Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Taith Newydd, Swansea Bay University Health Board

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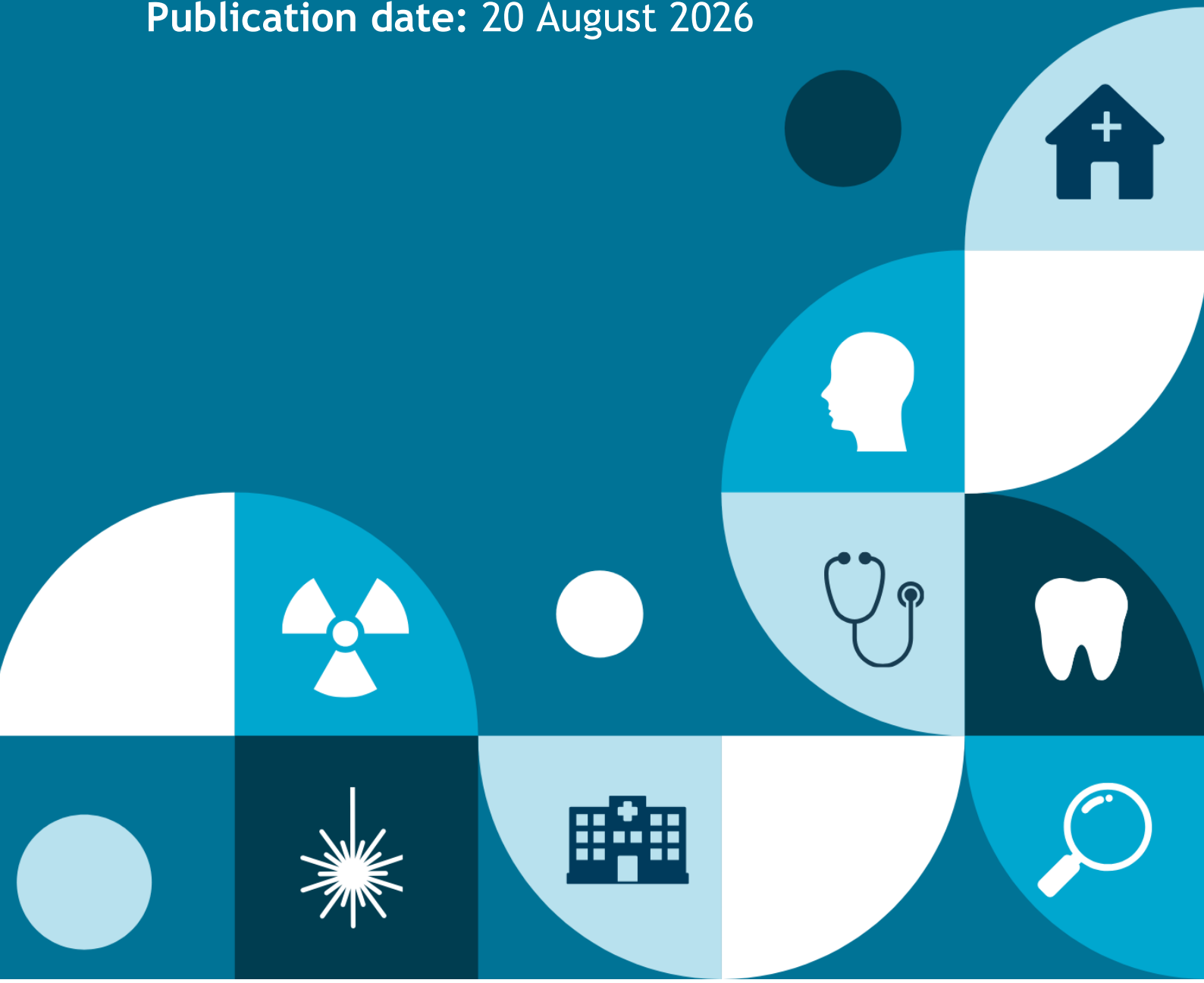

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

Our Purpose

We check the safety and quality of healthcare across Wales.

Our Vision

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

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 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 Taith Newydd, Glanrhyd Hospital, Swansea Bay University Health Board on 18, 19 and 20 May 2026. The following hospital wards were reviewed during this inspection:

- Rowan Ward - Low secure 14 rehabilitation recovery ward provide care for male individuals suffering from severe mental illness
- Cedar Ward – Low secure 14 rehabilitation recovery ward provide care for male individuals suffering from severe mental illness.

In 2024, a fire occurred on Cedar Ward, located within Taith Newydd. As a result, patients were temporarily relocated to Caswell Clinic at the Glanrhyd Hospital site while refurbishment and restoration works were undertaken. At the time of the inspection, the ward remained under refurbishment and patients had not yet returned to Taith Newydd.

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).

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. No questionnaires were completed by patients or their carers, and only a limited number were completed by staff, which reduced the amount of feedback available to inform our findings. We also spoke to patients and staff working at the service during our inspection. Feedback and some of the comments we received appear throughout the report.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

We found a calm and therapeutic environment across both wards, with staff consistently treating patients with dignity, kindness and respect. Patients spoke positively about their care and described staff as supportive and responsive.

Care was delivered with dignity, kindness, and compassion. Interactions between staff and patients were calm and respectful, and patients told us that staff were kind and responded to their needs. Staff supported personal care sensitively, maintained privacy and encouraged patients to personalise their rooms to create a more homely environment, while ensuring appropriate safety arrangements were in place.

Care delivery was individualised and responsive, with patients supported to make choices about daily routines, activities, and meals. Care records reflected planning, multidisciplinary input, and family involvement where appropriate. However, we identified some inconsistency in how patient views and perspectives were recorded within care plans.

Patients received timely care, with staff responding promptly to requests for assistance and providing reassurance and de-escalation when needed. Overall, systems supported communication, equality, patient rights, and safe, person-centred care.

There was good availability of patient information, advocacy services and health promotion materials, and staff demonstrated a good understanding of patients' needs.

However, we identified inconsistency in patient experience across wards, particularly in relation to catering provision, where patients on Rowan Ward reported concerns about the quality and choice of meals.

This is what we recommend the service can improve:

- Ensure consistency in catering provision across all wards
- Ensure patient views are consistently reflected in care planning.

This is what the service did well:

- Positive, respectful and therapeutic staff-patient interactions
- Strong advocacy provision and patient information

Delivery of Safe and Effective Care

Overall summary:

We identified a mixed picture in relation to the delivery of safe and effective care.

