

Independent Mental Health Service Inspection Report (Unannounced)

PCP Cardiff

Inspection date: 20 July 2026

Publication date: 20 October 2026



This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our [website](#) or by contacting us:

In writing: Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or Via: Phone: 0300 062 8163
Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-80853-500-0

© Crown copyright 2026



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	5
2. Summary of inspection	6
3. What we found.....	10
Quality of Patient Experience	10
Delivery of Safe and Effective Care	15
Quality of Management and Leadership	21
4. Next steps.....	25
Appendix A – Summary of concerns resolved during the inspection ..	26
Appendix B – Immediate improvement plan	27
Appendix C – Improvement plan	31



1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at PCP Cardiff on 20 July 2026.

Our team for the inspection comprised of two HIW healthcare inspectors, a clinical peer reviewer and a patient experience reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of six questionnaires were completed by patients or their carers and two were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Patient feedback and inspection findings indicated that the service provided generally positive care, with most patients reporting a good or very good experience. Patients consistently described staff as kind, approachable, respectful and available to provide support. All patients who responded stated that they were treated with dignity and that staff listened to them and answered their questions. Patients also reported being involved in treatment decisions, receiving clear information about costs and treatment options, completing consent procedures and having their medical histories reviewed before treatment.

The service demonstrated a strong commitment to health promotion and wellbeing. Patients had access to information and resources supporting healthier lifestyles, healthy eating options, external mental health and addiction services and a range of recreational activities. Facilities such as the calming corner, communal activity spaces and developing gardening project helped promote emotional wellbeing and recovery. The environment also promoted equality, diversity and independence, with accessible facilities, support for individual needs and opportunities for family contact where appropriate.

Despite these strengths, some patients raised concerns about aspects of care during detoxification. Patients reported difficulties associated with overnight observations, including disturbed sleep, unlocked bedroom doors and feelings of vulnerability. Several patients expressed concerns regarding occasions when only one member of staff was on duty overnight, particularly in relation to safety and security. Feedback also highlighted dissatisfaction with limited access to bedrooms during detoxification, restricted mobile phone access and the need for greater flexibility in attending therapeutic groups when physically unwell.

Patients valued opportunities to provide feedback through community meetings, suggestion boxes and other engagement methods. They reported confidence that staff would listen and respond to concerns. Overall, the inspection found a caring and supportive service that promotes dignity, wellbeing and recovery. However, improvements were needed to strengthen patients' sense of safety, privacy and individualised support, particularly during detoxification and overnight periods.

This is what we recommend the service can improve:

- Review overnight staffing arrangements to ensure more than one staff member is available overnight, or that robust risk assessments are in place to address patient safety and feelings of vulnerability
- Increase flexibility and patient-centred support during detoxification, including access to bedrooms, opportunities for rest, mobile phone access and additional exercise or wellbeing activities.

This is what the service did well:

- Staff treated patients with kindness, dignity and respect, with patients consistently reporting positive and supportive interactions
- Strong focus on health promotion and wellbeing, including healthy lifestyle support, recreational activities, mental health resources and a therapeutic environment
- Effective patient engagement and feedback mechanisms, with community meetings, suggestion systems and visible evidence that patient feedback is acted upon through the “You Said, We Did” approach.

Delivery of Safe and Effective Care

Overall summary:

The service delivered safe and effective care through well-established systems, responsive leadership and a positive commitment to continuous improvement. There was a clean, secure and supportive environment, with accessible ground-floor accommodation, freely available outdoor space, appropriate safety measures and prompt action when environmental concerns arose. Infection prevention and control (IPC) practices had also been embedded, with suitable hand-hygiene facilities, accessible personal protective equipment (PPE) and staff supporting patients to follow good hygiene routines.

There were robust governance and risk-management arrangements which supported patient safety. Environmental and clinical risks had been reviewed, incidents had been recorded and scrutinised through the Kipu system, a healthcare management platform designed for behavioural health organisations. Learning had been shared through audits, reflective practice, team discussions and governance meetings. Equipment had been serviced appropriately, while information and patient records had been protected through secure systems and clear access controls.

The service had promoted person-centred care and meaningful involvement. Patients had been supported to make choices about meals, refreshments and medicines, contribute to menu planning and raise concerns through weekly community meetings. Staff had been described as approachable and the registered manager had maintained a visible and supportive presence. Overall, these arrangements demonstrated a constructive culture in which staff and patient feedback informed improvement.

The service recognised opportunities to strengthen accessibility, cleaning oversight, controlled-drug checks, night-time safety arrangements and the assessment of risks associated with plastic bags, providing a positive basis for continued development.

Immediate assurances:

- On several occasions, the 'Quantity given' and 'Administered by (signature)' entries in the controlled drugs register (CDR) had been dually signed, but not by two competently 'medicines-trained' members of staff as required.

This is what we recommend the service can improve:

- Consider access to plastic bags to reduce the risk of asphyxiation
- Review nighttime arrangements to safeguard patients and staff.

