Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Felindre Ward, Bronllys Hospital, Powys Teaching 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 Bronllys Hospital, Powys Teaching Health Board on 10 (evening), 11 and 12 June 2025. The following hospital wards were reviewed during this inspection:

- Felindre Ward – 16 acute adult mental health bedded ward, inclusive of two crisis beds and a Section 136 suite.

Our team for the inspection comprised of one HIW senior healthcare inspector, one HIW healthcare inspector who undertook the patient experience role, and three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer).

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of five questionnaires were completed by patients 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:
We observed kind and respectful interactions between staff and patients, and we saw patients being assisted and responded to in an overall timely manner, despite the ward caring for several high acuity patients throughout the inspection.

There were a range of occupational therapy and activities co-ordinator led activities on the ward, delivered by enthusiastic staff. These were well structured and focused on supporting patient wellbeing and skills development. These included access to 1-1 and group cookery and well attended pottery classes. Other activities included television rooms, well maintained grounds and garden area, board games and consoles.

There is, however, a need for the health board to reflect on any access or time restriction on certain areas of the ward to maintain patient experience and to help prevent challenging behaviours.

It was positive that several environmental improvements to the bedroom areas had been implemented since the last inspection in support of maintaining patient privacy and dignity.

This is what we recommend the service can improve:

- Consideration should be given towards access and time restrictions for patients when using certain ward areas, such as the garden and other communal areas.

This is what the service did well:

- Kind and respectful interactions were observed between staff and patients
- A range of Occupational Therapy and Activities Co-ordinator led activities were available
- Several environmental improvements had been made since the last inspection.

Delivery of Safe and Effective Care

Overall summary:
The grounds, including the patient garden, were pleasant, well maintained, and free of obvious hazards, and the ward was visibly clean, tidy and well-organised. Access to the building and ward was always secure.

There was an overall effective multidisciplinary team on the ward. There was good medical cover, which included weekly patient reviews, with flexibility to review at other times, as needed. We found ward reviews to be well facilitated, cohesive with a good focus on discharge planning.

Several 'Safeward' principles were in use on the ward as a method of reducing instances of challenging behaviours. Despite the ward designation, there was an overall low use of full physical restraint techniques and other forms of restrictive practice.

There was good evidence of therapeutic observations being completed, and staff were aware of the need to engage meaningfully with patients. However, we were told and we observed some limitations to this when observation levels and ward acuity is high.

It was positive to find that there was a cautious approach towards the use of high dose anti-psychotics on the ward, and no medications were found to exceed British National Formulary (BNF) limits. However, aspects of medication chart completion and controlled drugs management required strengthening.

We reviewed a sample of patient documents who were detained under the Mental Health Act 1983 and found their detention was compliant with the Act. However, some areas required strengthening.

In the sample patient records reviewed, we found all patients to be in receipt of a full and comprehensive mental health assessment. This was accompanied by a WARRN risk assessment, which had been reviewed, as required. Whilst there were some omissions in physical health assessment, and care and treatment planning, there were instances of care plans clearly reflecting and supporting patients mental and physical health needs in an individualised and compassionate manner.

Immediate assurances:

- Aspects of Controlled Drugs (CD) management required strengthening
- Assurance was requested that all patients, particularly those with complex physical health needs, have a care plan in place upon admission.

This is what we recommend the service can improve:

- Elements of care planning documentation required strengthening, including care and treatment plans, physical health assessments, and medication charts
- Aspects of Mental Health Act documentation and application of powers required strengthening.

This is what the service did well:

- The grounds and patient areas were pleasant, well maintained and free of obvious hazards
- There was an effective multidisciplinary team, and we found ward reviews to be well facilitated, cohesive and with a good focus on discharge planning
- There was a cautious approach towards the use of high-dose anti-psychotics and use of full restraints or restrictive interventions.

Quality of Management and Leadership

Overall summary:
The ward was jointly managed by two registered nurses. The ward manager that we engaged with during the inspection was experienced and knowledgeable of the matters affecting the ward. There was a good emphasis placed on staff wellbeing.

