Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Laurels and Briary Complex Care Unit, Swansea Bay University Health Board

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

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 goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

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 Laurels and Briary Complex Care Unit, Swansea Bay University Health Board on 29 and 30 April 2025.

Swansea Bay University Health Board provides specialist adult learning disability services across the geographical area covered by Swansea Bay, Cwm Taff Morgannwg and Cardiff and Vale University Health Boards. Complex Care Units (previously Specialised Residential Services) were established in the early 90's to facilitate the closure of Learning Disability institutions, such as Ely and Hensol Hospitals. The Tier Three complex care units include Laurels and Briary Complex Care Unit, which is a unit for people with profound and multiple learning disabilities. The unit has six beds plus two respite beds.

Our team, for the inspection comprised of two HIW healthcare inspectors and two clinical peer reviewers.

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 four 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:
Feedback from patients, families and carers indicated that staff at the Laurels and Briary provide good holistic care, treating patients with dignity and respect. However, the environment needs significant refurbishment as a priority.

All resident patients were registered with a local general practice (GP) surgery and received annual health checks, although dental check-ups have been lacking since the COVID-19 pandemic and needs addressing promptly.

Monthly multidisciplinary team (MDT) meetings were held to discuss patient health conditions. Care plans were comprehensive and were reviewed monthly, however, staff must ensure that care plans reflect patient needs accurately, are dated and signed by relevant team members.

Patients had access to community facilities and activities. Staff supported them in various daily tasks, promoting independence and skill-building. However, regular planned activities and a systematic approach to engagement was lacking.

Patients received information tailored to their understanding, with methods like cards and pictures used alongside verbal communication. Staff were generally effective in their communication, with some speaking different languages, including Welsh.

Equality and diversity were promoted, with reasonable adjustments for accessibility. Staff were trained in equality diversity and they respected religious requirements. Food was tailored to patient dietary needs and preferences.

This is what we recommend the service can improve:

- Ensure patients receive regular dental check-ups
- Implement regular, timetabled activities and document these in care plans.

This is what the service did well:

- Care plans were comprehensive
- Patients were treated with dignity
- Staff supported patients with daily activities.

Delivery of Safe and Effective Care

Overall summary:
The unit aimed to deliver safe and effective care by creating a calm environment and using positive behavioural strategies to minimise restrictive practices. The unit did not typically admit patients with complex behavioural needs and none were present during the inspection. Staff were trained in positive behaviour support (PBS) and care plans were developed for any patients requiring physical intervention. There had been no restraints reported in the last 12 months, although restrictive practices had been used six times for one patient. Incident reporting and review systems were in place.

Several significant environmental and health and safety risks were identified at the unit. These included water damage, untidy external areas, broken equipment and security issues. Although some of these issues had been reported to the estates department, the repairs were not always carried out promptly. Consequently, the unit environment was not fully safe or well-maintained and there was a need for better processes to ensure timely remedial work. Immediate assurance measures were taken to address these issues.

The inspection highlighted issues with infection prevention and control (IPC) at the unit. Although staff understood their roles and responsibilities in IPC and there were policies and audits in place, there were lapses in labelling clean equipment.

Several hazardous substances were found in unlocked cupboards within laundry rooms, posing health and safety risks. These substances must be securely stored in locked areas to ensure patient safety.

There was high compliance with safeguarding training and staff were knowledgeable about safeguarding procedures and reporting. Safeguarding policies and flowcharts were in place and accessible.

The medicines management was found to be effective. Controlled drugs were secured and medication administration followed legal and policy guidelines. Staff were knowledgeable in medication administration. Protocols for as required medication were in place. A system was in place for electronic medication management and patient medications were reviewed monthly. There was an emphasis on individualised medication plans and patient understanding, although easy-read documents were recommended for better patient comprehension.

Patients' nutritional and hydration needs were generally met, with training provided for percutaneous endoscopic gastrostomy (PEG) feeding and there was a good awareness of food preferences. Meals were prepared by staff without a set menu, allowing patients to choose what to eat. The Adult Nutritional Risk

Screening Tool was used and input from the speech and language therapy (SALT) team and dietetic referrals were available as needed.

The admission and discharge processes were efficient, with respite beds available for short-term use. However, occasionally patients with behavioural or mental health needs were admitted without other healthcare needs due to bed pressures elsewhere. Draft procedures for admission criteria and medication reconciliation were noted. Regular transition meetings with other healthcare departments and patient participation were held. The availability of respite beds was highlighted as positive.

Immediate assurances:

- There were environmental and health and safety risks, which meant we could not be assured that the health, safety and welfare of patients, staff and visitors was being actively promoted and protected
- Control of Substances Hazardous to Health (COSHH) substances were not kept securely in a locked cupboard or in a locked room, to maintain the safety and wellbeing of patients and other individuals in the unit.

This was addressed under our immediate assurance process highlighted in Appendix B.

This is what we recommend the service can improve:

- Clearly label cleaned equipment to ensure IPC standards
- Develop easy-read materials to help patients understand their medications.

This is what the service did well:

- The environment was calm, reducing the need for restrictive practices
- IPC policies were in place and staff were trained
- Staff were knowledgeable about safeguarding procedures and reporting
- Patient records were accurate, up-to-date and well-maintained.

Quality of Management and Leadership

Overall summary:
Staff feedback highlighted that patient care was a top priority and concerns were addressed promptly. Staff were satisfied with safety measures for both patients and themselves, but felt the environment must be improved. Some suggestions for improvement included better-equipped units, more space, upgraded bathrooms, functional patient beds and better laundry facilities.

The unit demonstrated a strong commitment to high-quality, person-centred care, supported by a friendly, professional and knowledgeable staff team. Staff were

confident in their roles, well-trained and supported through supervision, preceptorships and personal development plans.

Leadership at the unit was strong, with knowledgeable and committed staff providing high-quality care to patients. The governance and reporting structures were effective, with accessible support from senior management. Regular performance and quality meetings ensured continuous improvement and most policies were up-to-date and reviewed promptly.

