informed of available spiritual and religious provision and are supported to access these services in line with their preferences and needs.

Delivery of Safe and Effective Care

Safe

Environment

We saw evidence that systems were in place to monitor and maintain the environment. Regular checks of the ward were undertaken, including daily security checks, which supported the identification and management of any risks.

We found that the ward environment was clean, tidy and generally well maintained. It was considered fit for purpose and suitable for the needs of the patient group, with no significant safety concerns identified.

However, we noted a small number of maintenance concerns that required attention. These included a damaged worktop in the main kitchen area and external lighting that was not functioning during the evening.

The health board must ensure that identified maintenance issues are addressed in a timely manner to ensure the environment remains fit for purpose for patients, staff and visitors.

Risk management

The service had systems in place to support the management of risk and health and safety, including the use of risk assessments and established arrangements for incident reporting and governance oversight.

Ligature risk assessments were undertaken and kept under review, supporting the identification and management of risks for individual patients. Ligature cutters were available and staff were aware of their location. During the first night of the inspection, we noted that one pair of ligature cutters was stored in a cluttered drawer; however, action was taken during the inspection to improve accessibility, with clearer signage and relocation to a more appropriate storage area.

Staff were observed to be wearing personal safety alarms, and call systems were available to patients where required. Fire safety arrangements were in place, with appropriate equipment available and staff demonstrating an understanding of emergency procedures.

Infection prevention and control (IPC) and decontamination

We found that, in general, the ward environment was visibly clean and tidy, with patient areas maintained to an acceptable standard. Cleaning schedules were in place and supported by dedicated domestic staff. There was evidence that equipment was cleaned between use, and sharps were managed safely. Hand hygiene facilities were available for staff, patients and visitors, with signage displayed across the ward,

although some notices were partially obscured.

Systems were in place to support infection prevention and control, including access to relevant policies and an identified IPC lead. However, some aspects of the environment, such as damaged flooring and door frames, limited the ability to fully maintain effective cleaning and infection control standards.

The health board must ensure that damaged fixtures, including door frames and flooring, are repaired or replaced promptly to support effective cleaning and maintain appropriate IPC standards.

We were told that facilities were available to support barrier nursing and isolation when required. However, we identified significant concerns in relation to the management of a patient with scabies, which required immediate assurance. The patient was being isolated and nursed on an adjacent ward. While staff were observed wearing personal protective equipment (PPE), arrangements for donning and doffing were not consistently clear or appropriately set up at the time of our arrival. We observed improvements being made during the inspection, including the introduction of a PPE station outside the ward and a bin for the disposal of used PPE.

Despite these improvements, inconsistencies in staff practice remained. For example, staff were seen leaving the ward and placing used gloves in their uniform pockets rather than disposing of them appropriately at the PPE station.

We found that there was no clear care plan in place to guide staff on the management of the patient's condition or to support consistent and safe delivery of care. There was a lack of clear, accessible guidance for staff on key aspects of care, including laundering of the patient's clothing, changing of bedding and the application of topical treatment. Staff were also undertaking enhanced observations for continuous periods of up to 6 hours, which was not in line with the health board policy of a maximum of 2 hours.

These findings meant that we were not assured that appropriate measures were in place to minimise the risk of infection transmission or ensure the safety of patients and staff. Our concerns were dealt with under our immediate assurance process. Further information on the immediate improvements and remedial action taken by the service, are provided in Appendix B.

Safeguarding of children and adults

We found that systems and processes were in place to support safeguarding on the ward, with staff demonstrating a good understanding of their responsibilities. Staff we spoke with were aware of safeguarding procedures, knew how to access relevant policies, and were clear about the actions to take if a concern arose. Staff also reported that they would escalate concerns appropriately and felt confident in using the whistleblowing process if required.

Processes were in place to manage safeguarding concerns, including the use of

reporting systems and regular review of incidents. Safeguarding issues were monitored through governance arrangements, with daily reviews and escalation where necessary. Staff described how safeguarding concerns would be discussed within the multidisciplinary team, with a focus on using the least restrictive options when managing risks between patients.

Patients told us they felt safe on the ward, and this was supported by feedback from family members. Patients were aware of who they could speak to if they had a concern, and staff were available to provide support where needed.

Management of medical devices and equipment

The service had arrangements in place to ensure that emergency equipment was available and accessible on the ward. This included resuscitation equipment and emergency drugs, which were generally held in line with local requirements. Staff were aware of the location of emergency equipment and demonstrated an understanding of their responsibilities in relation to its use. Staff told us they had received training in the use of equipment such as portable oxygen cylinders and were able to describe how concerns would be reported and escalated.

However, we identified concerns in relation to the management and checking of emergency drugs. During the inspection, we found five boxes of rectal diazepam stored on the ward which were out of date, some by several months. Staff were able to locate an in-date supply; however, this was stored separately, which could have delayed access in an emergency. This indicated that stock checks were not being undertaken effectively and that systems to ensure readiness of emergency medication were not consistently applied.