Staff meetings enabled an effective flow of information between management and staff, including learning, attendance from external guest speakers, and a positive emphasis on staff wellbeing. This was notable practice.

We observed a patient-focused team of staff who were working hard to provide patients with a good standard of care. There was, however, a reliance on agency staff to support the ward. Whilst this helps to provide the ward with safe staffing levels, the staff we spoke with expressed concern that this can often dilute the skill mix on each shift and cause some unfamiliarity and lack of continuity of care with patients.

Mandatory training and appraisal completion rates were generally maintained to a good level. However, some mandatory training areas required strengthening.

Some divisional policies and procedures required review to ensure their continued suitability and reflection of current guidelines. The health board should prioritise this action based on the clinical need of the relevant policy or procedure.

Immediate assurances:

- Immediate Life Support (ILS) training required improvement to ensure that a sufficient number of staff are trained.

This is what we recommend the service can improve:

- Clinical policies and procedures should be prioritised for review and, where required, amendment
- The frequency of agency staff use, particularly those not familiar with the ward and patient group, should be carefully balanced.

This is what the service did well:

- We observed a patient focused staff team who were working hard to provide patients with a good standard of care
- The contents and delivery of staff meetings were of good quality.

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

We received five completed patient questionnaire. Feedback and themes have been included into the relevant report sections below.

Person-centred

Health promotion
Health promotion materials were displayed throughout the ward. This included information on smoking cessation and healthy eating advice.

There were a range of occupational therapy (OT), and activities co-ordinator led activities on the ward delivered by enthusiastic staff. These were well structured and focused on supporting patient wellbeing and skills development. These include access to 1-1 and group cookery and well attended pottery classes. Other activities included television rooms, well maintained grounds and garden area, board games and consoles.

Through patient feedback, there were several comments regarding access and time restrictions in using certain areas of the ward, such as the garden and games rooms. This is due to the need for patients to be accompanied by staff, which can be challenging to facilitate immediately at times of heightened patient acuity on the ward. In order to maintain the patient experience and to prevent challenging behaviours, the health board should reflect on any [time] restrictions in place and should aim to ease these in line with staffing and ward acuity.

The health board should reflect on the access and time restrictions for patients when using certain ward areas, such as the garden and other communal areas, to ensure equitable and appropriate access to areas, such as the garden and games room.

Dignified and respectful care
We observed kind and respectful interactions between staff and patients.

It was positive to find that several environmental improvements to the bedroom areas had been implemented since the last inspection in support of maintaining patient privacy and dignity.

All patients had access to their own rooms, a small number of which were en-suite and others with shared communal bathrooms that were within the immediate vicinity of their room. The rooms were split into male and female corridors. Patients had a fob to lock their bedroom, which could be overridden by staff if necessary. Observation panels were installed on each door, which could be opened and closed by both patient and staff, as needed.

Individualised care
Everyday tasks, such as use of the kitchen and laundry facilities, were available to patients. At the time of the inspection, most patients were independent and were able to make and support themselves with these tasks. Staff confirmed that support would be provided to patients who required any additional assistance.

Unit activities and authorised leave from the ward were based on patient wishes and balanced against individual risks. These arrangements were considered in weekly patient reviews to ensure their on-going appropriateness. Leave was generally well facilitated, but some staff and patient feedback indicated that the dependency and acuity of people on the ward can sometimes restrict the ability of staff to facilitate leave when planned.

The health board should ensure that every effort is made to facilitate [Section 17] leave when planned.

Patients were able to keep mobile phones in their possession, with relevant risk management in place around the use and charging of these devices. Wi-Fi was available on the ward to help patients to stay in touch with friends and family.

Timely

Timely care
We saw patients being assisted and responded to in an overall timely manner, despite the ward caring for several high acuity patients throughout the inspection.

Weekly reviews took place, which included medical, nursing and other healthcare professionals, as required. Patients were invited to these meetings, along with their advocate, where desired. The weekly reviews were found to be well managed, cohesive, and with a good focus on progressing patient care and discharge planning.