There were areas of good practice, including detailed care planning, strong physical healthcare provision and appropriate safeguarding arrangements.

However, we identified concerns regarding environmental risks. These included ligature risks, damaged fixtures, compromised fire door safety and an unreliable alarm system. Some of these issues had the potential to affect patient and staff safety, including the risk of delayed staff response in an emergency.

Although the ligature and fire door safety risks were resolved during the inspection, we were informed that issues had previously been identified and escalated to estates but had not been addressed in a timely manner. The lack of timely resolution despite escalation is a significant concern and reduced our assurance that risks to patient and staff safety were being effectively identified, prioritised and addressed in a timely and sustained manner.

We also identified issues relating to record keeping, medicines management, infection control documentation and Mental Health Act compliance. These included disorganised patient records held across multiple systems, gaps in medication monitoring such as incomplete temperature checks, inconsistent recording of cleaning schedules, and omissions within statutory documentation, including incomplete Mental Health Act forms and a lack of clearly recorded capacity assessments.

This is what we recommend the service can improve:

- Timely resolution of environmental and estates risks
- Improvement in record keeping and unified systems
- Ensuring full compliance with Mental Health Act documentation.

This is what the service did well:

- Strong physical healthcare provision and GP in-reach service
- Appropriate safeguarding systems
- Good use of de-escalation and least restrictive practice.

Quality of Management and Leadership

Overall summary:

We found a positive and improving culture at ward level, with staff describing supportive leadership, good teamwork and improved working relationships. Staff spoke positively about senior leaders, who were visible, approachable and engaged with ward teams.

However, we were not assured that governance arrangements were consistently effective in ensuring safe and sustainable service delivery. As set out in the delivery of safe and effective care section, environmental and estates risks had not always been resolved in a timely way despite escalation. This indicated weaknesses in oversight, prioritisation and action, particularly where issues had the potential to affect patient and staff safety.

We also found that several policies were out of date or overdue for review, and requirements within policies, such as competency assessments, were not consistently implemented in practice.

We also found that audit processes were not consistently effective in driving improvement. Although a range of audits were undertaken, these had not identified or addressed key issues identified during the inspection, including concerns relating to record keeping and environmental risks.

In addition, workforce pressures were impacting leadership capacity. Ward managers were frequently required to undertake administrative duties, which reduced their ability to focus on core leadership responsibilities, including oversight of clinical practice and staff support. Opportunities for structured staff engagement, such as team meetings, were also limited.

This is what we recommend the service can improve:

- Strengthen governance and policy oversight
- Improve workforce capacity to support leadership roles
- Strengthen staff engagement in service development.

This is what the service did well:

- Visible and supportive ward-level leadership
- Positive team culture and improved staff relationships.

3. What we found

Quality of Patient Experience

Person-Centred

Health promotion

We found that patients were generally supported to maintain their health and wellbeing through access to a range of health promotion information and services.

Patient information across both wards was of a good standard and included a variety of health promotion materials. This supported patients to access information relevant to their physical and mental wellbeing. Information regarding advocacy services was also available, supporting patients to understand and exercise their rights.

We also identified strong practice in relation to physical healthcare provision. There was a breadth of evidence-based assessments in place, supported by detailed physical healthcare plans. Patients benefited from access to an in-reach GP service, which was identified as a particular strength and supported continuity and oversight of physical health needs.

Dignified and respectful care

We observed staff treating patients with dignity, kindness and respect across both wards. Interactions between staff and patients were consistently positive, with staff demonstrating a good understanding of patients' individual needs, behaviours and risk levels.

We saw staff engaging with patients in a calm and supportive manner, taking time to listen and respond appropriately. Patients we spoke with confirmed that they felt well cared for and supported by staff.

Staff maintained patients' privacy and dignity, including when supporting personal care needs, and we observed staff respecting personal space and confidentiality throughout the inspection.

We also noted that staff remained professional and responsive despite working in busy ward environments, ensuring that patients' needs were prioritised and met effectively.

Individualised care

We found that care was generally personalised and responsive to individual patient needs. Care plans were detailed, individualised and reflected multidisciplinary input, in

line with the requirements of the Mental Health (Wales) Measure.

Care delivery was tailored to individual needs and preferences, with patients encouraged and supported to make choices wherever possible. We observed staff offering patients choices about daily routines, including what to wear, when to shower, what activities to participate in and what they wished to eat.

Timely

Timely care

The hospital has clear processes for patient flow and bed management. These include regular communication about bed occupancy and planning for admissions and discharges.

We found that patients generally received timely care from staff. Despite the demands of the ward environment, staff remained responsive and ensured that patients' needs were met appropriately.

Staff demonstrated good awareness of patient needs and risk levels, which supported timely responses to requests for support and care.

Equitable

Communicating and language

We found that communication with patients was generally clear, respectful and appropriate to individual needs. Staff demonstrated good knowledge of patients and communicated in a way that supported understanding and engagement.

Patient information across both wards was of a good standard, including health promotion materials, details on advocacy services and relevant contact information. Information boards also included staff photographs, which supported patient familiarity and engagement.

Advocacy services were well established, with regular attendance and involvement in patient care, supporting patients to communicate their views and participate in decision-making.

Staff demonstrated an understanding of the importance of communicating in patients' preferred language. Welsh language provision was well supported, with some Welsh-speaking staff available across different roles and visible identification through "Iaith Gwaith" indicators. Staff recognised the importance of language in supporting patient care.

Where additional communication needs were identified, staff took appropriate action, including accessing interpretation services to support effective communication.

However, we identified variation in patient experience between wards, including differences in catering provision, which indicates that patients were not consistently receiving an equitable experience across the service.

The health board must ensure that services across all wards are delivered consistently to provide an equitable experience for all patients.

Rights and equality

Patients' rights were respected and supported. Patients had access to private spaces for visits with family and friends and were supported to use telephones and personal mobile devices in a safe and private manner. Information about advocacy services, patient rights and how to raise concerns was displayed on the wards.

We observed staff supporting equality and inclusion in practice, including making reasonable adjustments for patients with mobility needs using appropriate equipment and aids. Staff had completed equality and diversity training and were able to explain how they would respond to discrimination or concerns about patients' rights.

Staff demonstrated awareness of how to support patients with diverse needs, including those requiring language support or cultural considerations. Examples were provided of staff adapting communication approaches and accessing interpreters where required.