This is what the service did well:

- There was a clean, secure and supportive environment with IPC practices embedded
- Patients were supported to make individual choices about what, where and when they ate
- Safeguarding arrangements supported a positive culture in which staff and patients understood how concerns would be raised and managed if required.

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

Quality of Management and Leadership

Overall summary:

HIW found that the service had demonstrated positive and well-established arrangements across governance, incident management and workforce development. Senior management oversight had been maintained through six-monthly visits by the responsible individual, including unannounced visits, while regular handovers, meetings, audits and safety checks supported effective oversight of clinical risks, medicines, infection prevention and control, equipment and the care environment. The registered manager also felt well supported and current policies were accessible to staff.

Patients, relatives and carers had been provided with clear opportunities to raise concerns, including anonymously and the service promoted openness through community meetings, timely feedback and “You said, we did” displays. Incidents had been reviewed through established reporting arrangements, with learning shared at team and governance meetings to support continuous improvement.

Appropriate pre-employment checks had been completed, staffing arrangements and skill mix enabled patients’ needs to be met safely and staff reported feeling supported and appropriately supervised. Regular supervision, appraisal, induction and a comprehensive programme of mandatory and role-specific training further equipped staff for their responsibilities.

This is what we recommend the service can improve:

- Maintain clear audit trails showing staff review of policy changes and safety notices
- Review overnight of staffing against patient acuity and lone-working risks.

This is what the service did well:

- Good practice related to governance and accountability
- The management of concerns, incidents and near misses
- Workforce recruitment, support and development.

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued a questionnaire to obtain patient views on the care at the clinic for the inspection in July 2026. In total, we received six responses from patients at this clinic. All but one patient agreed that the service they received was ‘very good’ or ‘good’. Patients commented:

"Having to sleep in corridor on settee and not allowed access to room when detoxing. Was allowed on third day, after asking every day before. Was under hourly blood pressure checks at the time, so very little sleep."

"My experience here has been so beneficial. Staff are always at hand any time day or night, I would recommend to other people to get help here. The only thing I would suggest is to have another member of staff during the night."

"{Would like} Providing activities outside these four walls. Understanding individual needs. Being sold this rehab by owner nothing described put in motion. Largest concerns - given medication without asking my name, date of birth, one member of staff on night duty - terrible, nine inpatients with one female at night, females approached how scared they feel. No background checks."

"{Would like} Rooms open at lunchtime's when we have phone time to make sensitive/personal phone calls. More than one member of staff of an evening as with doors kept open feel vulnerable and impacts on my sleep which is necessary for recovery."

Health promotion, protection and improvement

Patients using the service had access to a range of information and resources designed to promote health, wellbeing, independence and healthier lifestyles. Health promotion materials relevant to the patient group were available throughout the setting, supporting individuals to maintain and improve their physical and mental health. Patients were signposted to external mental health and addiction support services where appropriate. We were told that healthy eating was actively encouraged, with healthy food options available.

The environment demonstrated a positive focus on holistic wellbeing. A dedicated “calming corner” provided a supportive space that considered both emotional and physical health needs. Patients also had access to a variety of meaningful activities, including board games, arts materials and communal resources that could be used freely. Outdoor facilities included seating areas, a smoking area and a developing

gardening project where patients would be able to grow vegetables.

Whilst opportunities for exercise were available, including access to a local gym after eight weeks, patient feedback suggested that additional exercise options would be welcomed. The service should consider exploring further opportunities to enhance physical activity provision. One patient commented:

“For my mental health exercise is important, gym training normality.”

Dignity and respect

Throughout the inspection, staff were observed interacting with patients in a kind, respectful and supportive manner. Patients spoken with consistently reported that staff were approachable, listened to them and treated them well.

The service promoted independence whilst providing support where required. The statement of purpose outlined that only minimal personal care was provided during detoxification, with a “no touch” approach adopted wherever possible. Staff could offer prompting, guidance and assistance with sequencing tasks. Nursing staff provided care within their professional scope, such as wound dressing management. Where additional care needs arose, referrals could be made to external professionals, including occupational therapists, physiotherapists and district nurses. However, one patient reported finding it difficult to attend all compulsory therapeutic groups whilst undergoing detoxification and felt greater flexibility could be considered to allow for rest and recovery during periods of physical ill health and poor sleep.

Most patients had access to private, en-suite bedrooms, there were two twin rooms with shared facilities, which is made known to patients before admission. There was also an accessible ground-floor room. Personal belongings could be stored securely within lockable cupboards and wardrobes and patients were encouraged to personalise their living space.

The service provided several opportunities for patients to socialise and participate in communal activities. Mixed-sex communal areas were available for group therapy, recreational activities and social interaction. Patients could also access community activities, including accompanied shopping trips. Bathroom and shower facilities were available, including female-only provision, although one facility was temporarily out of use pending replacement.