These issues formed part of our wider concerns in relation to medicines management, which are set out in more detail in the medicines management section of this report.

Medicines management

We were not assured that appropriate and robust medicines management procedures were being consistently followed or embedded in practice. We identified several concerns relating to the safe storage and management of medication. On the first night of the inspection, the medicines fridge was found to be unlocked and the medicines trolley unsecured. On subsequent visits, the fridge, cupboards and trolley were again found to be unsecured, with multiple drawers left unlocked. This indicated that required improvements had not been embedded in practice.

We also identified significant concerns in relation to stock management and oversight. Out-of-date medicines were identified within both general storage areas and the controlled drugs cupboard, and there was no evidence that routine stock checks were being completed effectively. Although action was taken during the inspection, including pharmacy involvement and removal of expired stock, further issues were identified on

follow-up. This did not provide assurance that systems were being applied consistently in practice.

In addition, processes for the management of controlled drugs were not always followed. Required checks were not consistently undertaken in line with policy and, where checks were recorded, they had not effectively identified expired stock. Responsibilities for medicines management, particularly in relation to stock control, were not clearly understood by staff.

We also identified concerns regarding the use of covert medication. Documentation was incomplete and did not demonstrate that appropriate legal or best interest processes had been followed. There was limited evidence of capacity assessment, multidisciplinary discussion, pharmacy involvement or family consultation. There was also no clear, individualised care plan to guide staff on the covert administration process or demonstrate that this approach was being used in line with least restrictive practice.

These findings meant that we were not assured that medicines management systems were sufficiently robust or consistently applied to ensure safe storage, effective stock control and appropriate oversight. Our concerns in relation to these issues were managed through our immediate assurance process. Further information on the immediate improvements and remedial action taken by the service is provided in Appendix B.

The prescribing and administration of medicines for individual patients was generally satisfactory. However, we identified weaknesses in the quality of record keeping. There were occasional omissions in the medication administration records, including missing signatures and incomplete recording of allergies, which may pose a patient safety risk for staff not familiar with a patient.

The health board must ensure that medication administration records are fully and accurately completed, including signatures, dates and allergy status, to support safe prescribing and administration of medicines.

Effective

Effective care

We found systems and processes in place to support the delivery of safe and effective care. Staff told us they had access to relevant clinical policies, procedures and professional guidance, including NICE guidance and the Mental Health Act Code of Practice. Staff described how they were kept up to date through meetings, email communication and access to information on the ward and intranet. Multidisciplinary team (MDT) meetings and ward rounds were used to review patient care and support decision-making.

Staff described the use of therapeutic activities, access to outdoor space and quieter

environments, as well as de-escalation techniques such as distraction and engagement, to support patients and reduce the need for restrictive practices. Ward-based initiatives, including elements of the Safewards model and regular patient meetings, were also described as contributing to a calmer ward environment and supporting communication between patients and staff.

However, we found that these approaches were not consistently reflected in care and treatment planning. There was limited evidence of clearly defined, individualised strategies to understand and manage behaviours, despite staff being able to describe triggers and appropriate responses in practice. This indicated that knowledge held by staff was not always translated into care plans to support consistent care delivery.

There was also limited evidence of structured assessment to understand behaviours or underlying causes, and restricted access to psychological input, reducing opportunities for specialist involvement and more tailored, therapeutic approaches. In addition, the patient voice was not consistently evident, and information from families and carers was not always incorporated into care plans.

The health board must ensure that care and treatment plans include clearly defined, individualised strategies to understand and manage behaviours, supported by appropriate assessment and specialist input where required.

Nutrition and hydration

Arrangements were in place to assess and meet patients' nutritional and hydration needs. Patients were assessed and screened for malnutrition or risk of malnutrition on admission using the MUST tool. The care records we reviewed included the use of food and fluid charts, which supported ongoing monitoring of intake and helped identify any risks. Patients were provided with diets appropriate to their needs, including modified diets where required to support safety, such as for those at risk of aspiration.

There was evidence that patients had access to specialist support where needed. This included input from speech and language therapy and dietetic services, with clear recommendations documented to guide care. These arrangements supported the provision of safe and effective nutritional care tailored to individual patient needs.

During the inspection, we observed mealtimes to be calm and well organised. Patients were seen sitting together and were encouraged to maintain independence, including being supported to manage aspects of their own meals where appropriate.

Patient records

Patient records were being maintained via paper and electronic formats. Records were stored securely, easy to locate, and clearly organised, with relevant sections easily identifiable. Members of the multidisciplinary team were able to regularly update and contribute to patient records, supporting continuity and consistency in care.