Equitable

Communication and language

Some bilingual (Welsh and English) language material was on display throughout the ward. Staff told us that whilst the patient group in the locality mostly preferred to communicate in English, active efforts would be made to speak in Welsh to patients, when applicable and wherever possible. We confirmed that language and other communication needs were recorded in each patients care and treatment plan, and that provision such as Language Line was available for other languages.

Delivery of Safe and Effective Care

Safe

Risk management
Access to the building and ward was secure on the evening of our arrival and throughout the inspection, and staff were observed to follow appropriate procedures when reviewing and providing access to visitors. Visiting space was available off the main ward area, which provided patients and their families with a secure, yet calm space to meet.

The grounds, including the patient garden, were pleasant, well maintained, and free of obvious hazards. Access to other areas of the ward were fob controlled, and patients would be accompanied by staff, as required.

Several environmental improvements had been completed since the last inspection, which included anti-ligature improvements. An anti-ligature audit had been completed and reviewed within the last 12 months, with evidence of mitigation identified and implemented, as required. Staff were aware of the location of the ligature cutters.

Personal alarms were worn by staff, and we observed evidence of the alarms being used and responded to effectively. Whilst call bells were not available in all patient bedrooms, we were assured that patient observations took place and that patients' needs were responded to in a timely manner.

Infection, prevention and control and decontamination
The ward was visibly clean, tidy and well-organised upon arrival and throughout the inspection. The unit was overall well maintained, which enabled effective cleaning and adherence to IPC principles.

Both ward and domestic staff were clear on their roles and responsibilities as they relate to IPC. Cleaning schedules were in place and were generally well completed. Stocks of personal protective equipment were plentiful, and any patient who required barrier nursing could receive this effectively. Sharps were effectively disposed of and stored in an appropriate location.

Examples of IPC related monthly audits were seen to be completed and were overall positively scored.

Safeguarding of children and adults
There were appropriate processes in place to identify, report and monitor safeguarding matters. This included adherence to established health board procedures, and staff had a good awareness of safeguarding relevant to their roles and responsibilities.

We reviewed a sample of safeguarding incidents on the ward. Incidents appeared to be well reported, with appropriate review, referral to the local authority when required, and closure within a suitable timeframe. The ward manager described good input was provided by the health board corporate safeguarding team.

Medicines management
It was positive to find that there was a cautious approach towards the use of high dose anti-psychotics on the ward, and no medications were found to exceed British National Formulary (BNF) limits.

There were regular reviews in place for patients who had been prescribed anti-psychotics. This included use of a side-effect rating scale to evaluate the side-effects that a patient might experience whilst taking this medication. Staff understood their responsibilities towards the physical health monitoring of patients prescribed these medications, both upon and throughout their admission on the ward.

We found the clinic room to be spacious and well-equipped. All drugs were found to be held securely and keys to the clinic and controlled drugs were held by a registered nurse on the ward.

We reviewed a sample of medication charts and found these to be generally well completed when administered, though with some omissions, including:

- Legal status recording / not amended when legal status has changed
- Incomplete patient details, e.g. addressograph labels
- Height and weight recording
- Patient name / ID recording on each page
- Prescription dose changes not always signed.

The health board must ensure that medication charts are fully completed.

We found aspects of controlled drugs (CD) management required strengthening. This included the need to reduce the overall amount of stock held on the ward, which included medication no longer in use, with the need for these to be returned to the pharmacy and / or destroyed appropriately.

The CD register was not found to be an accurate reflection of the CD's held in the clinic. This included some medications that were not logged and some medications that were logged but not stored. **This matter was dealt with under our immediate assurance procedure, which can be found in Appendix B.**

We found that the recently appointed clinic nurse had an overall good knowledge of matters affecting medication and management of the clinic. Qualified pharmacist input was, however, unavailable and was a recognised risk on the directorates risk register. As set out in our immediate assurance table in Appendix B, we recommended that the health board re-evaluates the associated risk on the risk register to ensure that a qualified pharmacist can support this function of the ward and the wider Multidisciplinary team.