Some aspects of practice impacted patients’ sense of privacy and security as during the initial detoxification period, patients required physical observations during the night. As a result they were woken for monitoring and bedroom doors remained unlocked overnight. Some patients reported that this made them feel vulnerable and affected their ability to sleep. Concerns were also raised regarding limited mobile phone access times and occasions when only one staff member was on duty overnight.

Overall, patients reported feeling respected and valued by staff and the service demonstrates a strong commitment to promoting dignity, respect and independence. Opportunities remained to further strengthen the patient experience by reviewing overnight arrangements, addressing identified concerns regarding feelings of vulnerability and considering greater flexibility to meet individual needs during detoxification.

The registered manager must review the staffing level to ensure more than one member of staff is on duty overnight to ensure the safety and care of the patients. Where this is not possible there must be a risk assessment in place to ensure the safety and wellbeing of patients at the setting.

In the patient questionnaire all patients stated that staff treated them with dignity and all but one patient believed that measures were taken to protect their privacy.

Patient information and consent

Written information for patients and their families was available and accessible through the statement of purpose, which was displayed in the hallway and the patient guide provided on admission. This included details of advocacy services, how to contact HIW, visiting arrangements, the complaints process and how to raise concerns. A staff information board was also available to help patients and visitors identify key personnel. The service did not accommodate detained patients under the Mental Health Act.

Information containing confidential patient details was observed to be appropriately secured from public view, with patient identifiers limited to initials where displayed operationally.

Communicating effectively

The service had some measures in place to support individuals with communication, sensory and cognitive needs. Pictorial signage was available for key areas, such as bathrooms and staff advised that individual needs were assessed prior to admission to ensure appropriate adjustments could be made. Translation services and communication aids could be arranged where required, based on individual need. Information was predominantly provided in English, although some materials, including fire safety notices, were available bilingually in Welsh and English and key Welsh words were displayed within the service.

Patients were provided with notebooks on admission to support learning and understanding of programme content. During the inspection staff were observed communicating with patients appropriately, using clear and supportive language.

Care planning and provision

All patients in the questionnaire stated that staff listened to them and answered patients questions. All but one patient stated that staff explained what they were doing throughout with four out of six patients stating that they were involved as much as they wanted to be in making decisions about their healthcare.

Relating to the treatment provided all patients said that the cost was made clear before treatment, they completed a medical history form and had their medical history checked before undertaking treatment. Additionally, all patients said that they signed a consent form before receiving new treatment and all but one patient said they were given enough information to understand treatment options and their risks and benefits.

All patients strongly agreed that staff were kind and sensitive to them when they carried out their care with two out of the three patients who replied said that staff provided care to them when they needed it.

Equality, diversity and human rights

The setting demonstrated a positive culture that promoted equality, diversity and inclusion. An up-to-date Equality and Diversity Policy was in place, outlining the organisation's commitment to promoting equality, valuing diversity and respecting the rights of all individuals. Discussions with staff reflected this commitment in practice. Staff described feeling welcomed, supported and treated fairly, with one nurse reporting that they had been assisted effectively on joining the service. Other staff members also spoke positively about working within the organisation.

Measures were in place to protect individuals from discrimination and to ensure services were accessible to those with protected characteristics. This included a purpose-designed ground floor accessible bedroom, with ramp access to the building, wheelchair-accessible space around the bed, a low-profile bed and a wet room facility. These adaptations supported patients with mobility needs to access the service on an equal basis. Staff advised that transgender patients were treated in accordance with their identified gender and preferred name.

Patients were provided with information regarding their rights and how to raise concerns. However, advocacy services were not prominently displayed during the inspection and the service could strengthen awareness of these arrangements.

Access to private areas, including quiet rooms, was available to patients, for meetings with family and friends. We were told that visitors were uncommon due to many patients living outside the local area. Evidence was provided of flexibility in supporting family contact, including arrangements for a patient to return to their home area following a bereavement.

Based on patient feedback, a potential area for improvement related to the mobile phone policy. This feedback indicated that access times did not always support contact with external organisations such as banks or GP surgeries during normal working hours. In addition, the policy identified attendance at church services as a reason for mobile phone access but did not explicitly recognise attendance at other faith-based activities.

The registered manager must review the mobile phone policy to ensure it promotes inclusivity, equality and consistency across all religions and beliefs, in line with its Equality and Diversity commitments.

Citizen engagement and feedback

The positive culture of openness and engagement helped ensure that patient voices contributed meaningfully to the ongoing development and improvement of the service. Patients were encouraged to share their views through regular community meetings, a suggestions box, quick response (QR) code feedback options and informal discussions with staff. These arrangements ensured that patients could raise concerns, make suggestions and contribute to decision-making within the service.

Information about how to provide feedback was displayed in communal areas and was readily accessible to patients, families and carers. The complaints procedure was available within the statement of purpose, which was displayed in the hallway and information relating to external bodies, including HIW was also provided. This supported patients to seek independent advice or raise concerns externally if required.