Overall, systems were in place to promote equality, protect human rights and support patient choice.

Delivery of Safe and Effective Care

Safe

Risk management

We identified a number of environmental and safety concerns which had the potential to impact patient safety. On Rowan Ward, these included a blocked bathroom which remained unavailable for patient use, exposed wiring presenting potential ligature risks, a missing glass panel in a corridor door, and a damaged fire door. The ligature risks and fire door were addressed during the inspection; however, we were informed that these issues had previously been identified and escalated to estates but had not been resolved in a timely manner. The lack of timely action to address these risks is a significant concern, given the potential impact on patient and staff safety.

On Cedar Ward, two bedrooms were out of use due to ongoing toilet issues. We also observed damaged patient lockers and a number of chairs in communal areas on both wards which were worn and in poor condition.

In addition, we identified concerns with the alarm system on Cedar Ward. The alarm control panel did not consistently display the correct location when activated. During the inspection, an alarm was triggered and although staff responded promptly, some attended an incorrect location. This presented a risk that staff could be delayed in reaching the correct location in an emergency, with potential consequences for patient and staff safety.

Staff also highlighted environmental concerns in relation to visibility on the ward, advising that some corridor areas created blind spots and that mirrors required improvement. This has the potential to impact staff observation and oversight of patients. Staff advised that these issues had been escalated to estates; however, they remained unresolved.

These findings indicate weaknesses in the oversight and management of environmental risks. The recurrence of issues, combined with the lack of timely resolution despite escalation, reduced our assurance that risks to patient and staff safety were being effectively identified, prioritised and addressed in a timely and sustained manner.

The health board must ensure that all environmental risks are identified, prioritised and addressed in a timely way, with clear oversight and effective escalation processes in place to ensure sustained improvement.

Infection prevention and control (IPC) and decontamination

We found that infection prevention and control arrangements were generally appropriate.

Most areas of the wards appeared clean and tidy, and staff demonstrated a good understanding of IPC procedures.

However, we identified inconsistency in the recording of cleaning activity. On Cedar Ward, cleaning records showed that room cleaning had not been recorded since April 2026, despite staff advising that cleaning had been undertaken.

This lack of accurate and up-to-date documentation reduced assurance that cleaning processes were being effectively monitored and maintained in line with policy.

The health board must ensure that cleaning schedules are consistently completed, monitored and accurately recorded to provide assurance that infection prevention and control standards are maintained.

Safeguarding of children and adults

We found that appropriate safeguarding arrangements were in place.

Staff demonstrated a good understanding of safeguarding procedures and were able to explain the actions required if they had a safeguarding concern. Safeguarding policies were accessible, and staff confirmed they would complete referrals and escalate concerns appropriately.

Patients were supported to access safeguarding information, and advocacy services were available to support individuals in raising concerns.

Safeguarding concerns were managed through established processes, including the use of incident reporting systems and referral to appropriate agencies, with oversight provided through governance arrangements. This provided assurance that safeguarding systems were effective and embedded within practice.

Management of medical devices and equipment

We found that appropriate systems were in place to manage medical devices and equipment.

There was evidence that routine checks of emergency and resuscitation equipment were being undertaken and recorded to ensure that equipment was available and in date.

Staff were aware of the location of key emergency equipment, including ligature cutters, and confirmed that these were accessible in the event of an emergency.

Overall, these arrangements provided assurance that medical equipment was appropriately maintained and ready for use.

Medicines management

We found that medicines management arrangements were generally appropriate.

Clinical rooms were clean, well-organised and appropriately maintained. Medication was discussed with patients, and there was evidence of audits being undertaken to support safe practice.

We also saw evidence that emergency equipment checks were regularly undertaken and documented.

However, we identified gaps in routine monitoring processes. On Rowan Ward, medication fridge temperature checks were not aways complete.

We were also informed that out-of-hours prescribing arrangements required improvement, as prescribing staff did not have access to the electronic prescribing system.

These issues reduced assurance that medicines management processes were consistently safe and effective.

The health board must ensure that all medication monitoring processes are consistently completed and that safe and effective out-of-hours prescribing arrangements are in place.

Effective

Effective care

Overall, we found appropriate governance arrangements in place to support the delivery of safe and clinically effective care. Systems for managing incidents and physical interventions were robust and well embedded.

We found that care was delivered through structured processes supported by multidisciplinary team working. Staff described a collaborative team environment and reported that they were generally able to provide safe care.

Regular MDT meetings were held, and audits were undertaken to monitor clinical practice. Staff had access to policies, guidance, and training relevant to their roles.

Staff confirmed that debriefs take place following incidents, and inspection evidence showed that all incidents and physical interventions (such as restraint) were reviewed and supervised.

We observed positive examples of staff using redirection and de-escalation techniques during the inspection. These interventions were delivered respectfully and in a supportive manner, demonstrating a commitment to least restrictive practice.

Nutrition and hydration

We found that appropriate systems were in place to support patients' nutritional needs.

Patients were provided with meals and had access to food and drink throughout the day. Patients on Cedar Ward reported satisfaction with the quality and range of meals available.

However, patients on Rowan Ward raised concerns about the quality and choice of meals, indicating inconsistency across wards.

This reduced assurance that patients were consistently receiving an equitable standard

of nutritional provision.

The health board must ensure that patients across all wards receive a consistent standard of catering provision, including quality and choice.

Patient records

We found that patient records were generally of a good standard, with evidence of detailed and individualised care planning.

Care plans reflected multidisciplinary input and included evidence of physical health monitoring and assessment.

However, we identified that records were not consistently organised or maintained within a single system. Documentation was held across both paper and electronic systems, and key information was not always readily accessible. Further details can be found in the care planning section.

Mental Health Act monitoring

We reviewed statutory detention documentation and found that records were generally well organised and confirmed that patients were legally detained. Patients had access to advocacy services and were provided with information regarding their rights.

However, we identified several areas where improvements were required.

A CO2 treatment certificate reviewed on Cedar Ward did not include the route of administration, which is required under the Mental Health Act Code of Practice. This reduced assurance that treatment documentation was complete and compliant with legal requirements.

The health board must ensure that all consent to treatment documentation is fully completed, including the clear recording of the route of administration, in line with the Code of Practice.