It was positive to note that medication errors, including prescribing and administration errors, had reduced. Ward staff described how learning is shared and how changes were implemented in response.

Effective

Effective care

There was an overall effective multidisciplinary team on the ward. There was good medical cover, which included weekly patient reviews, with flexibility to review at other times, as needed. We found ward reviews to be well facilitated, cohesive and with a good focus on discharge planning.

Whilst psychology input was limited to attendance on the ward on a weekly basis, staff confirmed there are occasions where psychological assessments can be provided, when required. However, it was noted that current capacity does not allow for intervention work or longer-term therapy to be provided.

The health board should ensure that its clinical psychology workforce provision is closely monitored to ensure patients are able to receive timely psychological interventions, as required.

Several 'Safeward' principles were appropriately used as a method to reduce instances of challenging behaviours on the ward. Despite the ward designation, there was an overall low use of full physical restraint techniques and other forms of restrictive practice. Staff were aware of the importance of verbal de-escalation, re-direction and other individualised preventative measures to meet the needs of patients. There was evidence of appropriate reporting and review of incidents through DATIX, and staff reported that there was a good feedback loop to capture any learning.

There was good evidence of therapeutic observations being completed, and staff were aware of the need to engage meaningfully with patients. However, we were told, and we observed, during the inspection, some limitations to this when observation levels and ward acuity was high. Staff described that use of agency staff, who may be unfamiliar to the patient group, can add to this. Ward managers were aware of this and made efforts to ensure that agency staff who are known to the ward were allocated, wherever possible.

The ward had several spaces available for patients to have 'quiet time' during or following a period of heightened behaviour. No seclusion facility was available on the ward.

Nutrition and hydration

Nutrition and hydration needs were appropriately assessed using the All-Wales Adult Nutritional Risk Screening Tool (WAASP). There was provision in place to refer to and readily access other services, such as speech and language therapy, if required.

Patients had access to their own kitchen on the unit where they could prepare hot and cold drinks, and light snacks. Access to an Occupational Therapy kitchen was also available for group classes and skills development.

Meals served on the ward looked appetising. Dietary needs and, wherever possible, individual preferences were considered when preparing meals.

Patient records

Patient information and records were found to be securely held on the ward and out of sight from visitors and patients.

At the time of the inspection, there had been a move from paper records to the Welsh Community Care Information System (WCCIS). This transitional phase meant that some paper records had not been uploaded to the system, causing some difficulties for staff to access documentation. We also noted that variable use of agency staff on the ward had increased the unfamiliarity of staff with the new electronic system, thereby increasing their reliance upon substantive staff to maintain records.

The health board must ensure that continued efforts are made to ensure WCCIS is implemented in a seamless, safe and effective manner for all staff to record patient care and maintain effective communication.

Mental Health Act monitoring
We reviewed a sample of patients who were detained under the Mental Health Act 1983 and found their detention to be compliant with the Act. There was documented evidence that patient rights were being upheld in line with the Code of Practice, and patients were regularly presented with their rights, and provided with verbal and written information to this effect.

There were, however, some areas that required strengthening. These included ensuring that:

- All detention papers are accepted on behalf of the hospital managers and in a timely manner
- Nursing staff are reminded of the scope and appropriate use of nurse holding powers (Section 5(4))
- Evidence of patient involvement, wherever possible, regarding Section 17 leave is recorded.

It was positive to note that a member of staff had been appointed to support the Mental Health Act Administrator to develop and continually improve this busy health board wide service.

Monitoring the Mental Health (Wales) Measure 2010: care planning and provision
In the sample of patient records reviewed, we found all patients to be in receipt of a full and comprehensive mental health assessment. This was accompanied by a WARRN risk assessment, which had been reviewed, as required.

There were some omissions to the completeness of physical health assessments, but there was evidence that relevant services and appointments had either been offered or attended by those patients.