Mental Health Act monitoring

We found that some systems were in place to support the application of the Mental Health Act (MHA). Staff we spoke with demonstrated an understanding of their roles and responsibilities under the Act and were aware of how to access relevant policies and guidance. There was evidence that MHA documentation was being completed and that key processes, such as medical recommendations and AMHP involvement, had been undertaken.

However, we had concerns about how statutory deadlines were being tracked, how detention and treatment authority were being monitored, and whether patients' legal safeguards were being consistently upheld. In one case, a patient's Section 2 had lapsed before a further assessment was completed, leaving a period where there was no legal authority for detention. In another case, a patient received treatment for two days after the three-month rule had expired and before a CO2 certificate had been completed.

Our concerns in relation to these issues were dealt with under our immediate assurance process. Further information on these issues, and the immediate action taken by the service, is provided in Appendix B.

We also identified issues with the quality and accessibility of MHA documentation. We found examples of statutory paperwork not being completed in line with the requirements of the Act and associated regulations. These included missing professional details and statutory requirements not being completed correctly on forms. While these errors did not necessarily invalidate detention papers, they did not provide assurance that documentation was being consistently checked and corrected.

In addition, during the inspection we could not easily access or locate key MHA documentation, which made it difficult to verify patients' legal status and treatment authority. Records were split between paper files, WCCIS and documentation held centrally by the MHA office. This fragmented approach made it difficult to track statutory paperwork and may have contributed to the gaps identified.

The health board must ensure that robust systems are in place to maintain, store and monitor Mental Health Act documentation, including ensuring that all statutory paperwork is complete, accessible within patient records, and subject to regular checking and verification to ensure compliance with legislative requirements.

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

We reviewed a sample of five care and treatment plans to assess compliance with the Mental Health (Wales) Measure 2010. Overall, we found mixed evidence regarding the quality and completeness of care planning. While some care and treatment plans reflected the structure and requirements of the Measure, this was not consistent across all records. For example:

- There were inconsistencies in the recording of care coordinators
- It was not always clear who had attended ward reviews
- Documentation did not consistently demonstrate that capacity assessments had been completed or clearly recorded where required
- There was limited evidence of patients' views being captured within care plans, and records did not always reflect how patients or their families had contributed to planning and decision-making.

The health board must ensure care and treatment plans are consistently completed in line with the Mental Health (Wales) Measure 2010, including accurate recording of key information, clear documentation of capacity assessments where required, and evidence of patient and family involvement.

Quality of Management and Leadership

Leadership

Governance and leadership

We found several positive arrangements in place to support leadership and governance within the ward. Staff spoke positively about the support they received from their immediate managers and described leaders as visible, approachable and responsive. There were established processes to escalate risks and incidents, including daily touchpoint meetings and divisional oversight arrangements, which helped ensure that emerging issues were routinely reviewed.

We saw evidence of a structured governance framework, including monthly quality and safety meetings, regular incident reporting through Datix, and processes to review patient deaths and implement learning through action plans. Information was shared with staff through a range of mechanisms, including handovers, emails and safety briefings. In addition, initiatives such as “Top Tip Tuesday” were used by senior management to communicate key messages and learning points to staff in a clear and accessible way, which was a positive feature.

However, staff reported that ward meetings were not always held as regularly as intended, which may limit opportunities for consistent communication, shared learning, and staff engagement.

The health board must ensure there are effective arrangements in place to support regular ward meetings, to promote consistent information sharing, staff engagement and learning across the team.

We also found that some policies were out of date, including the CCTV policy and the Clinical Management of Acute Disturbance, De-escalation and Rapid Tranquilisation Policy.

The health board must ensure that all relevant policies and procedures are regularly reviewed and kept up to date, and that staff are supported by current guidance to inform safe and consistent practice.

Workforce

Skilled and enabled workforce

Staff described working in a collaborative and supportive team environment. We were told that the team was welcoming, with positive contributions from both students and staff, and that daily handovers and ward rounds supported good communication with medical teams. Multidisciplinary team (MDT) meetings and ward rounds were used to review patient care and support decision-making, with DNACPR discussions carried out appropriately and sensitively.

We also found evidence of strong workforce support arrangements, including high levels of compliance with mandatory training and regular staff appraisals. Staff undertaking preceptorship programmes reported feeling well supported in their roles.

However, staff told us that staffing arrangements did not always fully reflect the needs of the patient group. Staff felt that workforce planning was sometimes based on patient numbers rather than acuity, including levels of observation and complexity of need, and that the skill mix did not always include a sufficient proportion of experienced staff. Staff reported that there were currently more newly qualified staff than experienced staff on the ward, which, when combined with shift patterns and the use of both wards, made it more difficult to ensure appropriate experienced cover. While overall staffing levels were generally considered sufficient, staff also felt that the introduction of 12-hour shifts was affecting continuity of care, including staff availability to attend patient reviews and consistently update care plans and provide one-to-one support.