We also reviewed Section 62 authorisation forms and found that, although the statutory grounds were indicated, there was insufficient detail to demonstrate how these grounds had been met. In addition, the documentation did not provide sufficient space to clearly record this rationale. This reduced assurance that the use of Section 62 was appropriately applied and subject to effective oversight.

The health board must ensure that all Section 62 authorisation forms are fully completed, including clear documentation of how the statutory grounds have been met, and that systems are in place to provide effective oversight of their use.

In one record reviewed, we did not find evidence of capacity assessments for medical

treatment in line with the Mental Health Act Code of Practice. The proforma in use did not demonstrate that a full capacity assessment had been completed, and no assessments were found within patient records. This reduced assurance that patients' capacity to consent to treatment was being appropriately assessed and recorded.

The health board must ensure that capacity assessments for medical treatment are completed and clearly documented in line with the Mental Health Act Code of Practice.

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

We reviewed the Care and Treatment Plans (CTPs) of four patients. Records evidenced a fully completed and current physical health assessment and standardised monitoring documentation, such as NEWS and MUST. Additional assessments were completed based on individual patient needs.

We found that patient records were not consistently organised or maintained within a single, unified system. Records were held across both paper and electronic formats, and key documentation, including multidisciplinary team records, risk assessments and pre-admission information, was not always available within the paper records. This limited the ability to effectively navigate records and reduced assurance that staff had access to complete and up-to-date information to support patient care.

The health board must ensure that patient information is maintained within an accessible and unified system to support safe and effective clinical decision making.

Although we saw evidence that audits of patient records were regularly undertaken, actions arising from these audits had not effectively addressed identified concerns, including missing care plans and risk assessments. This reduced assurance that audit processes were driving sustained improvement in record keeping practices.

The health board must ensure that audit processes relating to patient records are strengthened so that identified issues are effectively addressed, with clear action plans and monitoring in place to demonstrate sustained improvement.

We found some variation between wards. On Cedar Ward, records were generally well organised and maintained. However, pre-admission documentation was not consistently available within patient records. On Rowan Ward, we identified that patient views and perspectives were not consistently recorded within care plans, which reduced assurance that care planning was fully person-centred.

The health board must ensure that all relevant pre-admission documentation is consistently included within patient records to support continuity of care and

informed clinical decision making.

The health board must ensure that patient views and perspectives are consistently recorded within care plans to demonstrate that care is person-centred and reflects individual needs and preferences.

We identified strong practice in relation to physical healthcare records. There was a breadth of evidence-based assessments in place, supported by detailed physical healthcare plans. The in-reach GP service was identified as a particular strength, contributing to comprehensive physical health oversight and continuity of care for patients.

We found that discharge planning systems were in place and generally supported patient flow. Care records demonstrated that families were involved in the development of care packages where appropriate, and there was clear documentation when patients declined family involvement. However, this was not consistently evidenced across all records reviewed.

The health board must ensure that the involvement of families and carers in care planning is consistently documented, including clear recording where patients decline family involvement.

Efficient

Efficient

We found that staffing levels had been reviewed and enhanced, particularly on Rowan Ward, to reflect the ward's isolated nature and patient acuity.

However, system inefficiencies were identified, environmental and estates issues had not been resolved in a timely manner, impacting the availability of facilities and placing additional pressure on staff.

We were also informed that ward managers were frequently required to undertake non-clinical duties, which reduced their capacity to carry out leadership responsibilities.

These issues reduced assurance that resources were being used efficiently to support safe and effective care delivery.

The health board must ensure that resources are effectively planned and utilised, including resolving environmental issues promptly and enabling ward managers to focus on their core leadership responsibilities.

Quality of Management and Leadership

Leadership

Governance and leadership

We found that leadership at ward level was visible and supportive, with staff describing senior nurses as approachable and accessible. Staff reported that senior leaders were present on the wards regularly and engaged with staff through daily interactions and routine meetings.

Systems were in place to support communication between staff and senior management, including daily morning meetings where staffing, risks and operational issues were discussed.

However, we were not assured that governance arrangements were consistently effective in identifying, escalating and resolving risks.

As highlighted in the risk management section, we identified that environmental and estates issues had been escalated by staff but remained unresolved over an extended period.

In addition, we were not assured that governance arrangements were effective in ensuring that policies were reviewed and maintained in line with required timeframes.

Several policies provided during the inspection were out of date or overdue for review. These included the Management of Controlled Drugs policy (due for review December 2022), the Self-Administration of Medication policy (due for review July 2024), and the Observation policy (due for review June 2022). In addition, the Respect and Resolution policy was due for review in 2024, the Management of Violence and Aggression policy was due for review in October 2025, and the Infection Prevention and Control policy was due for review in March 2026.

We also identified that requirements within policies were not consistently implemented in practice. For example, the Observation Policy required staff to complete competency assessments; however, we found no evidence that these had been undertaken, and staff were not aware of any formal competency assessment process.

These findings reduced assurance that governance systems were effective in ensuring that policies were current, embedded in practice and supported by appropriate oversight.

The health board must ensure that governance systems are strengthened to provide effective oversight of risks, policy compliance and service delivery, and that identified issues are acted upon and resolved in a timely and sustained manner.

Workforce

Skilled and enabled workforce

We found that there were generally appropriate workforce arrangements in place to support the delivery of care.

Staffing levels on Rowan Ward had been reviewed and enhanced to reflect the ward's isolated nature and the acuity of patients. Staff described this as a positive development and reported that staffing levels were sufficient to meet patient needs.

Staff told us that there was good teamwork across both wards, and staff spoken to demonstrated commitment to their roles and a willingness to support each other, particularly during busy periods.

Staff had access to mandatory training and appraisal processes, with both wards demonstrating compliance rates of over 85%, supported by systems in place to monitor ongoing compliance. Induction processes were also established for new staff.

However, we identified pressures that impacted on workforce effectiveness.

Ward managers reported difficulty in facilitating regular staff meetings due to staffing constraints, which limited opportunities for structured team communication and shared learning.

The health board must ensure that ward managers are supported to facilitate regular staff meetings, with appropriate staffing arrangements in place to enable structured team communication, shared learning and staff engagement.

During the inspection, a concern was raised about staff alertness during night shifts and its potential impact on effective observation and oversight of patients. While this was not directly observed by HIW during the inspection, given the potential implications for patient safety, the concern was escalated to senior leaders during the inspection. This reduced assurance that staffing arrangements consistently supported safe and effective monitoring of patients during night-time hours.