The unit had an appropriate number of skilled and trained staff, including student nurses who were well-supported and training compliance overall was good. Newly qualified nurses underwent a structured induction and supervision process.

The unit encouraged feedback through quick response (QR) codes and verbal complaints, although formal complaints were logged via DATIX. There was a culture of openness and learning, supported by the Duty of Candour policy and regular quality and safety meetings. Staff were familiar with safeguarding procedures and training compliance was high.

We found that paper patient records stored in the manager's office in an unlocked cabinet and the office was often unattended and unlocked. We were therefore not assured that patient records were always stored securely. This was addressed under our immediate assurance process highlighted in Appendix B.

The unit demonstrated efficient multi-disciplinary team (MDT) working, with support from psychiatrists, GPs and community teams. Established procedures for collecting feedback were tailored to individual communication needs. While patient meetings were not held due to the complexity of needs, individual communication methods ensured patient voices were heard.

Immediate assurances:

- Patient records were not always stored securely. Paper patient records were stored in the manager's office in an unlocked cabinet. Although this was in the manager's rooms, the rooms were often unattended and unlocked.

This is what the service did well:

- Provided a safe, well-governed and compassionate environment
- A focus on continuous improvement, staff development and patient-centred care
- Good mandatory training compliance.

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

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued a questionnaire to obtain views of the patients, families and carers on the service provided at the setting. There were two patient surveys and two families and carers surveys completed, almost all the replies were positive.

Overall, patients thought the care given was good and that staff helped them when needed. They made the following comments about what was good at the setting:

> ***"Nice staff."***

> ***"Drives, activities with residents, support with community activities."***

Families or carers said they would rate the setting as good or very good and staff were kind and sensitive to patients when they carried out care and treatment and that staff provided care to patients when needed, comments received:

> ***"The care provided by the staff at the Laurels and Briary is excellent and holistic, they always treat my brother with dignity and respect, however the environment needs a refresh and refurbishment as it is a little shabby."***

> ***"The care [redacted] has received since arriving at the Laurels and Briary has been excellent and he has significantly improved since being in an environment where the staff are obviously very experienced Learning Disability nurses who are able to assess and meet his needs appropriately.***

> ***"They have always treated him with dignity and respect and have also been very supportive to us as a family. He has a comprehensive care plan in place which facilitates his holistic needs and there is an MDT on a monthly basis to discuss his progress and amend this plan as required, we are involved in this process."***

Due to the low numbers, it was not possible to identify any further themes.

Person-centred

Health promotion
We were told that all residents were registered with a local general practice (GP) and all residents had an annual health check. We saw evidence of the annual health check in a sample of two patients. We also noted that the patient health information documents were up to date, which accompanied the patients for any healthcare admissions. This provided extra detail to assist other staff to understand the complex physical health requirements and how to treat patients fairly and in accordance with their specific individual needs.

Support with diet was available through referral to a dietician. Patient health conditions would be discussed at the monthly multidisciplinary team (MDT) meetings, as well as being managed by individual risk assessments.

New patient referrals were made to various services, such as the dentist and the optician, upon arrival at the unit. However, we were disappointed to hear that whilst there had not been any problems with patients requiring dental treatment, there had not been any dental check-ups completed for over two years.

The health board must ensure that patients receive regular dental check-ups and treatment.

We were told that the notice boards in reception had been removed as they were unsafe and the unit was waiting for the maintenance department to install new notice boards. Consequently, there were several items that would normally be displayed that were not, such as NHS Wales Putting Things Right process and the complaints process. In addition, information for visitors, such as staff photographs and names, equality and diversity information, protection of vulnerable adults (POVA) and values and standards were also not displayed.

The health board must ensure that the notice boards are installed promptly and that the relevant information is displayed for patients and their family and carers.

Dignified and respectful care
All staff, interacted and engaged with patients appropriately and treated them with dignity, respect and kindness.

Patients had their own rooms, we noted that bedroom doors were closed when staff attended to patients' personal hygiene. Whilst there were locks on the shower rooms and patient rooms to protect patient privacy, these could be overridden by staff.

Those patients requiring less support were encouraged to take care of their personal hygiene and laundry themselves. Patients had their own property in their bedrooms and we saw posters and artwork on walls in bedrooms. Patients would be taken out for haircuts and other activities, if they wished.

We saw many examples where staff sat alongside patients to assist them to eat and drink, or to listen to them and hold conversations about their day. Throughout the inspection we observed committed and respectful interactions between staff and patients. Staff demonstrated a caring, compassionate and understanding attitude to patients.

Staff interacted with patients in a positive manner, they were knowledgeable about the patient's needs, behaviours and observation levels. During interviews, staff also demonstrated that they had a desire to improve the quality of services and care delivered to patients.

Individualised care
We looked at how care was planned, delivered and recorded for four patients. There were good patient care plans in place which looked at their needs, strengths and abilities. Care plans focused on needs and support and included a positive behaviour support (PBS) plan when needed. There were up to date risk assessments which had been regularly reviewed and these were reviewed and updated as appropriate. Care plans were reviewed monthly at MDT meetings and care bundles were reviewed daily.

Care plans we reviewed reflected both family and patient involvement and provided a detailed plan to help staff support patients. Whilst the care plans were good and comprehensive, they were not easy to navigate. The wording of the care plans addressed patient's problems rather than their needs and did not always reflect the positive attention and care that was given to manage people's needs.

The health board should ensure that the care plans reflect the positive attention to patient needs.

Patients were involved in their care plans and risk assessments, if they had capacity. However, we noted in one record the use of 'copy and paste' from other records, which was not appropriately amended for that patient. For example, the wrong name in the assessment and treatment care plan and incorrect pronouns used in other documentation. In addition, there was an absence of staff names, their signature and date of review on the record.

The health board must ensure that care plans accurately reflect a patient, they are dated, named and signed by the relevant team members.

Whilst there was equipment in place to support personal care, hoisting and mobilisation, the setting would benefit from ceiling track hoisting in individual rooms, as there was a lack of space and storage for the mobile hoists.