The health board must consider this feedback in relation to staffing arrangements, skill mix and rota design to ensure these continue to support consistent and effective care delivery.

Culture

People engagement, feedback and learning

We found that patients were supported to provide feedback on the service, including through regular patient meetings and a “you said, we did” approach to demonstrate how feedback had been acted upon. Complaints, incidents and compliments were recorded through Datix, with oversight arrangements in place to monitor themes and trends.

Staff described an open culture where concerns could be raised, with processes in place to support both informal resolution and formal escalation where required. Learning from incidents and complaints was shared through action plans and governance structures.

Information

Information governance and digital technology

We found arrangements in place to support the secure handling and storage of information. Paper records were scanned onto secure electronic systems and then confidentially disposed of, and records were kept in secure areas with restricted access. Staff confirmed that information was accessible to relevant staff to support patient care.

Learning, improvement and research

Quality improvement activities

Several quality improvement initiatives had been undertaken. These included a falls reduction project, which focused on environmental safety and medication review, and a workforce development initiative ("Journey of Achievement") to support induction and competency development for new healthcare support workers. Further work was planned to extend this approach to newly appointed Band 5 staff.

The service had achieved Bronze accreditation as part of a health board ward accreditation programme, demonstrating compliance with a range of quality, safety and improvement standards. There was evidence that audits and quality monitoring processes, including use of the All Wales Audit Management Tool (AMaT), were in place to support oversight of clinical practice and service performance.

However, in view of the issues identified during the inspection, including in relation to medicines management, the Mental Health Act and care and treatment planning, we were not assured that these systems were consistently effective in identifying and addressing areas of risk within the service.

The health board must strengthen the effectiveness of its audit, monitoring and quality improvement systems to ensure that risks are consistently identified, acted upon and embedded in practice and sustained.

Whole-systems approach

Partnership working and development

We saw evidence of partnership working to support discharge and aftercare planning where this was relevant. In one patient record, there was documented involvement of the community mental health team, alongside communication with the patient's family and the wider multidisciplinary team. This demonstrated a coordinated approach to supporting continuity of care beyond the ward.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.			

Appendix B – Immediate improvement plan

Service: **Hafan Deg Ward, Ty Siriol Unit**

Date of inspection: **18, 18 and 20 May 2026**

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

Findings	We reviewed Mental Health Act (MHA) legal documentation and identified gaps in statutory paperwork that did not provide assurance that patients' detention and treatment were being managed in line with legal requirements. We found the following issues: • In one case, a patient had been detained under Section 2 on 21 April 2026, with the 28-day detention period expiring on 18 May 2026. We found that a further assessment, which had been planned for Tuesday 19 May 2026, did not take place and was instead undertaken on Wednesday 20 May 2026. This resulted in the patient's detention lapsing for a period of two days, creating a gap in legal authority for detention during this time • In a second case, a patient's three-month rule for consent to treatment had expired at midnight on 02 March 2026; however, the appropriate consent to treatment certificate under the Mental Health Act was not completed until 04 March 2026. This meant that medication was administered for two days without the appropriate legal authority in place. These findings indicate that patients were subject to detention and treatment without valid legal authority, undermining the statutory safeguards in place to protect their rights under the Mental Health Act. As a result, we were not assured that appropriate systems and oversight arrangements were in place to monitor statutory timeframes, maintain compliance with legal requirements, and ensure that such lapses do not occur.

	Improvement needed	**Standard / Regulation**
1.	The health board must provide immediate assurance that a full review of all current detained patients' Mental Health Act documentation has been undertaken to confirm that there are no	Mental Health Act 1983 Code of Practice for Wales (Revised 2016)

	further gaps in legal authority for detention or treatment. The health board must also implement robust systems and oversight arrangements to ensure that key statutory timeframes are effectively monitored and that valid legal authority is maintained at all times.	

Service Action:	Responsible officer	Timescale
A full review has been conducted across all Mental Health & Learning Disabilities wards, including consent to treatment forms.	Mental Health Act Office	Complete
Systems are in place across the Health Board to ensure that detention expiry dates are recorded and monitored. An email alert system is also in place to notify staff from MHA Administration when consent to treatment forms are due to expire.	Mental Health Act Office	Complete
Quarterly audits to be undertaken to ensure compliance with detention expiry date monitoring.	Mental Health Act Office	31/07/26 and then on a quarterly basis
The daily safety briefing sheet has been amended for Senior Nurses to provide assurance that Mental Health Act detentions and expiry dates are reviewed in a timely manner.	Head of Nursing, MHLD	12/06/2026
Where there is a gap in consent to treatment (CO2/CO3), Responsible Clinicians are required to put a Section 62 form in place. This has been communicated to all Responsible Clinicians as a reminder.	Mental Health Act Office	Complete - 05/06/2026
MHA Administration will review the governance procedures currently in place, with a view to increasing automation and escalation to appropriate managers at key points, thereby reducing the risk of detention expiry or consent to treatment breaches.	Mental Health Act Office	31/07/2026

Findings	We reviewed the processes in place for administering treatment and medication to patients and identified concerns where practice did not provide assurance that appropriate legal and best interests processes were being followed.