The health board must ensure that staffing arrangements and supervision processes support staff to maintain appropriate levels of alertness during night shifts, to ensure effective observation and the safety of patients.

Culture

People engagement, feedback and learning

We found evidence of a positive and supportive culture at ward level.

Staff described improved working relationships and a shift towards a more open and supportive environment. Staff felt able to raise concerns and were aware of the processes for doing so.

There were systems in place to support learning from incidents and feedback. Processes were also in place to review themes and trends arising from incidents and complaints, with oversight provided through quality and safety meetings.

In addition, staff on Cedar Ward expressed concerns about returning to the Taith Newydd environment following relocation to another setting. These concerns highlighted the need for stronger engagement with staff in service development and change processes.

The health board must ensure that staff are supported to engage in regular team meetings and that their views are actively sought and considered in service development and improvement.

Information

Information governance and digital technology

We found that appropriate information governance systems were in place to support the safe management of patient information.

Patient data was held securely within electronic systems, with access restricted to authorised staff. Staff had completed information governance training and demonstrated an understanding of data protection requirements.

Systems were in place to support secure communication and information sharing between teams, and records were accessible to relevant staff.

Learning, improvement and research

Quality improvement activities

The service undertook a range of audits, including those relating to patient records, medication management, infection prevention and control and the environment. However, some of these audits did not consistently identify the risks observed during the inspection, which reduced assurance that audit processes were effective in reflecting ward-level practice.

Audit findings did not always result in timely or sustained improvement, indicating a need for stronger oversight to ensure learning from audits is translated into effective action.

Whole-systems approach

Partnership working and development

We found evidence of effective partnership working at an individual patient level. Care records demonstrated good engagement with families, advocacy services, and wider multidisciplinary teams. Staff worked with services, including primary care, dietetics, speech and language therapy and pharmacy, to support patient needs.

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
Broken panel on fire door on Rowan Ward.	Compromised fire safety and increased risk to patients and staff in the event of a fire.	Escalated to senior management during the inspection.	The fire door panel was replaced during the inspection.
Exposed ligature wires in patient area.	Presented a significant ligature risk and potential harm to patients.	Escalated to senior management during the inspection.	The ligature risks were addressed and made safe during the inspection.
Fault with alarm activation box on Cedar Ward	Potential delay in staff response to emergencies, impacting patient safety.	Escalated to senior management during the inspection.	The issue was escalated and external contractors were arranged to attend and resolve the fault.

Appendix B – Immediate improvement plan

Service: **Taith Newydd**

Date of inspection: **18 – 20 May**

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			
Improvement needed		**Standard / Regulation**	
1.	No Immediate Assurances		
Service Action:		**Responsible officer**	**Timescale**

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

Service representative:

Name (print):

Job role: **Date:**

Appendix C – Improvement plan

Service: **Taith Newydd**

Date of inspection: **18 – 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.

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.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Variation in patient experience between wards, including, differences in catering provision which indicates that patients were not consistently receiving an equitable experience across the service.	The health board must ensure that services across all wards are delivered consistently to provide an equitable experience for all patients	Patient experience	A review of patient experience across both wards will be undertaken to identify areas of variation, including catering provision. Patient feedback mechanisms, including community meetings and patient surveys, are in place to monitor patient experience. Disparity in catering provision is due to current location of	Ward Manager	January 2027

				Cedar Ward (temporarily located in Caswell Clinic, which holds standalone management of its housekeeping and catering services). A standardised catering provision will be in place when Cedar Ward patients return to Taith Newydd in January 2027.		
2.	Blocked bathroom on Rowan Ward	The health board must ensure that all environmental risks are identified, prioritised and addressed in a timely way, with clear oversight and effective escalation processes in place to ensure sustained improvement.	Safe Risk Management	This specific defect had been resolved, however has reemerged and Estates are actioning. Environmental audit assessments continue to be undertaken to identify defects and risks to staff and patients. Escalation processes are well established. Any ongoing or outstanding issues are monitored via a	Operational Estates Manager Cwm Taf Morgannwg University Health Board & Directorate Manager	August 2026 and continuous

				spreadsheet maintained by the Directorate manager. The Directorate Manager holds local responsibility for the monitoring and oversight of any estates defects, working in collaboration with the Estates Manager who holds responsibility for undertaking the necessary repairs, escalated and progressed to resolution in a timely manner. Monthly meetings with the Directorate Manager and the Estates Supervisors are in place, where all actions are discussed.		
3.	Missing glass panel on corridor door Rowan ward	The health board must ensure that all environmental risks	Safe Risk Management	This work is ongoing by Estates	Operational Estates Manager Cwm Taf Morgannwg	August 2026 (address defect) and continuous

		are identified, prioritised and addressed in a timely way, with clear oversight and effective escalation processes in place to ensure sustained improvement.		Environmental audit assessments continue to be undertaken to identify defects and risks to staff and patients. Escalation processes are well established. Any ongoing or outstanding issues are monitored via a spreadsheet maintained by the Directorate Manager. The Directorate Manager holds local responsibility for the monitoring and oversight of any estates defects, working in collaboration with the estates manager who holds responsibility for undertaking the necessary repairs, escalated and progressed to resolution in a timely manner.	University Health Board & Directorate Manager	(monitoring & escalation – as per Recommendation 9)

				Monthly meetings with the Directorate Manager and the Estates Supervisors are in place, where all actions are discussed.		
4.	Toilets in two bedrooms on Cedar ward broken.	The health board must ensure that all environmental risks are identified, prioritised and addressed in a timely way, with clear oversight and effective escalation processes in place to ensure sustained improvement.	Safe Risk Management	This defect has been rectified. Environmental audit assessments continue to be undertaken to identify defects and risks to staff and patients. Escalation processes are well established. Any ongoing or outstanding issues are monitored via a spreadsheet maintained by the Directorate Manager. The Directorate Manager holds local responsibility for the monitoring and oversight of any estates defects,	Operational Estates Manager Cwm Taf Morgannwg University Health Board & Directorate Manager	July 2026 (address defect) Complete

				working in collaboration with the Estates Manager who holds responsibility for undertaking the necessary repairs, escalated and progressed to resolution in a timely manner. Monthly meetings with the Directorate Manager and the estates supervisors are in place, where all actions are discussed.		
5.	Damaged patient lockers on Cedar ward	The health board must ensure that all environmental risks are identified, prioritised and addressed in a timely way, with clear oversight and effective escalation processes in place to ensure sustained improvement.	Safe Risk Management	Replacement lockers approved and are on order. Environmental audits continue to be undertaken to identify defects and risks to staff and patients. Escalation processes are well established.	Operational Estates Manager Cwm Taf Morgannwg University Health Board & Directorate Manager	August 2026 (address defect) and continuous (monitoring & escalation – as per Recommendation 9)

				Any ongoing or outstanding issues are monitored via a spreadsheet maintained by the Directorate Manager. The Directorate Manager holds local responsibility for the monitoring and oversight of any estates defects, working in collaboration with the Estates Manager who holds responsibility for undertaking the necessary repairs, escalated and progressed to resolution in a timely manner. Monthly meetings with the Directorate Manager and the estates supervisors are in place, where all actions are discussed.		