Patient consultation was primarily facilitated through regular community meetings, where concerns, suggestions and service developments were discussed. Patients spoken with during the inspection reported that they felt comfortable raising issues and were confident that staff would listen to them and respond appropriately to their views. Feedback gathered through these forums was recorded and acted upon where necessary, with evidence of outcomes being communicated through a visible “You Said, We Did” display.

The service also benefited from oversight and engagement from senior management. The responsible individual visited the service every six months, providing an additional opportunity to gather patient views. The registered manager maintained a visible and hands-on presence within the service.

Delivery of Safe and Effective Care

Environment

The environment was generally accessible, clean, tidy, secure and suitable for its intended use. External and internal ramps had been provided, alongside a spacious ground-floor bedroom and an accessible bathroom for patients with mobility needs. Discussions were held with the service around reviewing outdoor paths and internal access routes to identify practical improvements for people using wheelchairs or walking aids. The setting was considered to be difficult to navigate with narrow corridors, multiple steps and only a narrow concrete path in the garden. However, it was positive to note that efforts had been made to provide accessible accommodation within the constraints of the building type and footprint.

Patients were able to use outdoor space freely and staff always carried personal safety alarms with them. There was closed circuit television (CCTV) throughout the communal areas and a communal approach supported safety during the day. Privacy was promoted through several quiet or separate discussion areas for individual conversations. Bedrooms had been undergoing redecoration and the completion of planned installation of call bells above beds and in bathrooms was discussed with the registered manager who confirmed these actions will be finished shortly. Staff responded promptly when a chair broke during the inspection and removed it immediately. These findings demonstrated responsive local management and a continued commitment to maintaining a safe and supportive care environment. The service discussed how it would continue its programme of environmental improvements by completing bedroom redecoration and refreshing communal areas where needed.

Regarding building accessibility three of the five patients with an opinion in the questionnaire said the building was accessible. A patient commented:

“Poor facilities, from the bed having no comfort very cheap like the taps being the wrong way around. Garden furniture very poor, visual impairments poor.”

Managing risk and health and safety

The service had established positive arrangements for managing environmental safety, clinical risks and incidents. Environmental risk assessments had been reviewed annually, with identified actions flagged, addressed and updated following completion. Ligature risks had been assessed frequently and ligature cutters were readily available on each floor, supported by floor-map posters showing their locations.

Quality, safety and risk had been monitored through audits, reflective practice, team discussions and actions arising from reports. Incidents had been reported to the

registered manager and recorded electronically on the Kipu system, with shared management oversight, cross-checking of audits and discussion at governance meetings. Themes and learning from other services had also been considered proactively to support prevention. Fire-safety arrangements had included a completed risk assessment, appropriate equipment and procedures and a maintained fire logbook.

In response to emerging Health and Safety Executive information, environmental and patient risk assessments should also have explicitly considered access to plastic bags, including small bin liners and documented proportionate measures to reduce the risk of asphyxiation.

The registered manager must consider access to plastic bags, including bin liners, in the environmental risk assessment to reduce the risk of asphyxiation.

Infection prevention and control (IPC) and decontamination

The environment was observed to be of a generally good standard throughout the inspection. Clinical and communal areas were clean, tidy and free from clutter, with patient bedrooms and bathrooms also maintained to a satisfactory standard. The physical environment appeared well maintained, with walls, ceilings, floors and furnishings intact and suitable to support effective cleaning practices. However, it was noted that cleaning arrangements would benefit from strengthened oversight, including routine removal of dust from higher-level surfaces and appropriate storage of mops in a clean, dry condition.

Arrangements were in place to support IPC requirements such as the availability of single rooms that could be utilised for isolation or barrier nursing where necessary. Everyday IPC practices were found to be well established. Laundry facilities were available and in good working order and personal protective equipment (PPE) was readily accessible for staff use. Staff were observed to use PPE appropriately and suitable hand hygiene facilities, including sinks, soap and alcohol gel, were available for staff, patients and visitors. Clear signage promoting hand hygiene and IPC practices was displayed throughout the setting and patients were encouraged and supported by staff to maintain good hand hygiene practices, such as washing their hands before meals.

There was evidence that cleaning schedules were being maintained and monitored in line with local arrangements. The service demonstrated a positive approach to cleanliness through the regular presence of domestic support staff and by involving patients in therapeutic duties that contributed to maintaining the environment.

Half the patients with an opinion in the questionnaire believed that IPC measures were being followed and five out of the six patients who responded said the setting was clean in their opinion.

Nutrition

Patients were supported to make individual choices about what, where and when they ate. Main meals had been prepared by a chef, while patients had also been able to purchase and store their own food. A weekly menu was displayed on a whiteboard and patients had been encouraged to discuss preferences or specific dietary requirements with the chef, who provided alternatives where needed. The menus included healthy options, such as salads and healthy-eating information had been promoted through various posters. Patients were able to prepare their own drinks and snacks outside group-work sessions, which supported independence and flexible access to refreshments. Food storage arrangements had been managed through clear expectations that items were appropriately stored, dated, checked and discarded when required. The food inspected had been appropriately stored and was in date.