In one case, a patient had been placed on a covert medication plan on 15 May 2026. However, documentation was incomplete and did not demonstrate that the required safeguards had been followed. There was no evidence that:

- The capacity assessment outlined in the service's covert medication pathway (i.e. whether the patient had capacity to understand the nature and purpose of the medication) had been undertaken or recorded
- A best interests decision-making process had been completed to support the use of covert medication
- Multidisciplinary input had been obtained, including pharmacy involvement or consultation with family members or representatives
- A care plan was in place outlining how medication should be administered covertly and in line with least restrictive practice
- Clear guidance was available to support staff in determining whether medication had been successfully administered where the patient did not fully consume it, which did not provide assurance that dosing could be safely monitored or that the intended therapeutic effect would be achieved.

During the inspection, we also observed discussions regarding the potential use of covert medication for another patient. It appeared that covert medication was being considered at an early stage in response to patient refusal, without clear evidence that alternative approaches had been explored, such as reviewing treatment, supporting the patient to engage with medication, or considering less restrictive options. In addition, given the gaps already identified in the application of the service's covert medication pathway, we could not be assured that the correct process would be followed in this or other cases if covert medication was deemed to be in the patient's best interests.

These findings indicate that covert medication was being implemented and considered without clear evidence that the service's own procedures, required legal and best interests processes, and less restrictive alternatives had been fully explored, undermining the safeguards in place to protect patients' rights. As a result, we were not assured that appropriate governance, oversight and multidisciplinary processes were in place to support the safe and lawful use of covert medication or to ensure compliance with relevant legislation and guidance.

Improvement needed	**Standard / Regulation**

2.	The health board must provide immediate assurance that: • The identified instance of covert medication is immediately reviewed to confirm that appropriate legal and best interests processes have been followed, including completion of a capacity assessment, multidisciplinary decision-making, and the development of a clear care plan to support the safe administration and monitoring of covert medication • Robust systems and oversight arrangements are in place to support a structured decision-making process, whereby less restrictive alternatives are fully explored and documented prior to the consideration of covert medication • Where covert medication is deemed necessary, the service's covert medication pathway is fully and consistently followed, including appropriate documentation and monitoring, in line with relevant legislation.	Mental Capacity Act 2005 and Mental Health Act 1983 Code of Practice for Wales (Revised 2016)

Service Action:	**Responsible officer**	**Timescale**
The ward has completed a capacity assessment, multidisciplinary decision-making (via a Best Interests meeting), and developed a clear care plan for the instance identified above.	Ward Manager	Complete
The revised 'Covert Administration of Medicines' policy is in place across the Health Board. This will be shared with all wards across the Division, with a read-and-sign acknowledgement required from registered nursing staff. This will be monitored on a monthly basis, via AMaT.	Head of Nursing, MH&LD	19/06/2026

Findings	We reviewed the arrangements for the storage, administration and monitoring of medicines and were not assured that appropriate or robust medicines management procedures were being consistently followed or embedded in practice. We identified the following issues: • On the first night of the inspection, the medicines fridge was found to be unlocked and the medicines trolley unsecured, which did not support the safe storage of medication • We identified out-of-date stock within general medication cupboards and the controlled drugs (CD) cupboard, including five boxes of expired rectal diazepam. In addition, we found medication belonging to patients no longer at the setting

	• There was no evidence that regular stock checks were being undertaken effectively. Although a weekly controlled drug check process was in place, this had not been completed consistently, and where checks had been recorded, they had not identified the presence of expired medication • We found that medication storage arrangements did not provide assurance that staff could access the correct medication promptly in an emergency. For example, while an in-date supply of rectal diazepam was later identified in a different cupboard by the ward manager, there was no assurance that staff would have been able to locate this in a timely manner • Although the service sought to provide assurance during the inspection, including a pharmacy review and removal of out-of-date stock on the second day of the inspection, further issues were identified on the third day. The medicines fridge, cupboards and trolley were again found to be unsecured, and individual patient medication lockers were also unlocked, indicating that required improvements had not been implemented or embedded in practice • There was a lack of clarity regarding roles and responsibilities for ongoing medicines management processes. Discussions with the ward manager did not provide assurance that there was a clear understanding of accountability for completing and monitoring stock checks, or that appropriate oversight arrangements were in place to ensure these were undertaken consistently. These findings indicate that medicines management procedures were not being effectively implemented or embedded in practice, including in relation to safe storage, stock control and governance arrangements. The repeated nature of these concerns, despite intervention during the inspection, increased the risk of unauthorised access to medicines and medication errors, including the potential administration of expired medication. As a result, we were not assured that effective governance and staff compliance were in place to ensure the safe management of medicines.