6.	Damaged furniture in lounge and kitchen areas on both wards	The health board must ensure that all environmental risks are identified, prioritised and addressed in a timely way, with clear oversight and effective escalation processes in place to ensure sustained improvement.	Safe Risk Management	Directorate and Divisional senior team are meeting to review the furniture requirements across the service. Environmental audits continue to be undertaken to identify defects or issues with furniture and any risks to staff and patients. Escalation processes are well established. Any ongoing or outstanding issues are monitored via ward-based audits and where there are highlighted risks or IPC concerns, escalation for approval to replace the furniture takes place via direct email as well as via the directorate Quality and Safety reporting.	Ward Manager and Directorate Manager	September 2026 (address defect) and continuous (monitoring & escalation – as per Recommendation 9)

7.	Blind spots on Rowan ward, creating staff and patient safety issues.	The health board must ensure that all environmental risks are identified, prioritised and addressed in a timely way, with clear oversight and effective escalation processes in place to ensure sustained improvement.	Safe Risk Management	Blind spots identified on Rowan Ward have been reviewed as part of the ward environmental risk assessment. Convex safety mirrors have been ordered and are now fitted.	Operational Estates Manager Cwm Taf Morgannwg University Health Board	July 2026 Completed
8.	Alarm control panel on Cedar ward must be functioning correctly	The health board must ensure that all environmental risks are identified, prioritised and addressed in a timely way, with clear oversight and effective escalation processes in place to ensure sustained improvement.	Safe Risk Management	Initial review has been undertaken by contractor – awaiting on a part to complete repair. These are monitored through routine environmental and security audits and testing. Maintenance arrangements are in place and the escalation process regarding reporting, monitoring and rectifying defects are in place.	Operational Estates Manager Cwm Taf Morgannwg University Health Board & Directorate Manager	August 2026 (address defect) and Continuous (monitoring & escalation – as per Recommendation 9)

9.	Lack of timely resolution on environmental issues, reduced assurance that risks were being effectively identified, escalated and addressed in a timely and sustained manner.	The health board must ensure that all environmental risks are identified, prioritised and addressed in a timely way, with clear oversight and effective escalation processes in place to ensure sustained improvement.		Environmental audit assessments continue to be undertaken to identify defects and risks to staff and patients. Escalation processes are well established. Any ongoing or outstanding issues are monitored via a spreadsheet maintained by the Directorate Manager. The Directorate Manager holds local responsibility for the monitoring and oversight of any estates defects, working in collaboration with the Estates Manager who as part of the Service Level Agreement (SLA) in place, holds responsibility for undertaking the necessary repairs,	Operational Estates Manager Cwm Taf Morgannwg University Health Board & Directorate Manager	July 2026 and continuous (monitoring & escalation processes)

				escalated and progressed to resolution in a timely manner. Monthly meetings with the Directorate Manager and the Estates Supervisors are in place, where all actions are discussed.		
10.	Inconsistency in the recording of cleaning activity. On Cedar ward, cleaning records showed that room cleaning had not been recorded since April 2026, despite staff advising that cleaning had been undertaken.	The health board must ensure that cleaning schedules are consistently completed, monitored and accurately recorded to provide assurance that infection prevention and control standards are maintained.	Infection, prevention and Control.	There is a governance process in place, which is in keeping with IPC requirements via weekly cleaning logs for all bedrooms, including instances where patients decline access. Compliance will continue to be monitored and reported via the directorates Quality and Safety forum/report	Head of Housekeeping & Administration, Caswell Clinic & Ward Manager	July 2026

11.	On Rowan ward, medication fridge temperature checks were not aways complete	The health board must ensure that all medication monitoring processes are consistently completed	Medicines Management	An updated form has been established to ensure checks are documented and completed. Compliance will continue to be monitored through routine spot checks, medicines management audits and local governance processes to provide ongoing assurance that medication monitoring processes are completed consistently.	Ward Manager	July 2026
12.	Out-of-hours prescribing arrangements required improvement, as prescribing staff did not have access to the electronic prescribing system.	The health board must ensure that safe and effective out-of-hours prescribing arrangements are in place.	Medicines Management	The extent of the issue is currently being investigated, findings and actions taken/required will be reported back to the Directorate Quality and Safety forum, via the medication administration and safety report.	Clinical Director	July 2026

13.	Patients on Rowan ward raised concerns about the quality and choice of meals, indicating inconsistency across wards.	The health board must ensure that patients across all wards receive a consistent standard of catering provision, including quality and choice.	Nutrition and Hydration	A revised menu has been introduced within the last three weeks, providing patients with a greater variety of meal options and increased choice. Patient feedback regarding the new menu and overall catering provision will continue to be monitored through community meetings, patient surveys and ward discussions. Catering services are delivered under an SLA and utilise a standardised 'All Wales' menu framework.	Ward Manager & Lead Nurse	July 2026 Completed
14.	A CO2 treatment certificate reviewed on Cedar ward did not include the route of administration, which is required under the Mental Health Act Code of Practice. This reduced assurance	The health board must ensure that all consent to treatment documentation is fully completed, including the clear recording of the route of administration, in line with the Code of	Records – Mental Health Act	Clinical staff have been reminded of the requirement to fully complete Consent to Treatment documentation in accordance with the Mental Health Act Code of Practice.	Ward Manager & Responsible Clinicians	July 2026 Completed and continuous

	that treatment documentation was complete and compliant with legal requirements.	Practice.		Daily Mental Health Act documentation checks and routine audits will continue, with any omissions reviewed, rectified and escalated as appropriate. Findings will be monitored through governance processes, with learning and quality improvement actions implemented where required. Medical staff have been informed of these requirements, and additional support or refresher training will be provided where needed through the Mental Health Act Team.		