Patients were supported to access community facilities, activities and to do their shopping. We observed patients being supported to do their own laundry and we were told that more active support would be introduced now that more mobile patients were resident. Staff not only supported the patients with their health needs, they also supported them with cleaning, shopping, cooking and arranging activities. Staff interacted kindly and in a bespoke way with patients. There was evidence of person-centred approaches within the care provision.

Patients could access activities within the unit and in the community, but there was no systematic approach to support active engagement and promote independence and skill development. Although there were occasional group activities, such as a visit by llamas and a silent disco, they were provided on an ad hoc basis with no regular planned events. Additionally, there was no weekly planner to help organise activities and skill-building opportunities for patients.

The health board must ensure that there are regular planned activities for patients and that evidence of this is recorded in the care plans.

Independent Mental Capacity Advocates (IMCAs) attended the monthly ward round and MDT meetings were reported to be very effective. There were also opportunities for the patient and their family to attend. There was evidence that patient's physical health needs were assessed and managed well.

It was widely accepted that active staff support helped maintain patient mental wellbeing by encouraging engagement in meaningful activities. Applying the nursing process (assessment, planning, implementation and evaluation) to help patients access these activities could also enhance patient's skill building, mental wellbeing and independence.

Healthcare was delivered promptly and met quality standards and physical health monitoring was consistently recorded in patient records and embedded throughout patient files.

Patients were mostly reliant on the staff to access activities, although, one patient had external support. Staff were respectful and warm in their interactions with patients and it was clear staff and patient relationships were good. Staff also had good knowledge of their patients.

Timely

Timely care

Patients received support and treatment that was designed to meet their health needs and prevent deterioration. The unit admitted patients who had a primary health need with Continuing Healthcare (CHC) Funding. As part of the admission criteria, evidence had to be provided to show that all other alternatives had been explored. There was also a care coordinator allocated to each patient

We noted that one patient had prior involvement with the Children and Adolescent Mental Health Service and that there had been good communication supporting the transition.

The setting appeared appropriate for most patients. However, there was one patient whose needs did not appear to meet the usual demographic for this setting. It appeared that pressure was placed on the unit to accept the patient from an assessment and treatment unit so they could admit another patient.

Equitable

Communication and language

We examined whether patients received full information about their care in a way that they could understand. Depending on the patient's level of understanding, the staff tailored the information provided to patients on an individualised basis. Staff also used a variety of methods to communicate with patients, such as cards, screens and pictures, though healthcare support workers (HCSWs) reported that most communication was verbal. Patients were also supported with some easy read information, provided by the health board's speech and language therapy (SALT) department.

Overall, staff were observed communicating with patients, taking time to listen and answer questions.

Staff understood the importance of speaking with patients in their preferred language, supporting the delivery of good healthcare. There were three Welsh speaking staff at the setting, but they did not wear a 'iaith gwaith' badge or other method, to indicate they were able to speak Welsh. Staff at the setting spoke several different languages including Welsh.

The health board must ensure that patients and visitor can easily identify staff who could speak Welsh or were Welsh learners.

Rights and equality

We were told how equality and diversity was promoted within the organisation. Staff had access to online materials, including equality and diversity policies and procedures as well as staff training modules.

We noted that reasonable adjustments were in place to ensure that everyone could access and use the services on an equitable basis. Some patients with physical disabilities had motorised wheelchairs and staff support them with these.

All external doors to the building were secure, however, the intercom and electronic door release at the internal front door were not functional. The setting had level access and wide corridors, but the room doors could be wider for motorised wheelchairs. The environment was mostly accessible, some exits presented difficulties for wheelchair users as the doors were only just wide enough for wheelchairs and there was also a slight lip to the conservatory exit. The paintwork in all corridors needed refreshing with doorways and skirting boards evidencing a lot of scratching. Cupboard doors in both laundries were missing and one laundry sink was leaking. Bedrooms were clean and spacious. The furniture in the bedrooms was easy to clean.

Food was provided in accordance with patient's preferences and staff would purchase food for patients in accordance with their dietary requirements and preferences.

The staff were a diverse team and treated each other with dignity and respect and they said they had no concerns in reporting any issues to senior staff. Whilst staff explained no transgender or non-binary patients had been residents at the unit, they were aware of the need to address patients as they wished.

Staff were aware of the Mental Capacity Act 2005 and how to apply this in practice with their patients. There was evidence of patient best interest processes being followed where appropriate, with decisions recorded in their care plans.

There were five patients at the unit who were subject to Deprivation of Liberty Safeguards (DoLS). We noted that one DoLS authorisations recently expired though on discussion with the manager, they explained that a DoLS assessment and application had been completed and they were waiting for the relevant documentation. All DoLS expiry dates were noted on an office notice board, to support timely assessment and application for renewal. However, staff explained the response from the local authority was not always provided in a timely manner. Senior staff were aware of their responsibilities with how to make a DoLS application. There was evidence that staff had appropriate mandatory DoLS training.

Delivery of Safe and Effective Care

Safe

Risk management
We reviewed the documentation and policies in use to minimise the need for restrictive practices of patients with challenging behaviours.

The environment was calm and relaxed which lent itself to minimising behaviours of concern. To support a clam environment patients had access to an outside space and quiet areas.

The unit specialised in supporting patients with continuing physical healthcare and mobility issues. However, whilst patients with additional behavioural needs could be supported at the unit, those with more complex or challenging behaviour were not usually admitted. Therefore, admission of patients with an identified restrictive practice intervention (RPI) need, would not usually meet the admission criteria for the unit. None were resident during the inspection. However, staff explained that if a patient with such needs was admitted, they would have a physical intervention care plan developed with support from the positive behaviour management team.

PBS was used where indicated and there was a good standard of PBS plans written by psychology staff and the unit staff team were trained in its use. A patient care and treatment plan included strategies for managing behaviours of concern with proactive and reactive strategies in place.