Food appeared appetising and meals were served through a hatch into a communal dining and snack-preparation area. We found positive arrangements with patients contributing to menu planning and review, routinely documenting the range of healthy and culturally appropriate choices available and maintaining clear evidence of access to meals, snacks, hot and cold drinks, food-storage checks and individually assessed restrictions.

Medicines management

Medicines management arrangements were generally safe, secure and well organised. Medicines, including controlled drugs (CDs), had been stored securely, with cupboards, medicine trolleys and fridges kept locked, while fridge temperatures had been monitored consistently in line with local procedures. Emergency medicines met national guidance, had remained in date and had been supported by an established replacement and checking system through links with the community pharmacy. Appropriate resuscitation equipment including defibrillators were available, staff had understood the Yellow Card reporting process and medical emergency and resuscitation training had been provided by an external provider.

Patients had been actively involved in decisions and reviews concerning their medicines and staff had been available to discuss treatment and provide information leaflets when requested. Medication administration records had been completed with patient identification, administration decisions and reasons for omitted doses recorded. However, on several occasions, the 'Quantity given' and 'Administered by (signature)' entries in the CD register had been dually signed, but not by two

competently 'medicines-trained' members of staff as required. **This was dealt with under HIW's immediate assurance process and detailed at [Appendix B](#).**

Medicines had been reflected within individual care plans, prescribing remained within British National Formulary (BNF) limits and had been reviewed regularly and antipsychotic or sedating medicines had been administered as prescribed. Governance arrangements had been supported by medicines management and CD policies. In addition, there was close working with the local pharmacy and a constructive approach in which medication errors had been discussed with patients and clinicians and used as opportunities for learning.

The service had since discussed how it would strengthen assurance around controlled drugs by completing and documenting stock checks at the frequency required by its policy, reconciling stock against the controlled drugs register and electronic records and promptly reviewing any discrepancies. This was particularly important for diazepam as it had been dispensed more frequently, sometimes several times each day, while intervals of up to 28 days had occurred between checks.

Further information had been obtained to confirm that controlled drugs were being recorded, signed for and administered in accordance with legislation and guidance. In addition, the service confirmed that an appropriate rapid tranquillisation policy was available, current and accessible to relevant staff. These actions had built on the positive systems already in place and provided clearer evidence of consistent compliance.

Safeguarding children and safeguarding vulnerable adults

Safeguarding arrangements generally supported a positive culture in which staff and patients understood how concerns would be raised and managed if required. Staff knew where to access safeguarding procedures, with policies available online and in paper format in policy folders. Safeguarding policies were dated, regularly reviewed and subject to clear version control, as was the whistleblowing policy. Training had helped staff to understand how to contact the appropriate people and complete the required documentation. Staff were aware of whistleblowing routes and patients described staff as approachable and knew who they could speak with about concerns. Advocacy support had been available through signposting to relevant services and patients spoken with had generally reported feeling safe.

Patients would raise concerns and speak up in community meetings, one recurring theme was staffing levels overnight, how they felt it was inadequate to maintain patient safety. An example was given where if the sole staff member was attending to an emergency what happened if someone else needed them or how could they call for help and sustain cardiopulmonary resuscitation (CPR) in the event of a cardiac arrest. Patients' feeling of safety was in question.

Safeguarding concerns had been recorded electronically and within patient records, with registers maintained and management oversight provided through electronic systems, quarterly quality governance reporting, monthly team meetings and shared learning by email. Risk had been managed through pre-admission assessments, consideration of known risks, staff presence, CCTV where applicable, clear visiting arrangements and links with external organisations, including local authority safeguarding teams. The service did not treat patients subject to Deprivation of Liberty Safeguards authorisations.

To strengthen patients' experience of safety, the registered manager must consider the feedback about night-time arrangements, particularly bedroom access, doorbell disturbances, emergency cover and the availability of a second member of staff and to record the assessment and actions taken through its governance processes.

Medical devices, equipment and diagnostic systems

Suitable equipment-maintenance arrangements were in place. An external company maintained medical devices, while electrical maintenance support was used as needed. Equipment inspected displayed current service-check stickers, confirming that routine servicing and checks had been completed. Clear fault-reporting procedures required defective equipment to be removed from use immediately, labelled accordingly and reported to the registered manager, who contacted the maintenance provider. Records were kept electronically and in hard copy.

Safe and clinically effective care

Overall, staff described a positive and supportive working environment in which staffing levels and the skill mix had generally enabled safe and timely patient care. Staff had been able to complete one-to-one meetings, care plans and risk assessments within appropriate timescales, supported by quarterly supervision, an open-door approach and the registered manager's visible presence within the service. Relevant National Institute for Health and Care Excellence (NICE) guidance and the Code of Practice had been accessible, while changes to policies, procedures and safety advice had been communicated through email, WhatsApp and team meetings.