15.	A review of Section 62 authorisation forms and found that, although the statutory grounds were indicated, there was insufficient detail to demonstrate how these grounds had been met. In addition, the documentation did not provide sufficient space to clearly record this rationale. This reduced assurance that the use of Section 62 was appropriately applied and subject to effective oversight.	The health board must ensure that all Section 62 authorisation forms are fully completed, including clear documentation of how the statutory grounds have been met, and that systems are in place to provide effective oversight of their use.	Records – Mental Health Act	The service continues to utilise the nationally agreed All Wales Section 62 authorisation form, ensuring a standardised approach to documentation across Wales. Communication has been issued to clinicians highlighting the importance of clearly recording the rationale for the use of Section 62 powers and how the statutory grounds have been met. Compliance will continue to be monitored through Mental Health Act audit and governance processes, with any learning themes shared through clinical and governance forums.	Mental Health Act Manager/Ward Manager	July 2026 completed and continuous

16.	In one record reviewed, we did not find evidence of capacity assessments for medical treatment in line with the Mental Health Act Code of Practice. The proforma in use did not demonstrate that a full capacity assessment had been completed, and no assessments were found within patient records. This reduced assurance that patients' capacity to consent to treatment was being appropriately assessed and recorded.	The health board must ensure that capacity assessments for medical treatment are completed and clearly documented in line with the Mental Health Act Code of Practice.	Records – Mental Health Act	Assessment of a patient's capacity to consent to treatment forms part of routine clinical practice and ongoing treatment reviews. The current Capacity to Consent documentation is compliant with the Mental Health Act Code of Practice and Mental Capacity Act requirements. In response to the inspection finding, the service will work with the Mental Health Act Team to review documentation and recording arrangements to ensure capacity assessments and supporting clinical rationale are clearly evidenced and readily identifiable within patient records. Daily Mental Health Act documentation audits	Mental Health Act Manager/Ward Manager	August 2026

				undertaken by Registered Nurses will continue, with any omissions escalated to the Responsible Clinician for review and action. A review of patient records will be undertaken to identify documentation gaps, with findings and actions monitored through Mental Health Act governance arrangements and reported to the Directorate Quality and Safety Forum to provide assurance of compliance and sustained improvement.		
17.	We found that patient records were not consistently organised or maintained within a single, unified system. Records were held across both paper and electronic formats,	The health board must ensure that patient information is maintained within an accessible and unified system to support safe and effective clinical	Records	The RIO system which will operate as a contemporaneous electronic patient record, is scheduled for rollout across Secure Services during 2027/28 as part	Ward Manager	October 2026 (interim record storage solution & audit) and March 2028 (rollout of RIO)

	and key documentation, including multidisciplinary team records, risk assessments and pre-admission information, was not always available within the paper records. This limited the ability to effectively navigate records and reduced assurance that staff had access to complete and up-to-date information to support patient care.	decision making.		of the Service Group's Digital Strategy. In the interim, a review of current documentation, recording and storage processes is being undertaken to improve the accessibility, organisation and oversight of patient information across existing paper and electronic systems. Particular focus will be given to ensuring that key clinical documentation, including MDT records, risk assessments and pre-admission information, is readily accessible to staff regardless of where it is stored. Compliance will continue to be		

				monitored through Primary Nurse Checklists and Quality Assurance Audits, which will provide assurance regarding the accessibility, availability and management of patient records. Evidence from these audits will be used to inform and strengthen local record management processes where required.		
18.	Audits of patient records were regularly undertaken, actions arising from these audits had not effectively addressed identified concerns, including missing care plans and risk assessments. This reduced assurance that audit processes were driving sustained	The health board must ensure that audit processes relating to patient records are strengthened so that identified issues are effectively addressed, with clear action plans and monitoring in place to demonstrate sustained improvement.	Records	Re-audit and governance oversight arrangements will be strengthened to ensure identified concerns, including missing care plans and risk assessments, are addressed and sustained improvements achieved. Primary Nurse Checklists and	Ward Manager & Lead Nurse	October 2026

	improvement in record keeping practices.			Quality Assurance Audits will continue to support the assurance framework, with audit findings reviewed through governance processes, actions allocated to named leads and monitored through to completion. Re-audit activity will provide assurance that improvements have been embedded in practice.		
19.	On Cedar ward, records were generally well organised and maintained. However, pre-admission documentation was not consistently available within patient records.	The health board must ensure that all relevant pre-admission documentation is consistently included within patient records to support continuity of care and informed clinical decision making	Records	A Ward Clerk has been appointed to support the consistency, organisation and upkeep of patient records, including ensuring pre-admission documentation is filed appropriately and readily accessible.	Ward Managers	July 2026 and continuous

				Ongoing records audits will provide assurance that documentation standards are maintained.		
20.	On Rowan ward, we identified that patient views and perspectives were not consistently recorded within care plans, which reduced assurance that care planning was fully person-centred.	The health board must ensure that patient views and perspectives are consistently recorded within care plans to demonstrate that care is person-centred and reflects individual needs and preferences.	Records	Primary Nurse checklists have been reviewed and updated to reinforce the requirement to record patient views, preferences and perspectives within care plans. This will support Primary Nurses in evidencing patient involvement, engagement and individual goals, ensuring care plans remain person-centred and reflective of patients' needs and preferences. Compliance will be monitored through care plan audits, clinical supervision and routine	Ward Manager	July 2026

				documentation reviews.		
21.	Care records demonstrated that families were involved in the development of care packages where appropriate, and there was clear documentation when patients declined family involvement. However, this was not consistently evidenced across all records reviewed.	The health board must ensure that the involvement of families and carers in care planning is consistently documented, including clear recording where patients decline family involvement.	Records	Occupational Therapy to be reminded to update contacts and review of family and carer involvement, including consent discussions and decisions regarding participation in care planning. This will be incorporated into routine patient documentation to ensure these discussions are consistently evidenced within care records. Compliance will continue to be monitored through routine record audits and governance processes to provide assurance that family and carer involvement is documented appropriately and consistently.	Occupational Therapy Lead & Ward Manager	August 2026