There had been no reported use of restraints over the last 12 months. However, on reviewing one patient record, there were six reported uses of RPI strategies. These included five occasions of increasing personal space and one occasion of blocking the patient's blow. Behaviour was reviewed by the patients' primary nurse and presented at the monthly MDT meeting.

There were eight patients at the unit at the time of the inspection and all were on differing levels of observation. There were sufficient staff on duty to conduct the observations, with appropriate numbers of male and female staff to carry out the observations, to uphold patient privacy and dignity. Observation levels ranged from basic level, general observation, to level four, close observation at arm's length. There were adequate processes in place to support staff when needing to escalate a level of observation.

The health board had a robust reporting and review systems in place to record patient safety incidents. Incidents were recording using the electronic Datix system.

A Reducing Restrictive Practices policy which was accessible to staff on the health board intranet. We noted that the violence and aggression module A was identified as mandatory training for the unit and it was positive to find that staff training compliance of 100%.

There were risk assessments completed for the unit. This included a general health and safety walk through inspection completed in April 2023, a ligature environmental risk assessment completed January 2025 and a fire risk assessment and an environmental checklist completed in January 2025. However, we noted a business continuity plan, dated December 2022 was overdue review since December 2023.

The health board must ensure that the unit's business continuity plan is reviewed and updated in a timely manner.

We were told there was an all staff messaging application in place, to share and disseminate information to staff, including any known risks. All staff were involved in mitigating risks and were aware of their responsibilities.

Ligature points had been identified and basic risk assessments completed. Senior staff at the setting told us that additional assessments would be carried out if a patient was identified as being at risk of harm.

The environment of the internal and external areas was considered and we found arrangements were in place to ensure that the premises were maintained and repaired through an electronic maintenance system. However, staff highlighted that maintenance teams did not always carry out remedial works promptly.

We found immediate environmental and health and safety risks, which meant we could not be assured that the health, safety and welfare of patients, staff and visitors was being actively promoted and protected. We found several issues including:

- Several areas where there had been water ingress into the building, in the past, but the damage caused by the ingress was still evident on the ceilings and walls of various areas of the building, or the repairs made were inadequate, such as boarding up a hole in the ceiling. This included the shower rooms and bathrooms, offices, the kitchen and the laundry room. In

addition, there were other internal issues, such as the bath in one of the two units out of use due to leaking pipes and broken cupboards and drawers

- The external rear areas of the setting were untidy and posed several trip and other injury hazards. This included an uneven path, overgrown trees and foliage, an accessible area to keep broken items, such as a TV and chair and a loose-fitting drain cover

- The front of the building included discarded rubbish, such as crisp packets, facemasks and an empty can of alcohol, overgrown foliage and broken pieces of equipment on a pallet

- The gate on one side of the building was broken and allowed entry to the rear of the building. Whilst all exit doors were not accessible from the outside, the conservatory doors could be left open to allow garden access and patients could be using the garden (accompanied by staff), this presented a security risk to the staff and patients.

We saw evidence that a number of these issues had been reported to the estates department (which was part of Cwm Taf Morgannwg University Health Board) and highlighted in the environmental checklist in January 2025, which also included other remedial work required and indicated some of these had been reported for some time.

As a result of these findings, we were not assured that:

- The unit provided a safe, secure environment for patients, staff and visitors

- The unit environment was being kept in a good state of repair

- There was an effective process in place to ensure that estates issues were being robustly addressed and in a timely manner.

This was addressed under our immediate assurance process highlighted in Appendix B.

Infection, prevention and control (IPC) and decontamination
We were told that a member of the nursing staff had recently been appointed as the IPC lead. There was an in-date health board IPC policy available through the intranet.

Staff we spoke with understood their role and responsibility in upholding IPC standards and knew how to escalate any concerns. Staff were observed undertaking cleaning duties effectively during the inspection.

We saw evidence of infection control audits taking place which were recorded on the audit management and tracking tool (AMaT). This included hand hygiene, maintaining bare below the elbow and personal appearance.

There were personal protection equipment stations throughout the unit and there were also disinfectant wipes in every patient bedroom. Hand sanitisers were also available at the setting entrance and at various points around the building. Whilst patients were encouraged and supported by staff to practise good hand hygiene, only two patients were able to do this independently, the other patients were assisted by staff.

Whilst the bathroom and equipment were cleaned, there was an absence of green labels to identify equipment was clean and ready for use. Staff explained the reason being the bathroom and equipment was in regular use and was cleaned after each use. However, to ensure effective IPC, equipment should be clearly identified as clean and ready for use, such as with the designated green labels.

The health board must ensure that the unit staff and patients can easily identify that equipment is clean, sanitised and ready for use.

Any sharps, such as needles or glass products were disposed of safely.

During the inspection we found several substances in both laundry rooms which, could be hazardous to health if consumed or through skin contact. These were kept in unlocked cupboards in unlocked rooms and we were told that there were no keys on site to secure the unlocked cupboards. Examples of substances included floor cleaner, caustic cleaning tablets, hand sanitiser, laundry powder, liquid detergent, bactericidal air freshener, toilet cleaner, bleach and oven cleaner. Whilst we were told that patients would not use the laundry room unsupervised, there were patients on the unit who were ambulatory and could access these rooms unsupervised.

There was not a robust process in place to prevent unauthorised access to the Control of Substances Hazardous to Health (COSHH) storage areas. COSHH substances must be kept securely in a locked cupboard or in a locked room, to maintain the safety and wellbeing of patients and other individuals in the unit. This was addressed under our immediate assurance process highlighted in Appendix B.

Safeguarding of children and adults
Staff we spoke with said they would manage any potential safeguarding risks between patients by following the care plan or from guidance in the PBS plan. Staff would report any issues to the nurse in charge who would escalate as needed within the health board and report to the relevant local authority as indicated through the safeguarding flowcharts available at the unit.

There was evidence that safeguarding data was collected and reported to the health board who monitored and supported engagement in processes through regular quality and safety meetings. Safeguarding of adults and children training was mandatory and compliance for safeguarding adults was over 94% and children over 88%. From the sample of training records checked, we noted that four out of five staff had completed safeguarding to level three, others had completed the training at level two.