Improvement needed		**Standard / Regulation**
3.	The health board must provide immediate assurance that: • Staff are aware of and adhere to their responsibilities for medicines management, ensuring that all medicines storage areas, including fridges, cupboards, trolleys and individual patient medication lockers, are secured in line with safe storage requirements • Expired or inappropriate stock is identified and removed promptly through effective stock control systems which are consistently followed	Health and Care Quality Standards 2023 – Safe

	• Routine medicines checks, including controlled drug checks, are completed in line with policy, are effective in identifying issues such as expired stock, and are subject to regular oversight • Robust systems and governance arrangements are in place to ensure compliance with medicines management procedures, including clear roles and responsibilities for staff and appropriate monitoring of practice • Required improvements are implemented and embedded in day-to-day practice to ensure sustained compliance with safe medicines management standards.	

Service Action:	Responsible officer	Timescale
Posters have been added to all medication cupboards, trolleys, fridges and individual patient lockers stating that they must be locked after use.	Ward Manager	Complete - 05/06/2026
A memo has been sent to all registered staff reminding them of their responsibilities for medicines management.	Ward Manager	Complete - 05/06/2026
Checks for expired or inappropriate stock have been incorporated into the weekly checklist.	Ward Manager	Complete - 05/06/2026
The Daily Safety Briefing Sheet will be signed off and monitored by the Senior Nurse, and any gaps or omissions will be reviewed and raised with the ward immediately.	Senior Nurse	Complete and ongoing
The Standard Operating Procedure for the Daily Safety Briefing Sheet will be revised so that all staff understand its purpose and the associated responsibilities. This will also be added to the newly qualified staff training package (JoE).	Head of Nursing, MH&LD	30/06/2026

Findings	We reviewed the arrangements in place to manage infection prevention and control (IPC) and identified concerns relating to the management of a patient with scabies on Hafan Deg Ward A. We were not assured that appropriate IPC measures were in place or being consistently followed to minimise the risk of transmission and ensure the safety of patients and staff.

We found the following issues:

- A patient with suspected crusted scabies had been admitted to the ward on the previous Wednesday; however, there had been no visit from the central IPC team to support staff until the final day of the inspection, despite the known risks associated with this condition
- On arrival on the first night of inspection, we observed staff on the ward who were not wearing PPE. Following our arrival, staff began to use PPE available within the ward. Arrangements to support safe donning and doffing outside the ward were introduced during the inspection, with a PPE station introduced on the second day and appropriate waste disposal only in place by the third day. This indicated that IPC measures were being implemented reactively rather than through a structured and supported approach
- We observed unsafe and inconsistent staff practice, including staff leaving the ward and placing used gloves in their pockets, which did not reflect appropriate IPC procedures and indicated a lack of understanding of staff responsibilities in preventing the spread of infection
- We found a lack of clear and consistent guidance for staff on managing and treating the patient's condition, including laundering of clothing and bedding, and no care plan in place to support safe and consistent treatment. This could result in variation in practice and did not provide assurance that the patient's care was being managed appropriately
- Staff were undertaking continuous enhanced observations for six hours at a time, which exceeded the health board's policy of a maximum of two hours without evidence of justification or approval within a care plan.

These findings indicated that IPC arrangements were not being effectively implemented, including access to specialist advice, staff adherence to safe practices, and the provision of clear guidance and care planning. The absence of consistent procedures and oversight reduced assurance that infection risks were being appropriately managed, particularly where staff were required to move between wards to support the administration of intramuscular medication, increasing the potential for cross-transmission. As a result, we were not assured that appropriate measures were in place to minimise the risk of infection transmission or ensure the safety of patients and staff.

Improvement needed	Standard / Regulation

4.	The health board must provide immediate assurance that: • The identified case is immediately reviewed to ensure that appropriate IPC measures are in place for the safe and consistent management of the patient's condition, supported by clear care planning and guidance for staff, including arrangements for isolation, laundering and treatment, and that any requirement to exceed standard observation limits is appropriately assessed, documented and authorised in line with health board policy • Robust systems and oversight arrangements are in place to ensure timely access to specialist IPC advice and support for ward staff when managing infectious conditions • Staff are aware of and adhere to IPC procedures, including the correct use and disposal of personal protective equipment (PPE), to minimise the risk of transmission.	Health and Care Quality Standards 2023 – Safe

Service Action:	Responsible officer	Timescale
The identified case was reviewed immediately. IPaC was contacted at the point of identification, and advice on isolation and laundering procedures was received and added to the patient care plan.	Ward Manager	Complete
IPaC advice was sought immediately. Going forward, an onsite review will be requested to support adherence to IPaC policies and procedures. An email has been sent to ward managers confirming the requirement to request attendance.	IPC Leads / Ward Manager	Complete
IPaC procedures, including the correct use and disposal of PPE to minimise the risk of transmission, were addressed immediately. A contact precautions poster was displayed straight away to support compliance with the IPC process, including donning and doffing.	Ward Manager	Complete
IPC audits are in place on AMaT.	Senior Nurse	Complete