Clinical audit findings had been implemented in practice and internal monitoring of records and records keeping had been undertaken. Arrangements relating to Do Not Attempt Cardiopulmonary Resuscitation decisions had appropriately remained with individuals' own general practitioners. Although staffing arrangements had worked well overall, staff had identified occasional difficulty in securing reliable bank staff. The registered manager explained how the service would continue to strengthen and

expand its pool of dependable bank staff to maintain resilience and consistently support safe care.

Participating in quality improvement activities

There was a positive commitment to continuous quality improvement noted through its continuous improvement and quality improvement register. Staff suggestions had been reviewed collectively and implemented where appropriate, while patient feedback had been valued as part of service development. Clinical audit had been used as a tool for improvement through Kipu and adverse incidents, complaints and near misses had been regarded as opportunities for organisational learning. Patients had also been actively involved through weekly community meetings held each Monday morning, where they had been able to raise concerns and reflect together. This inclusive approach had supported open communication and ensured that the views of staff and patients had contributed to ongoing improvement.

The service described how it would continue to maintain and review its quality improvement register, strengthen the recording of actions and learning arising from audits, incidents, complaints and near misses and document how feedback from staff and patients could continue to inform measurable service improvement.

Information management and communications technology

The service demonstrated that appropriate systems and protocols had been established to support the safe and secure management and sharing of information. A records and information governance policy was available and the service reported that relevant guidance was followed to ensure that information collected, used and retained was managed in accordance with General Data Protection Regulation (GDPR) requirements.

Personal and sensitive information was protected through individual staff logins with a clear expectation that passwords were not shared and system audit arrangements supporting staff accountability. Information shared with partner organisations was transferred using password-protected compressed files, which had supported the secure exchange of information and the provision of good patient care. Overall, the arrangements reviewed had provided positive assurance that information governance and data security were being managed effectively.

Records management

The service maintained secure and appropriately accessible record-management arrangements. Electronic records were protected through a password-controlled system, while paper records were stored in locked cabinets or behind locked doors. Relevant staff had been able to access the records required for their roles, supporting continuity of service delivery while maintaining suitable information safeguards. The service confirmed that an up-to-date records retention policy was in place and complied with the relevant regulations. The service reviewed its retention policy regularly, retained evidence of those reviews and maintained appropriate access controls for both electronic and paper records.

Quality of Management and Leadership

Staff Feedback

HIW issued a questionnaire to obtain staff views on the clinic for the inspection in July 2026. As only two completed questionnaires were received it was not possible to form a view based on the responses. Staff comments made during the inspection included:

"I have been consistently impressed by the commitment of the staff team to providing compassionate, person-centred care."

"Any training that I have wanted relevant to my role has been given to me."

Governance and accountability framework

The service demonstrated generally positive governance and oversight arrangements. The statement of purpose and patient guide had been reviewed and previously submitted to HIW with the relevant information. Senior management oversight had been maintained through six-monthly visits by the responsible individual, including unannounced visits undertaken in accordance with regulation 28 of the Independent Health Care (Wales Regulations 2011 and the registered manager reported feeling well supported. Clear reporting and accountability arrangements had been set out within the governance policy. Information had been shared effectively between managers and staff through regular meetings, handovers, email, WhatsApp groups, verbal communication and noticeboards.

The service had also established a broad quality improvement and risk-management framework. Governance arrangements included daily handovers, monthly team meetings, patient-record and clinical-risk audits, medicines checks, daily defibrillator and refrigerator-temperature checks. Additionally, there was food-fridge monitoring, IPC audits and monthly reviews of medication processes, PPE and medical equipment. Incidents, accidents, hospital admissions, safeguarding referrals and associated

learning and actions had been monitored through the incident-reporting procedure. There were quarterly risk reviews, supervision, appraisal, monthly team meetings and quarterly quality-governance meetings.

Policies and procedures were accessible to all staff and evidence had shown that policies were current and version controlled. Safety information had been received through external updates, including Social Care Wales newsletters shared internally through established communication routes.

Discussions were held with the registered manager on how the service would build on these positive arrangements by ensuring that all policies were consistently version controlled, dated and tailored to the Welsh regulatory context, with clear reference to HIW where relevant, particularly within the complaints policy.

It was discussed how a formal audit trail should be maintained of when staff read and understood policy changes and how external safety notices from bodies such as the Medicines and Healthcare products Regulatory Agency (MHRA) and the Welsh Government had been assessed, implemented and monitored. These actions would strengthen the consistency, transparency and assurance provided by the service's existing governance systems.

The registered manager must maintain an audit trail of when staff have reviewed policy changes or relevant safety notices.

Dealing with concerns and managing incidents

The service had established arrangements for managing complaints, incidents and near misses and the evidence reviewed had indicated a positive commitment to openness, responsiveness and organisational learning. Patients, family members and carers had been able to raise complaints, including anonymously where required and relevant information had been included within the statement of purpose, admissions pack, patient guide and other supporting documents. HIW details was listed in relevant materials and on the suggestions board, while advocacy arrangements had also been described within the statement of purpose and patient guide.