Staff were compliant with the Wales Safeguarding Procedures and local safeguarding policies and procedures were in place. We also noticed a safeguarding flowchart in the manager's office, with contact details of the local safeguarding teams.

Senior ward staff confirmed they were confident that staff were aware of the correct procedure to follow should they have a safeguarding concern. During discussions with staff, they were able to show knowledge of the process of making a safeguarding referral.

Medicines management
There were appropriate medicines management systems in place. The room storing the medicines cabinet was locked and the nurse in charge was the designated key holder. The medicine cabinets were also locked and secured to the wall and the ambient room temperature was monitored and recorded. Controlled drugs were locked in cupboards and their use was documented and administered correctly in accordance with legislation and health board policy. Staff were knowledgeable and confident when administering medication.

There were protocols in place for 'as required' (PRN) medication, which may be used to manage patient symptoms or behaviour in line with their care plan.

All medication was managed by the Hospital Electronic Prescribing and Medication Administration (HEPMA) system, an electronic prescribing and medication administration system. Medications were reviewed at monthly ward rounds.

There was good evidence of staff ensuring that patients had individualised medication management plans. Medication records were comprehensive and

complete. To help patients understand the medicines they took and their effects, the setting should develop easy read documents to support this.

The health board should develop easy read documents to assist patients to understand the reasons for their medication and their effects.

The Disability Distress Assessment Tool (DisDAT) was completed by the community team prior to admission, to help identify distress cues in patients with cognitive impairment or limited communication. The inpatient clinical team were skilled at identifying issues through changes in facial expression, body language and behaviour, which would inform ongoing health assessments. SALT support was also provided using communication key rings and a collection of symbol cards for patients to express their needs.

Nutrition and hydration
Patients hydration and nutritional needs were generally met. Staff had received training in percutaneous endoscopic gastrostomy (PEG) feeding and were also aware of patient's food preferences.

Patients had a choice of what to eat and drink, all meals were prepared and cooked by staff with no set menu. Breakfast was provided at various times depending on the patients' needs or choice. Lunch was usually a lighter meal with the main meal in the evening.

Patients were encouraged to choose a healthy diet and we found fresh fruit and vegetables for patients in the kitchen. The kitchen was not locked and patients were encouraged to use this if ambulant and appropriate.

The Adult Nutritional Risk Screening Tool (WAASP) was used for the patients, although it was noted that one patients' weight loss was not recorded on this tool. It was noted that supplements were prescribed where required.

The SALT team had input into the MDT meetings, though they normally attended online. The setting could also refer patients for SALT review when required. Additionally, referrals could be made to the dietetic service if needed.

Patient records
Patient records were maintained in accordance with legislation, clinical standards and guidance, including health board policies, with clear accountability and effective sharing of information.

Within patient records, there was clear evidence of how decisions relating to patient care were made. This included pre assessments before admission,

comprehensive nursing assessments, medication reviews and risk assessments which informed the care plan. Patient records were of a good quality completed appropriately, legibly and were contemporaneous.

Efficient

Efficient
There were processes in place for inpatient admission and discharge and respite beds were also available for short term use.

Planned admissions and discharges appeared efficient and appropriately managed. However, we found that on occasions, a patient was admitted with behavioural or mental health needs without any other healthcare needs, due to bed pressures elsewhere in the service. Whilst the unit staff had sufficient knowledge, skills and experience with their usual patient demographic, admission of patients outside of their usual cohort can pose additional risk, therefore additional training should be provided to staff if this continues. The senior nurse reported that they would be undertaking a training needs analysis with individuals to help gain their understanding of the role, the patients and function of the unit.

We noted that the "Learning Disabilities Laurels and Briary Respite Standard Operational Procedure" was in draft and there was a "Laurels and Briary Unit Operational and Clinical Policy" dated 2022. The draft procedure listed the referral process and the admission criteria, including pre-assessment and medication reconciliation and information. This also formally documented how the community health team interacted with the setting to ensure well planned pathways for people. The community team attend the monthly transfer and transition meetings.

Regular transition meetings were held, involving other healthcare departments as appropriate. Patients and families also participated in the meetings where appropriate to discuss transition and discharge planning.

Quality of Management and Leadership

Staff feedback

HIW issued a questionnaire to obtain staff views on the care at Laurels and Briary. In total, we received two responses from staff at this setting. Both agreed the care of patients was the organisation's top priority and that they would act on concerns raised by patients. They were happy with the organisation's efforts to keep staff and patients safe, and they highlighted the environment was not suitable for patient needs. Due to the low numbers of responses, it was not possible to identify any further themes.

Staff comments on how the setting could be improved included:

> ***"Better equipped unit. More spaces for both patients and staff. Storage areas for equipment and COSHH/supplies. Improved bathrooms / washrooms. New patient beds that are fully functional. Better laundry facilities."***
>
> ***"By ensuring the equality law/act is practised at workplaces and unit."***

As highlighted earlier in the report, we were told how equality and diversity was promoted within the unit and staff had access to online materials, including equality and diversity policies and procedures as well as staff training modules. The staff comment about ensuring the equality act is practiced at the unit must be considered and the health board must explore staff perceptions around this matter.

The health board must ensure it explores staff feedback around maintaining the equality act and ensure improvements are made, if it identifies any issues with this.

Leadership

Governance and leadership
We saw a friendly, professional and kind staff team who demonstrated a commitment to providing high quality care to patients. Staff were able to describe their roles and appeared knowledgeable about the care needs of the patients they were responsible for. Staff were confident and competent in their roles.

The unit was well led with appropriate governance, reporting lines and oversight from the health board. The ward manager stated that the lead nurse and nurse

managers were available as required and there was access to senior staff out of hours on call provision as and when needed. The ward manager would at times work clinically with patients and thus being seen as a positive role model. The manager and nurses appeared approachable and valued by their team. We saw evidence of good teamwork, both internally and through links with community teams and assessment and treatment units. It was clear that staff worked well together.