Oversight and Monitoring

Oversight and monitoring of the action plan will be undertaken by the following groups: -

- MH/LD Divisional QPS Group
- Quality Management Group
- Patient Quality Safety and Outcomes Committee

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): Amy Buckley

Job role: Divisional Nurse MHLD **Date: 05 June 2026**

Appendix C – Improvement plan

Service: **Hafan Deg Ward, Ty Siriol Unit**

Date of inspection: **18, 19 and 20 May 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.	Room fixtures were not consistently maintained, with some bedroom curtains poorly fitted or missing hooks, potentially impacting patient privacy.	The health board must ensure that all bedroom curtains are properly fitted and maintained, with curtain rails and hooks kept in good repair to support patients' privacy and dignity.	Dignified and respectful care	All bedroom curtains to be checked, remedial action to be taken to fix identified issues.	Deputy Directorate Manager, OAMH	Complete 14 July 2026
2.	Care and treatment plans were generally effective in supporting patients' needs and promoting independence, although improvements were required to ensure consistent quality and	The health board must ensure that care and treatment plans clearly set out identified needs, outcomes to be achieved and the specific actions required to meet those outcomes, in line with the requirements of the Mental Health (Wales) Measure 2010.	Individualised care	The All Wales CTP audit tool will be added to the Audit Management and Tracking System (AMaT) to provide a more in-depth review of the quality of patient care and treatment plans. The audit will be undertaken monthly by the Ward Manager and/or Senior Nurse, with actions recorded, allocated and	Deputy Head of Nursing, OAMH	30 September 2026

	person-centred detail across all records.			tracked to completion. Findings will be reviewed through local governance arrangements and escalated where compliance or quality is not sustained.		
3.	Some staff we spoke to showed limited awareness of the Welsh language 'active offer'.	The health board must ensure that all are aware of the Welsh Government's 'More than Just Words' framework and the 'active offer' and ensure the Health Board's Welsh language leads engage with staff across the mental health service to raise awareness promptly.	Communicating and language	Older Adult Mental Health (OAMH) have a dedicated Welsh Language Awareness champion. She attends the quarterly Welsh Language Group meeting, and all relevant information is shared throughout OAMH. Introduction of Welsh Language champions at a more local level is required. Identify Welsh Language champions within Borough Teams, information can be disseminated. Business Support Manager will also have a standing agenda item on the Community and Inpatient workstream to feedback updates. Welsh Language training compliance to be closely monitored and added to training matrix.	Deputy Directorate Manager, OAMH	31 August 2026

4.	Patients and families told us that they were not aware of advocacy services available at the ward.	The health board should ensure that patients and their families are consistently informed about available advocacy services and how to access them.	Rights and equality	Leaflets for advocacy will be given on admission. Posters are displayed on the entrances for the ward. The provision of advocacy information will be included within admission checks and discussed with patients and, where appropriate, families or representatives. Compliance will be reviewed through admission documentation checks and ward-level audit.	Senior Nurse, Torfaen	31 July 2026
5.	Limited access to and awareness of spiritual and religious support was identified, with opportunities to improve how these needs are communicated and facilitated for patients.	The health board must ensure that patients are routinely informed of available spiritual and religious provision and are supported to access these services in line with their preferences and needs.	Rights and equality	There is a Health Board guide available regarding religious care and understanding spiritual needs, including contacts who can support. This has been circulated to all wards in OAMH. Awareness will be reinforced through ward meetings and local communication routes.	Deputy Head of Nursing, OAMH	Complete
6.	Some maintenance issues were identified that required attention	The health board must ensure that identified maintenance issues are addressed in a timely	Environment	All environmental/ maintenance issues have been rectified.	Deputy Directorate	Complete

	to ensure the ward environment remained well maintained and fit for purpose.	manner to ensure the environment remains fit for purpose for patients, staff and visitors.		There is a clear escalation process for outstanding Works and Estates issues. Any that remain unresolved are discussed with Head of Works and Estates at monthly Capital and Estates meeting.	Manager, OAMH	
7.	Some environmental issues were identified, including damaged door frames and flooring, which limited effective cleaning and infection prevention and control.	The health board must ensure that damaged fixtures, including door frames and flooring, are repaired or replaced promptly to support effective cleaning and maintain appropriate IPC standards.	Infection prevention and control (IPC) and decontamination	Costings will be obtained for replacement of damaged door frames and flooring where repair is not sufficient. Repairs that can be completed locally will be undertaken by Works and Estates colleagues. Progress will be tracked through Works and Estates requests, with any delays escalated through the monthly Capital and Estates meeting. IPC-related environmental risks will remain under review until the required repairs or replacements are completed.	Deputy Directorate Manager	31 August 2026
8.	Medication administration records were not consistently completed, with	The health board must ensure that medication administration records are fully and accurately completed, including	Medicines management	NHS Wales Medicine Administration, Recording, Review, Storage and disposal training on ESR has been	Senior Nurse, Torfaen	31 July 2026