The service had promoted an ethos of honesty and transparency through community meetings, recorded verbal or informal concerns in patient records and escalated them to the Registered Manager by email where appropriate. Complainants had received initial and final feedback within three and 20 days respectively and wider learning had been communicated through community meetings and "You said, we did" displays.

In relation to incidents and near misses, policies and procedures had supported reporting, investigation and management, with the registered manager retaining oversight and information being reported monthly and quarterly to relevant teams and assurance groups. Learning had been discussed at monthly team meetings and shared with absent staff.

To build on these positive arrangements, the service described plans to implement a consistent process for recording, analysing and reporting themes and trends from complaints, incidents and near misses, even where no patterns had emerged, so that preventive actions and evidence of learning could be demonstrated over time to strengthen assurance that learning had been embedded across the organisation. A staff comment included:

“The service has strong governance processes and is receptive to feedback. Where improvements are identified, they are acted upon promptly with clear action plans and learning shared across the team.”

Workforce recruitment and employment practices

The service had demonstrated a broadly positive and well-established approach to workforce governance, employment practice, staff development and training. Appropriate pre-employment checks had been completed, including references, identity and employment documentation, professional registration or revalidation where applicable and Disclosure and Barring Service (DBS) checks, with employment records held electronically on the human resources portal and in hard copy within the registered manager’s office. Staff had relevant job descriptions and processes had been in place to keep checks under review. Daytime staffing included a registered nurse, administrator, counsellor and registered manager, with therapeutic input also available, while one night support worker had usually been deployed overnight. Additional cover had been provided when a patient required 15-minute observations.

During the inspection staff had reported that the skill mix, supervision arrangements and time available had enabled them to meet patients’ needs safely. This was also confirmed in the staff comments in the HIW questionnaire.

Team meetings took place monthly, with minutes shared by email so that staff who had been unable to attend could remain informed of discussions. Learning from incidents and examples of good practice had been discussed collectively and, where appropriate, individually.

Workforce planning, training and organisational development

Regular supervision and appraisal arrangements had been evident, with reviews undertaken every three months and the fourth review forming the annual appraisal and all staff had been reported as up to date. Induction arrangements had included an induction policy and health and safety checklist, while the training programme covered mandatory subjects, role-specific learning, National Vocational Qualifications, psychosocial support and one-to-one key working. Records indicated completion of training in medication awareness and competency, equality and diversity, resuscitation, health and safety, information governance, fire safety, safeguarding, IPC, manual handling, violence and aggression management and physical intervention, where relevant. Staff also had access to continuing professional development and managers tracked mandatory training.

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: PCP Cardiff

Date of inspection: 20 July 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	HIW was not assured that suitable arrangements were in place to safely administer controlled drugs (CDs) to patients. Weekly CD stock checks were also not being completed consistently in the Controlled Drugs Register (CDR).	
	On several occasions, the ‘Quantity given’ and ‘Administered by (signature)’ entries in the CDR had been dually signed, but not by two competently ‘meds-trained’ members of staff as required.	
	This issue was identified as a required improvement during the July 2025 inspection. Although some action had been taken, the medication management policy was not being fully followed.	
Improvement needed		Standard / Regulation
1.	The registered manager must: • Immediately review the management of CDs • Immediately carry out a check of the CDR • Ensure weekly CD checks are completed consistently • Ensure CD doses are checked and dually signed by two appropriately trained staff members	Regulation 15(5)(a) of the Independent Health Care (Wales) Regulations 2011

Risk/finding/issue response		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	HIW was not assured that suitable arrangements were in place to safely administer controlled drugs (CDs) to patients On several occasions, the 'Quantity given' and 'Administered by (signature)' entries in the CDR had been dually signed, but not by two competently 'meds-trained' members of staff as required.		Regulation 15(5)(a) of the Independent Health Care (Wales) Regulations 2011	The Controlled Drug administration procedure has been reinforced. Effective immediately, all Controlled Drugs must be checked and signed by two appropriately trained and medicines-competent staff members. Non-medically trained staff are no longer permitted to witness Controlled Drug administration. Staff have been reminded that any deviation from this process will be managed through the organisation's governance procedures.	Registered Manager / Clinical Team	Completed immediately following inspection

2.	Weekly CD stock checks were also not being completed consistently in the Controlled Drugs Register (CDR).		Regulation 15(5)(a) of the Independent Health Care (Wales) Regulations 2011	A complete audit of the Controlled Drugs Register was undertaken. All balances were reconciled against physical stock and no discrepancies were identified.	Registered Manager / Clinical Team	Completed immediately following inspection
3.				A formal weekly CD stock check schedule has been implemented. A designated Registered Nurse and an appropriately trained medicines-competent staff member are responsible for completing and documenting the weekly reconciliation. Compliance will be monitored through monthly governance audits.		