There was regular reporting on the various units within the Mental Health and Learning Disabilities Service Group, which included Laurels and Briary. The monthly performance scorecard included information on training, workforce, patient flow and feedback. Also, there were monthly quality and safety meetings which included identified learning, development or support needed, leadership and governance and performance management.

The policies and procedures we reviewed were mostly in date and had been reviewed in a timely manner by the health board.

Workforce

Skilled and enabled workforce

The staffing establishment was reviewed and there were enough staff employed with the right skill mix to run the service safely. We were told that student nurses were supported when they attended the unit and were assigned a supervisor and an assessor. There was an established staff team and shift vacancies would usually be undertaken by substantive staff. Agency staff were only used to support one patient with their external daily activities. Managers ensured there were appropriate levels of staff on duty and we were told that more staff would be rostered if patient acuity or dependency was higher than usual.

Evidence at the setting showed staff were appropriately recruited, trained, qualified and competent for the work they undertook. All the nurses were registered learning disability nurses.

Mandatory training compliance was at 89%, we also noted that staff in this setting had undertaken additional training, such as how to manage the suprapubic catheter training, PEG feed training and skin integrity training.

Compliance with staff annual personal development reviews was at 80%, with a plan in place to improve this percentage soon.

We were told that the unit had previously used an external team to support staff with debriefing following significant incidents, such as Trauma Risk Management

(TRiM) training. Occupational health support was available to staff if needed, including counselling and staff injury. Staff could self-refer to this service, or they could be referred by unit management.

There was evidence that newly qualified nurses would be supernumerary for two weeks initially, then they would have a preceptorship for key skills and competency for approximately six months. We were told that registered nurses were supervised and supported appropriately. Staff roles were allocated to patients as the primary nurse (registered nurse) and key worker (HCSW).

Culture

People engagement, feedback and learning
We looked at how the service listened and learned from feedback. We were told that verbal feedback was encouraged. The complaints procedure and NHS Wales Putting Things Right were not clearly displayed at the setting this, however this was because the staff were waiting for the new notice boards to be installed.

Senior staff we spoke with said that feedback and compliments were welcomed to improve the service provided. The unit would aim to address complaints immediately where possible. There was no complaints register in place to capture verbal complaints, however, formal complaints would be reported on DATIX and managed by the patient feedback team. The learning disability service then works alongside the team to respond.

Advocates and family members would normally support patients to make complaints or raise concerns. Staff involved in a complaint would be supported through the process by the unit's management team.

There were robust systems in place for reporting and reviewing incidents which fed into any lessons learned, this included the learning from formal complaints.

Staff reported that there was an open and honest culture at the unit.
The health board Duty of Candour policy was accessible to staff and all were compliant with the relevant training. There had been no incidents which required the duty of candour to be exercised.

Feedback from patients, families and carers was encouraged through quick response (QR) codes and the information was published in the monthly performance scorecard. Nine responses were received during April 2024 to March 2025 and comments included:

"I want to say thank you to all the team in Laurels and Briary for looking after my son. He is cared for so well there."

"My sister is at Laurels and Briary, and they look after her so well. The whole team are excellent. They do a great job."

"Laurels and Briary look after my daughter and they do it so well. The whole team are fantastic and always go the extra mile. Thank them."

"Laurels and Briary staff are first class. They look after my sister with care and compassion and us as a family when we visit"

"My friend is being looked after in Laurels and Briary. The team there are excellent and always keep me informed of his care."

Information

Information governance and digital technology
We found paper patient records stored in the manager's office in an unlocked cabinet and the office was often unattended and unlocked. We were therefore not assured that patient records were always stored securely. This was addressed under our immediate assurance process highlighted in Appendix B.

Learning, improvement and research

Quality improvement activities
The unit promoted and ensured participation in audit and quality improvement activities. There were monthly staff quality improvement meetings held, chaired by the lead nurse.

There were also good training opportunities, such as respite care and catheterisation. Staff also explained that specialist training had been provided on managing patients with more complex needs.

Staff demonstrated a desire to improve their skills such as diabetic training to improve patient care. Clinical audits were completed on the unit, which included medication and IPC. These were recorded on the AMaT system for senior manager monitoring. Daily environmental checks were also completed.

There were measures in place to implement recommendations from the audits and checks. Measures were also in place to share patient safety notices received from outside agencies, such as national patient safety alerts and the Medicines and Healthcare products Regulatory Agency (MHRA).

Whole-systems approach

Partnership working and development

There was good evidence of efficient MDT working and frequent communication and support from both the psychiatrist and the GPs. This included access to an out of hours on call psychiatrist and a service level agreement with a GP surgery to support patient care. There was also access to the Cardiff community MDT through referrals to SALT, physiotherapy and the specialist behaviour teams. Advocacy support was also available to the patients.

There were established procedures for gathering feedback from individuals, which accounted for individual communication needs to ensure comprehensive collection of opinions. It was conveyed to us that patient meetings did not occur due to the complexities associated with the patients' learning disabilities.

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: Laurels and Briary Complex Care Unit

Date of inspection: 29 and 30 April 2025

The table below includes any immediate 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.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	During the inspection, HIW considered the environment of the internal and external areas on Laurels and Briary Complex Care Unit. We found immediate environmental and health and safety risks, which meant we could not be assured that the health, safety and welfare of patients, staff and visitors was being actively promoted and protected. We found a number of issues including the gate on one side of the building was broken and allowed entry to the	The health board must ensure the security of the unit is prioritised and maintained to support staff, patient and visitor safety.	Delivery of safe and effective care – Environment, Managing Risk and Health and Safety	A remediation programme has been agreed with CTMUHB as part of the Service Level Agreement with SBUHB. However, SBUHB is directly taking forward the environmental, security and health & safety risks through an SBUHB appointed contractor and overseen by an SBUHB Estates Officer. A quotation was obtained and has been approved (8 May). Work should commence on the 21 May, which was the first	Assistant Director Estates	No later than the end of May 2025.