Care and treatment planning was maintained to a reasonable standard, but with some key omissions noted, such as fully completed assessments or care plans. **This matter was dealt with under our immediate assurance procedure, which can be found in Appendix B.**

Positively, in one record reviewed, the care and treatment plan clearly reflected and supported this patients individual mental and physical needs. Additional services, such as the optician and dentist had been offered and there was evidence of patient and family involvement in their care. This included access to advocacy services. Overall, an individualised, understanding and compassionate approach to care was well demonstrated.

Quality of Management and Leadership

Staff feedback

Only two staff responses were received to our survey. Due to the low number of responses, it is not possible to include the usual level of feedback in this report. The health board is advised to consider using its own methods for seeking staff feedback.

Leadership

Governance and leadership
The ward was managed by a joint ward management team of two registered nurses. The ward manager that we engaged with during the inspection was experienced and knowledgeable of the matters affecting the ward. There was a good emphasis placed on staff wellbeing.

The approach taken by the ward manager towards staff meetings, including its contents, was of good quality. This enabled an effective flow of information between management and staff, including learning, attendance from external guest speakers, and a positive emphasis on staff wellbeing. This was notable practice.

Governance and oversight processes appeared to enable a flow of quality and safety related information between the ward, divisional managers, and health board level meetings.

Some divisional policies and procedures required review to ensure their continued suitability and reflection of current guidelines. The health board should prioritise this action based on the clinical need of the relevant policy or procedure. This included: rapid tranquilisation, restraint, therapeutic observation, and a review of the extra care policy to ensure that it is appropriately tailored to Felindre Ward. This could include an appendix to the main policy.

The health board must ensure that its divisional policies and procedures are prioritised and reviewed according to their clinical need.

Workforce

Skilled and enabled workforce
We observed a patient-focused team of staff who were working hard to provide patients with a good standard of care. There was, however, a reliance on agency

staff to support the ward. Whilst this helps to provide the ward with safe staffing levels, the staff we spoke with expressed concern that this can often dilute the skill mix on each shift and cause some unfamiliarity and lack of continuity of care with patients.

The health board is advised to continue to be mindful of the balancing exercise that is required when utilising agency staff, and should continue to utilise regular agency, bank or substantive staff, wherever possible.

Mandatory training and appraisal completion rates were generally maintained to a good level. However, some mandatory training areas required strengthening, these included: immediate life support (ILS) and safeguarding level 2. **This ILS training matter was dealt with under our immediate assurance procedure, which can be found in Appendix B.**

Culture

People engagement, feedback and learning
There were opportunities displayed on the ward for patients to provide feedback and to raise any concerns. These included the NHS Wales Putting Things Right process to capture formal concerns and feedback. Information on how to contact external organisations, such as advocacy support, Llais and HIW, were available and also a weekly 'Come talk to us' session with a member of the ward management team.

Despite these opportunities for patients to engage and provide feedback, some patients that was spoke did not feel sufficiently listened to on day-to-day matters. The health board might wish to consider implementing daily morning meetings to foster a reflective and listening space between staff and patients.

The health board should consider if any additional informal methods of engaging with patients are required, alongside existing formal concerns and complaints processes.

Learning, improvement and research

Quality improvement activities
There was evidence of nursing audits undertaken on the ward. These included hand hygiene, environmental, IPC and sharps audits. These were completed monthly, and the outcomes were generally positive. Some areas highlighted by these audits showed improvement where strengthening was needed.

Whole-systems approach

Partnership working and development

The ward team had good internal partnership working, which included crisis and community teams, and external relationships, including the local advocacy service.

We observed a directorate wide commissioning meeting during the inspection, where discussions are held regarding the placement of patients within the health board footprint and out of area. Despite some of the challenges regarding finance and capacity, there was a good emphasis on bringing Powys patients closer to home to receive care.