22.	Ward managers were frequently required to undertake non-clinical duties, which reduced their capacity to carry out leadership responsibilities.	The health board must ensure that resources are effectively planned and utilised, enabling ward managers to focus on their core leadership responsibilities.	Leadership & Workforce	Recruitment has also been undertaken (1.0 WTE secured with a further post offered) which will reduce the requirement of clinical staff to cover reception gaps.	Lead Nurse/Ward Manager/Directorate Manager	September 2026
23.	Patient records were not consistently organised or maintained within a single, unified system. Records were held across both paper and electronic formats, and key documentation, including multidisciplinary team records, risk assessments and pre-admission information, was not always available within the paper records. This limited the ability to	The health board must ensure that patient information is maintained within an accessible and unified system to support safe and effective clinical decision making.	Records	The RIO system which will operate as a contemporaneous electronic patient record, is scheduled for rollout across Secure Services during 2027/28 as part of the Service Group's Digital Strategy. In the interim, a review of current documentation, recording and storage processes is being undertaken to improve the accessibility,	Ward Manager	October 2026 (interim record storage solution & audit) and March 2028 (rollout of RIO)

	effectively navigate records and reduced assurance that staff had access to complete and up-to-date information to support patient care.			organisation and oversight of patient information across existing paper and electronic systems. Particular focus will be given to ensuring that key clinical documentation, including MDT records, risk assessments and pre-admission information, is readily accessible to staff regardless of where it is stored. Compliance will continue to be monitored through Primary Nurse Checklists and Quality Assurance Audits, which will provide assurance regarding the accessibility, availability and management of patient records.		

				Evidence from these audits will be used to inform and strengthen local record management processes where required.		
24.	Audits of patient records were regularly undertaken. However, actions arising from these audits had not effectively addressed identified concerns, including missing care plans and risk assessments. This reduced assurance that audit processes were driving sustained improvement in record keeping practices.	The health board must ensure that audit processes relating to patient records are strengthened so that identified issues are effectively addressed, with clear action plans and monitoring in place to demonstrate sustained improvement.	Records	Re-audit and governance oversight arrangements will be strengthened to ensure identified concerns, including missing care plans and risk assessments, are addressed and sustained improvements achieved. Primary Nurse Checklists and Quality Assurance Audits will continue to support the assurance framework, with audit findings reviewed through governance processes, actions allocated to named leads and monitored through to	Ward Manager & Lead Nurse	October 2026

				completion. Re-audit activity will provide assurance that improvements have been embedded in practice.		
25.	Policies provided during the inspection were out of date or overdue for review. These included the Management of Controlled Drugs policy (due for review December 2022), the Self-Administration of Medication policy (due for review July 2024), and the Observation policy (due for review June 2022). In addition, the Respect and Resolution policy was due for review in 2024, the Management of Violence and Aggression policy was due for review in October 2025, and the Infection Prevention and Control policy was	The health board must ensure that governance systems are strengthened to provide effective oversight of risks, policy compliance and service delivery, and that identified issues are acted upon and resolved in a timely and sustained manner.	Leadership and Governance	Policy management and implementation are kept under continual review and updated as required. A local policy group is established to maintain all local service policies and procedures. All local policies and procedures will be reviewed and updated. Whilst specific policies were identified as overdue for review, all of these policies continue to be operational and adhered to until such time as they are formally reviewed, updated or	Directorate Manager/Lead Nurse Divisional Manager/Head of Nursing	December 2026 July 2026

	due for review in March 2026. We also identified that requirements within policies were not consistently implemented in practice. For example, the Observation policy required staff to complete competency assessments; however, we found no evidence that these had been undertaken, and staff were not aware of any formal competency assessment process. These findings reduced assurance that governance systems were effective in ensuring that policies were current, embedded in practice and supported by appropriate oversight.			superseded. The service will however escalate a request for all outdated HB policies to be updated. In relation to consistent policy implementation and competency, the service is in the process of reviewing this position and identifying gaps in staff knowledge, training and compliance via an evaluation of a recently completed Training Needs Analysis. Actions will be identified and a plan developed, which will be shared and monitored through the divisional training and development group.	Directorate Manager/Lead Nurse Head of Nursing	October 2026

26.	Ward managers reported difficulty in facilitating regular staff meetings due to staffing constraints, which limited opportunities for structured team communication and shared learning.	The health board must ensure that ward managers are supported to facilitate regular staff meetings, with appropriate staffing arrangements in place to enable structured team communication, shared learning and staff engagement.		Staff meetings are scheduled in advance and held (subject to operational pressures). If meetings are unable to proceed alternative communication methods, including safety huddles, team briefs and electronic communications, will be utilised to ensure effective communication, shared learning and staff engagement.	Ward Managers	July 2026
27.	Staff on Cedar ward expressed concerns about returning to the Taith Newydd environment following relocation to another setting. These concerns highlighted the need for stronger engagement with staff in service development and change processes.	The health board must ensure that staff are supported to engage in regular team meetings and that their views are actively sought and considered in service development and improvement.		Regular communication and engagement opportunities, including question-and-answer sessions, team meetings and service updates, have been established for some time. These will be maintained to support staff involvement in service	Lead Nurse & Directorate Manager & Ward Manager	Completed and remain ongoing

				developments and change processes. Psychology leads are currently engaging with staff and developing a bespoke package to support staff who will be transitioning back to Taith Newydd following the completed of the building works. Access to wider wellbeing and psychological support services continues to be available to all staff as and when required.	Professional Lead for MHLD Psychology and Consultant Forensic Psychologist	October 2026
28.	Concerns were raised regarding staff working on night shifts, which may impact on effective observation and oversight of patients. While this was not directly	The health board must ensure that staffing arrangements and supervision processes support staff to maintain appropriate levels of alertness during night shifts, to		Staffing arrangements and supervision processes continue to be reviewed to ensure the safe and effective monitoring of patients.	Ward Manager/Nurse Lead	Completed and ongoing

	observed during the inspection, the concerns highlighted a potential risk to maintaining appropriate levels of alertness and ensuring patient safety during night-time hours. This reduced assurance that staffing arrangements consistently supported safe and effective monitoring of patients.	ensure effective observation and the safety of patients.		In relation to an allegation of staff sleeping on night shift, the ward manager has investigated this incident and appropriate outcomes has been reached. Ward managers and senior nursing staff will maintain oversight of staffing levels, staff welfare and observation practices through routine management processes.		Completed May 2026 Completed and ongoing

Service representative:

Name (print): Dermot Nolan

Job role: Interim Service Group Director **Date: 16/7/26**