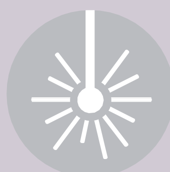
Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Caswell Clinic, Tenby, Newton & Penarth Wards, Swansea Bay University Health Board
Inspection date: 11,12 & 13 September 2023
Publication date: 14 December 2023

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

Digital ISBN 978-1-83577-256-0
© Crown copyright 2023



We found a dedicated staff team that were committed to providing a high standard of care to patients.

We observed staff interacting with patients respectfully throughout the inspection.

Patients we spoke to told us they were happy and stated that they were receiving good care at the hospital.

Staff were positive about the support and leadership they received. However, some improvements are required in relation to mandatory training compliance.

.

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 Caswell Clinic, Swansea Bay University Health Board on 11, 12 and 13 September 2023. The following hospital wards were reviewed during this inspection:

- Tenby Ward – 14 bed male assessment and treatment ward
- Newton Ward – Eleven bed female admission, rehabilitation, and recovery ward
- Penarth Ward - Eight bed male Psychiatric Intensive Care Unit (PICU).

Our team for the inspection comprised of two HIW Healthcare Inspectors, two clinical peer reviewers and one patient experience reviewer. 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.

Patients told us that improvements were required regarding menu choices.

Where the service could improve

- Improvements to menu choices
- Improved access to electronic devices.

What we found this service did well

- Good team working and motivated staff
- Patients spoke highly of staff and told us that they were treated well.

Patients told us:

Patients provided us with the following comments:

"Best hospital I've been in."

"Food is boring and menu needs changing".

Delivery of Safe and Effective Care

Overall Summary

There were established processes and audits in place to manage risk, infection control, and health and safety. This enabled staff to continue to provide safe and clinically effective care. However, some improvements are required in relation to making the outdoor areas safe.

Staff appeared committed to providing safe and effective care. We noted a good standard of care planning which reflected the domains of the Welsh Measure. The care plans were well detailed, individualised, reflected a wide range of MDT involvement, and there was clear and documented evidence of patient involvement.

Where the service could improve

- Redecoration of ward and communal areas
- Review of staff personal alarms and location of current alarm points
- Estates response to environmental issues requires improvement
- Tumble dryers should be fixed and available for patient use.

What we found this service did well

- Safe and effective medicine management
- Good standard of care planning
- De-escalation skills of staff when managing patient behaviours.

Patients told us:

Patients provided us with the following comments:

"Not enough to do".

"Staff are great".

Quality of Management and Leadership

Overall Summary

We found a friendly, professional, and kind staff team who demonstrated a commitment to providing high quality care to patients.
We found an effective governance structure in place in terms of meetings to discuss incidents, complaints and issues related to patient care.
Staff told us that they would feel secure raising concerns about patient care or other issues at the hospital and felt confident that the health board would address their concerns. A whistleblowing policy was in place to provide guidance on how staff can raise concerns and staff had access to the Guardianship Service. Some improvements are required in relation to updating policies and compliance with mandatory training.

Where the service could improve

- Review and update of policies
- Compliance with mandatory training
- Staff and patient meetings should 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:

“Teams work well together and are supportive”.

Staff told us that they felt safe to raise concerns.

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.