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:

Job role: Registered Manager

Date: 22-07-2026

Appendix C – Improvement plan

Service: PCP Cardiff

Date of inspection: 20 July 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
4.	Some aspects of practice impacted patients' sense of privacy and security as during the initial detoxification period, patients required physical observations during the night. As a result they were woken for monitoring and bedroom doors remained unlocked overnight. Some patients reported that	The registered manager must review the staffing level to ensure more than one member of staff is on duty overnight to ensure the safety and care of the patients. Where this is not possible there must be a risk assessment in place to ensure the safety and wellbeing of patients at the setting.	Quality of Patient Experience - Dignity and respect	Overnight staffing and detoxification observation arrangements have been reviewed. Standard overnight cover remains one trained staff member. A lone-working and overnight staffing risk assessment will record occupancy, individual clinical	Registered Manager	Immediate and ongoing

	this made them feel vulnerable and affected their ability to sleep. Concerns were also raised regarding limited mobile phone access times and occasions when only one staff member was on duty overnight.			risk, observation frequency, emergency procedures and when a second staff member or one-to-one support is required. Additional cover is arranged when a risk assessment identifies the need. Detoxification observations are mandatory, starting at 30-minute intervals and reducing to one, two and four hours at the nurse's discretion, based on presentation and risk. Patients are informed at admission and throughout detoxification. They		
--	--	--	--	---	--	--

				may lock their door but are told that staff must unlock it to complete observations, which may cause unavoidable disturbance. Staff minimise disruption while maintaining safe monitoring.		
--	--	--	--	---	--	--

5.	Patient feedback indicated that access times did not always support contact with external organisations such as banks or GP surgeries during normal working hours. In addition, the policy identified attendance at church services as a reason for mobile phone access but did not explicitly recognise attendance at other faith-based activities.	The registered manager must review the mobile phone policy to ensure it promotes inclusivity, equality and consistency across all religions and beliefs, in line with its Equality and Diversity commitments.	Quality of Patient Experience - Equality, diversity and human rights	Phone access is structured to keep patients engaged in detoxification and treatment while allowing necessary external contact. Phones are normally available at lunch, within business hours. Additional access may be requested for GP, banking, legal, family or other essential contact. Non-essential use during the programme remains restricted. The policy is being revised to record this flexibility and apply it consistently. Church-specific	Registered Manager	Review in progress; controls ongoing
----	---	--	---	---	---------------------------	---

				wording will be replaced with inclusive wording covering all faith and belief activities. Patients will be informed at admission and staff will receive the revised policy.		
6.	In response to emerging Health and Safety Executive information, environmental and patient risk assessments should also have explicitly considered access to plastic bags, including small bin liners and documented proportionate measures to reduce the risk of asphyxiation.	The registered manager must consider access to plastic bags, including bin liners, in the environmental risk assessment to reduce the risk of asphyxiation.	Delivery of Safe and Effective Care - Managing risk and health and safety	Following the Health and Safety Executive notice, bin liners were removed from unrestricted patient areas. They are stored in a secure, staff-controlled cupboard and issued only when a waste bag requires replacement. Environmental and patient risk assessments will record the	Registered Manager	Storage control complete; assessment update ongoing

				asphyxiation risk and these controls. Compliance will be checked during routine environmental inspections and after any relevant incident or safety notice.		
--	--	--	--	--	--	--

7.	Patients would raise concerns and speak up in community meetings, one recurring theme was staffing levels overnight, how they felt it was inadequate to maintain patient safety. An example was given where if the sole staff member was attending to an emergency what happened if someone else needed them or how could they call for help and sustain cardiopulmonary resuscitation (CPR) in the event of a cardiac arrest. Patients' feeling of safety was in question.	To strengthen patients' experience of safety, the registered manager must consider the feedback about night-time arrangements, particularly bedroom access, doorbell disturbances, emergency cover and the availability of a second member of staff and to record the assessment and actions taken through its governance processes.	Delivery of Safe and Effective Care - Safeguarding children and safeguarding vulnerable adults	Night-time arrangements have been reviewed. Bedrooms are accessible from 17:00 on weekdays and 12:15 at weekends, or earlier when clinically indicated. The door-opening alert remains necessary to notify night staff when an external door opens. Staff minimise disturbance. Each patient's overnight staffing needs will be individually risk assessed and documented. If a second member of staff is needed, cover will be	Registered Manager	Immediate and ongoing
----	--	---	---	--	---------------------------	------------------------------

				allocated for the required period and recorded in the assessment. Assessments will cover simultaneous incidents, emergency-service contact, lone-rescuer CPR and changes in presentation or risk. Governance will review decisions.		
--	--	--	--	---	--	--

8.	It was discussed how a formal audit trail should be maintained of when staff read and understood policy changes and how external safety notices from bodies such as the Medicines and Healthcare products Regulatory Agency (MHRA) and the Welsh Government had been assessed, implemented and monitored	The registered manager must maintain an audit trail of when staff have reviewed policy changes or relevant safety notices.	Quality of Management and Leadership - Governance and accountability framework			
----	--	--	--	--	--	--

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: Registered Manager

Date: 10 September 2026