	rear of the building. Whilst all exit doors were not accessible to the outside, the conservatory doors could be left open to allow garden access and patients could be using the garden (accompanied by staff), but this presented a security risk to the staff and patients.			available date that resources could be deployed. Dates have not been provided by colleagues in CTMUHB at the time of writing, but this is being followed up by SBUHB Estates.		
2.	Several areas where there had been water ingress into the building, in the past, but the damaged caused by the ingress was still evident on the ceilings and walls of various areas of the building, or the repairs made were inadequate, such as boarding up a hole in the ceiling. This included the unused shower room, the other shower room and both bathrooms, the managers offices, the kitchen and the laundry room. In addition, there were other internal issues such	The health board must ensure that the maintenance of the building is prioritised so that the unit ensures that infection prevention and control (IPC) risks are reduced and provides a pleasant ambience for patients and staff which is conducive to improving the outcomes for patients.	Delivery of safe and effective care – Environment, IPC, Managing Risk and Health and Safety	SBUHB Estates carried out their own condition survey on 2nd May: This is the first of the LD bungalows to be surveyed by SBUHB in recent years and will be followed by all of the remaining properties to inform a prioritised 2-year investment programme, which will be organised to ensure greater economies of scale, e.g. a painting programme for all of the bungalows rather than on an ad hoc basis.	Assistant Director Estates	Condition surveys should be completed by 30th September 2025 (subject to access and availability of resource). Improvement programme will be

	as the bath in one of the two units out of use due to leaking pipes and broken cupboards and drawers The external rear areas of the setting were untidy and posed several trip hazards as well as potential hazards to health, this included uneven flagstones to the rear of the building in the garden area, overgrown trees and foliage, a corner of the garden being used to keep broken items such as a TV and chair and a loose-fitting drain cover The front of the building included discarded rubbish such as crisp packets, facemasks and an empty can of alcohol, overgrown foliage and broken pieces of equipment on a pallet.			A further building condition survey has been commissioned from Aecom. This will be a more in-depth report on building condition that will inform further works subject to funding given competing priorities.		developed as surveys are completed with priority works scheduled for completion in advance of a rolling programme .

3.	We saw evidence that a number of these issues had been reported to the estates department (which was part of Cwm Taf Morgannwg University Health Board) and highlighted in the environmental checklist in January 2025, which also included other remedial work required and indicated some of these had been reported for some time.	The health board must implement robust governance oversight to improve the unit's estates management and ensure maintenance issues are resolved promptly and effectively.	Delivery of safe and effective care – Environment, Managing Risk and Health and Safety	The current SLA with CTMUHB is based on the number of calls logged and attended, with an upper limit of 62% of the activity that was undertaken in 2018, which equates to the estimated cost of maintaining the buildings of circa £130k per annum. The funding was based on an average cost per square meter for this type of building. Priority is given to statutory compliance. However, this is not addressing the care environment, nor ongoing deterioration of the fabric and infrastructure of the buildings. The Executive Director of Finance & Performance has asked the Assistant Director of Estates to prioritise a review of the Service Level Agreement with CTMUHB and to undertake an option appraisal with reference to risks and patient	Assistant Director Estates	31st October 2025

				care requirements. The condition surveys will inform this work. This has been set as a 25/26 objective. This review will include more robust governance arrangements. The target date for completion of the option appraisal is October 2025.		
4.		The health board must ensure that due to the numerous environmental issues identified at this inspection our findings are not systemic across all other units in the Learning Disabilities Division.	Delivery of safe and effective care – Environment, Managing Risk and Health and Safety	As noted above SBUHB Estates will be undertaking condition surveys to inform a rolling 2-year programme of investment. This will be undertaken in parallel with the review of the CTMUHB SLA.	Assistant Director Estates	30th September 2025
5.	During the inspection we found several substances in both laundry rooms which, could be	The health board must ensure that:	Control of Substances Hazardous to	CTM Estates have arranged for the COSHH Cupboard fronts	CTM Estates Supervisor (& SBU	16th May 2025

	hazardous to health if consumed or through skin contact. These were kept in an unlocked room in unlocked cupboards and we were told that there were no keys on site to secure the unlocked cupboards. Examples of substances found were floor cleaner, caustic cleaning tablets, hand sanitiser, laundry powder, liquid detergent, bactericidal air freshener, toilet cleaner, bleach and oven cleaner. Whilst we were told that patients would not use the laundry room unsupervised, there were patients on the unit who were ambulatory and could access these rooms unsupervised.	• Any broken cupboards are replaced with lockable doors • There are locks with keys or keypad locks installed to the cupboards in the laundry rooms to securely store COSHH substances • All COSHH substances are kept secured at all times.	Health Regulations 2002 Delivery of safe and effective care –Managing Risk and Health and Safety	and surface tops in the laundry room to be replaced. The lock to the laundry room will be replaced on the 12 May. All substances hazardous to health have been temporarily removed to a secure location within the unit for immediate safety.	Assistant Director Estates) Assistant Director Estates Unit Manager	 12th May 2025 Completed
6.	During our tour of the setting, the HIW inspection team saw paper patient records being stored in the manager's office	The health board must ensure that patient records are	General Data Protection Regulation (UK GDPR) and the	All Health Records have been temporarily removed to secure location within the unit.	Unit Manager	Complete

	in an unlocked cabinet. Although this was the manager's rooms, the rooms were often unattended and unlocked. Previously the patient group were not mobile, but now several were independently mobile. HIW was not assured that patient records were stored securely at all times.	kept securely, in a lockable cabinet.	Data Protection Act 2018 Health and Care Quality Standard – Governance	Replacement keys for existing lockable storage within ward office have been ordered. Secure combination lock to be fitted to Ward Manager's office Additional lockable cabinets to house daily patient recording files to be supplied.	Directorate Manager Assistant Director Estates Directorate manager	16th May 2025 12th May 2025 19th May 2025