	omissions identified in signatures and allergy documentation.	signatures, dates and allergy status, to support safe prescribing and administration of medicines.		added to the OAMH training matrix, compliance is updated monthly and circulated to all Team Leads, Ward Managers and Senior Nurses. The checking of completed medication administration records is incorporated into the 'one patient one day' audit on AMaT. Kardex to be checked in handover daily, any blanks to be raised with the medical team. Medication administration records to be checked by the Pharmacy and Medical colleagues in Ward Round. Monthly AMaT audit outcomes, ESR training compliance and ward-level medicines safety checks will be reviewed by the Ward Manager and Senior Nurse, with recurring omissions escalated through OAMH governance arrangements.		

9.	The care and treatment plans did not consistently detail approaches to managing behaviours, with limited documentation of individualised strategies, assessment and patient involvement.	The health board must ensure that care and treatment plans include clearly defined, individualised strategies to understand and manage behaviours, supported by appropriate assessment and specialist input where required.	Effective care	Where individuals display behaviours that require additional support, an individualised management plan will be developed and documented within the care and treatment plan. This will include assessment of potential causative factors, agreed supportive strategies, evidence of patient and/or family involvement where appropriate, and specialist input where required. Plans will be reviewed regularly and updated following incidents, changes in presentation or multidisciplinary review.	Deputy Head of Nursing, OAMH	31 July 2026
10.	Inconsistencies were identified in the quality and completeness of care and treatment plans, including gaps in documentation and limited evidence of patient involvement.	The health board must ensure care and treatment plans are consistently completed in line with the Mental Health (Wales) Measure 2010, including accurate recording of key information, clear documentation of capacity assessments where required, and evidence of patient and family involvement.	Monitoring the Mental Health (Wales) Measure 2010: care planning and provision	A care and treatment planning session will be arranged with the CTP training lead to reinforce requirements under the Mental Health (Wales) Measure 2010, including outcomes, capacity, patient and family involvement, and quality of documentation. A CTP audit will be developed for use in AMaT. Results will	Deputy Head of Nursing, OAMH	30 September 2026

				be reviewed monthly by the Ward Manager and Senior Nurse, with improvement actions recorded, allocated and monitored to completion through OAMH governance arrangements.		
11.	Staff reported that ward meetings were not held consistently.	The health board must ensure there are effective arrangements in place to support regular ward meetings, to promote consistent information sharing, staff engagement and learning across the team.	Skilled and enabled workforce	Ward meetings will be reintroduced and held quarterly, using a standard agenda to support consistent information sharing, learning, staff engagement and review of improvement actions. Minutes and action logs will be retained, with outstanding actions reviewed at each meeting and escalated to the Senior Nurse where progress is delayed.	Deputy Head of Nursing, OAMH	31 July 2026
12.	Staff reported that staffing levels and skill mix did not always reflect patient acuity, potentially impacting the consistency of care planning and patient engagement.	The health board must consider this feedback in relation to staffing arrangements, skill mix and rota design to ensure these continue to support consistent and effective care delivery.	Skilled and enabled workforce	The ward have 6-monthly establishment reviews with Directorate, Divisional and Corporate colleague involvement. Staffing, skill mix and patient acuity will continue to be reviewed through the daily Safe to Start process and six-monthly establishment	Deputy Head of Nursing, OAMH	Complete

				reviews. Any emerging concerns will be escalated through Directorate and Divisional governance routes, with actions recorded where staffing risks impact care delivery.		
13.	We were not assured that audit and quality improvement processes were consistently identifying and addressing key risks and issues.	The health board must strengthen the effectiveness of its audit, monitoring and quality improvement systems to ensure that risks are consistently identified, acted upon and embedded in practice and sustained.	Quality improvement activities	AMaT audit schedules will be reviewed and updated to ensure they include the key themes identified within this inspection, including care and treatment planning, medicines management, advocacy, Welsh language active offer, environmental checks and IPC-related maintenance. Audit outcomes will be reviewed monthly by the Ward Manager and Senior Nurse, with actions recorded, tracked to completion and escalated through the OAMH governance structure where required. Evidence of sustained improvement will be monitored through repeat audit results, training	Deputy Head of Nursing, OAMH.	30 September 2026

				compliance reports, ward meeting action logs and Directorate Quality and Safety reporting arrangements.		

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): Christopher Jones

Job role: Head of Nursing **Date: 13 July 2026**