

Inspection Summary Report

Ward 12 & 16, Mental Health Services for Older Persons, Llandough Hospital, Cardiff and Vale University Health Board

Inspection date: 20, 21 and 22 March 2023

Publication date: 16 June 2023



This summary document provides an overview of the outcome of the inspection



We found a dedicated staff team that were committed to providing a high standard of care to patients. We saw staff interacting with patients respectfully throughout the inspection.

Staff were positive about the support and leadership they received from ward managers.

However, some improvements are required in relation to mandatory training compliance, the hospital environment and patient care records should include evidence of discharge planning and care records should be fully completed.

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



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 Llandough Hospital, Cardiff & Vale University Health Board on 20, 21 and 22 March 2023. The following hospital wards were reviewed during this inspection:

- Ward 12 - mixed gender ward with 14 beds providing older person dementia care
- Ward 16 - female ward with 14 beds providing older persons dementia care.

Our team for the inspection comprised of two HIW Healthcare Inspectors, three clinical peer reviewers and one patient experience reviewers. The inspection was led by a HIW Senior Healthcare Inspector.

This summary version of the report is designed for members of the public.

A full report, which is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients can be found on our [website](#).



Quality of Patient Experience



Overall Summary

We found a dedicated staff team that were committed to providing a high standard of care to patients. We saw staff interacting with patients respectfully throughout the inspection. Staff demonstrated a caring, kind and compassionate attitude towards patients.

Where the service could improve

- Display HIW posters
- Replace some of the worn furniture in dining room on both wards.

What we found this service did well

- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff
- Staff team communicated well with patients.

Delivery of Safe and Effective Care



Overall Summary

Staff appeared committed to providing safe and effective care. Patient care and treatment plans were being kept to a good standard. Safe and therapeutic responses were in place to manage challenging behaviour and promote the safety and wellbeing of patients. Suitable protocols were in place to manage risk, health and safety and infection control. Legal documentation to detain patients under the Mental Health Act was compliant with the requirements of the legislation.

Where the service could improve

- Patient areas require redecorating and new flooring
- Dirty linen storage and disposal processes require review.

What we found this service did well

- Safe and effective medicine management
- Strategies and intervention for managing aggression (Sima) trainer works on the ward.

Quality of Management and Leadership



Overall Summary

We observed a committed staff team who had a good understanding of the needs of the patients at the hospital. There was dedicated and passionate leadership displayed by the ward managers. However, some improvements are required in updating policies and compliance with mandatory training.

Where the service could improve

- Mandatory training compliance
- Review and update policies
- Regular staff meetings should take place and be minuted.

What we found this service did well

- Motivated and patient focussed team
- Staff team were cohesive and positive about the support and leadership they received from ward managers.

Staff told us:

Staff provided us with the following comments:

“Offer more staff and patient feedback to help improve the service”

“There should be no pressure to work on certain numbers which results in nursing staff becoming burnt out and stressed out on shifts”.

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 appendices of the full inspection report.

When we identify concerns that pose an immediate risk to patient safety we ask the health board to undertake urgent action. These concerns are outlined in the appendices and outline the action taken by the health board to protect patient safety and approved by us. We also provide a detailed table of improvements identified during the inspection where we require the service to tell us about the actions they are taking to address these areas and improve the quality and safety of healthcare services. In addition we outline concerns raised and acknowledge those resolved during the inspection.

At the appropriate time HIW asks the health board to confirm action has been taken in line with management responses documented in the improvement plan. We also ask health boards to provide documented evidence of action taken and/or progress made.