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): **Dermot Nolan**

Job role: **Service Director**

Date: **12th May 2025**

Appendix C - Improvement plan

Service: Laurels and Briary Complex Care Unit

Date of inspection: 29 and 30 April 2025

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Whilst there had not been any problems with patients requiring dental treatment, there had not been any dental check-ups completed for over two years.	The health board must ensure that patients receive regular dental check-ups and treatment.	Health promotion	1.Each patient has an identified primary nurse and allocated team within the Laurels and Briary. Primary nurse to link in with specialised Cardiff and Vale UHB Dental Service to arrange dental appointments for patients. Email has been sent and dates now awaited. Primary nurses to chase confirmation. For Noting: Patients will be supported to attend appointments and any reasonable adjustments to be discussed with primary nurse and dental services for in house appointments.	Unit Manager	24 July 2025 (Confirmation of dates)

				Staff will identify as a care need in patients care plans and evidence needs are being met. Urgent dental care is sought through St. David's emergency dental service.		
2.	We were told that the notice boards in reception had been removed as they were unsafe and the unit was waiting for the maintenance department to install new notice boards. Consequently, there were several items that would normally be displayed that were not.	The health board must ensure that the notice boards are installed promptly and that the relevant information is displayed for patients and their family/ carers.	Health promotion	Request already logged with CTM Estates via portal and notice boards have been replaced and hung up. Documentation and information sharing to be added to notice boards.	Directorate Manager	31 July 2025
3.	The wording of the care plans addressed patient's problems rather than their needs and did not always	The health board should ensure that the care plans reflect the positive	Individualised care	1. Primary nurses to review care plans monthly and amend the template to change wording from problem to need to reflect individualised needs and the positive	Unit Manager	14 August 2025

	reflect the positive attention and care that was given to manage people's needs.	attention to patient needs.		attention and care that was given to manage people's needs. 2. Unit manager and deputy manager to audit care plans during staff nurse supervision. 3. This will be reviewed quarterly by the Lead Nurse through the Quality Assurance Framework Review. For noting: Monthly multidisciplinary team (MDT) meetings are held to discuss patient health conditions.	Unit Manager Unit Manager	30 September 2025 31 October 2025
4.	We noted in one record the use of 'copy and paste' from other records, which was not appropriately amended for that patient. For example, the wrong name in the assessment and treatment care plan and incorrect pronouns used in other	The health board must ensure that care plans accurately reflect a patient, they are dated, named and signed by the relevant team members.	Individualised care	1. Unit Manager to liaise with primary nurse who are identified for each patient to review care plan and address any errors so plans are person centred and individualised to meet each patient's needs. Review of all patient care plans by Primary nurse. Any errors to be amended and personalised and patient centred.	Unit Manager	Completed

	documentation. In addition, there was an absence of staff names, their signature and date of review on the record.			(See R3 for additional notes in respect to care plan audit & MDTs).		
5.	Although there were occasional group activities, such as a visit by llamas and a silent disco, they were provided on an ad hoc basis with no regular planned events. Additionally, there was no weekly planner to help organise activities and skill-building opportunities for patients.	The health board must ensure that there are regular planned activities for patients and that evidence of this is recorded in the care plans.	Individualised care	Identify two activity coordinators within their role as health care support workers. These staff will link in with the primary nurses to identify suitable activities and develop weekly planner to help organise activities and skill-building opportunities for patients. Staff and patient meetings to discuss appropriate activities in house and in the community. Individual activity timetable to be developed for each patient with alternative activity to be offered. This process has started. Activity co-ordinators to complete scoping review of local community for suitable activities.	Unit manager	30 September 2025

				Activity timetables to be reviewed in monthly MDT. Identify drivers to be allocated on shift or inhouse activities when drivers unavailable.		
6.	There were three Welsh speaking staff at the setting, but they did not wear a 'iaith gwaith' badge or other method, to indicate they were able to speak Welsh. Staff at the hospital spoke several different languages including Welsh.	The health board must ensure that patients and visitor can easily identify staff who could speak Welsh or were Welsh learners.	Communication and language	Identify Welsh speakers and Welsh language learners within the current team and new recruitments. Contact laundry rooms at Neath Port Talbot to order uniforms with appropriate logo that can be stitched into the uniform through usual ordering processes so that staff's Welsh language skills are identifiable to patients, family and other staff.	Unit manager	1 September 2025.
7.	We noted a business continuity plan, dated December 2022 was overdue review since December 2023.	The health board must ensure that the unit's business continuity plan is reviewed and	Risk Management	Business Continuity Plan updated and copy held on unit.	Directorate Manager	Completed

		updated in a timely manner.				
8.	Whilst the bathroom and equipment were cleaned, there was an absence of green labels to identify equipment was clean and ready for use.	The health board must ensure that the unit staff and patients can easily identify that equipment is clean, sanitised and ready for use.	Infection Prevention and Control	Where items can be used by multiple staff for multiple patients, staff have been advised to use 'I am clean' stickers to show that the equipment has been cleaned and is ready for the next use.	Unit Manager	Completed
9.	To help patients understand the medicines they took and their effects, the hospital should develop easy read documents to support this.	The health board should develop easy read documents to assist patients to understand the reasons for their medication and their effects.	Medicines Management	1. Communication Development Officer (CDO) and /or Speech and Language Therapist (SALT) to support with easy read documentation support. Primary Nurses to support with identifying medications and work alongside pharmacy and CDO/SALT to provide or develop easy read medication documentation. 2. Review use of the very easy read (VERA) info leaflets via Choice & Medication	Unit Manager Unit Manager	31 October 2025 31 October 2025

				website which is a subscription hosted for use across Wales.		
10.	The staff comment about ensuring the equality act is practiced at the unit must be considered and the health board must explore staff perceptions around this matter.	The health board must ensure it explores staff feedback around maintaining the equality act and ensure improvements are made if it identifies any issues with this.	People engagement	Meet with staff team to explore what was meant. Offer opportunity for individual conversations. If feedback identifies issues that require addressing use it to inform the development of the Directorate's action plan in response to the NHS Wales survey.	Directorate Lead Nurse	1 September 2025

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): **Dermot Nolan**

Job role: **Service Group Director**

Date: **25/06/25**