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
Not applicable			

Appendix B - Immediate improvement plan

Service: Felindre Ward, Bronllys Hospital

Date of inspection: 10-12 June 2025

Findings

ILS training

A review of the Mental Health Quality Assurance Report (May 2025) and the Electronic Staff Records (ESR) system identified that the completion rate for Immediate Life Support (ILS) training among registered staff was 29%. This low compliance rate meant that assurance could not be provided that a sufficient number of appropriately trained staff were available on each shift, to respond effectively to a medical emergency.

Although ward management had taken steps to book some staff onto the next available ILS training courses, the risk remained present at the time of the inspection. This was particularly concerning given the vulnerability of the patient population and the isolated location of the unit, with only minimal mitigation measures in place.

Furthermore, the inspection highlighted the need for the health board to strengthen ILS training compliance across other inpatient mental health services, specifically within Tawe and Clywedog Wards. The health board is required to provide broader assurance regarding its efforts to improve timely access to ILS training and to outline any interim mitigation strategies currently in place.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	The health board must ensure that staff are able to access ILS training in a timely manner and that robust interim mitigation measure have been implemented.	Safe Care	PTHB fully understands the importance of ensuring staff are adequately trained and prepared to respond to medical emergencies in MH settings. To this end the HB has recently recruited an experienced GP with extensive emergency and acute care experience into a full-time	ILS lead / In Patient Service Manager	

	Broader assurance, at a divisional level, must be provided in relation to all three mental health inpatient wards.		resuscitation officer post. To provide assurance to HIW regarding resuscitation training matters we can report that: 1. 3 qualified staff are fully ILS compliant, with another 3 booked on ILS training between now and the end of August. There are no spaces in September, however a further 3 are booked in October, 3 in November and 2 in January. This covers the whole of the team and 100% ILS compliance will be achieved within 6 months. We will continue thereafter with rolling month on month audit and booking before expiry dates. In the interim, the rota will be managed as a mitigation until full compliance, with additional mitigation of medic cover (inc on call) for rapid tranquilisation. 2. ILS training for PTHB staff is provided through a commissioning agreement with CTMHB. As training dates and capacity is fixed we have mitigated the risk of ILS non-compliant staff by arranging 2 half-day bespoke resuscitation training events for our MH staff in July. The courses will be delivered by the PTHB resuscitation officer and include AED use, airway adjuncts,		October 2025 - 64% compliant November 2025 - 80% compliant January 2026 – 100% compliant July 2025

			manual ventilation, CPR and the management of medical emergencies using the A-E approach as per RCUK ILS course content. These courses, delivered in a clinical rather than classroom setting, will ensure all out of date ILS staff will receive resuscitation and scenario training whilst awaiting attendance on a formal RCUK accredited course. 3. Similar bespoke training is planned for Clywedog and Tawe. PTHB will shortly have a new Resuscitation policy and will be undertaking a training needs analysis to ascertain the appropriate level of life support training for our teams.		Trajectory of improvement with 100% compliance by January 2026

Findings

<u>Controlled Drugs (CDs)</u>

A review of the safe use and management of Controlled Drugs (CDs) identified several areas of concern:

- Discrepancies in stock levels, including both omissions and surplus stock, with no clear rationale.
- Inadequate monitoring of CDs entering and leaving the ward, including patients' own medications brought in on admission.
- The use of two CD registers instead of a single, consolidated record.
- Excessive, unsegregated stock awaiting collection and destruction by the pharmacy department.

The nurse currently overseeing the clinic had only recently assumed this responsibility and was aware of the issues. However, there was a notable lack of pharmacist input on the ward. Although a pharmacy technician attended, their role was limited in scope. The health board had acknowledged this gap in pharmacy support, and the issue had been recorded on the divisional risk register.

The health board must undertake a comprehensive review of its processes for managing CDs on the ward. It should also re-evaluate the associated risk on its risk register, particularly the absence of a dedicated pharmacist to support this function and other activities that would benefit the ward and the wider multidisciplinary team (MDT).

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
2.	The health board must ensure that CDs and their on-going management at Felindre ward is reviewed. This must include a re-evaluation of the associated risk (re: registered pharmacist input) on the risk register.	Safe Care Controlled drugs: safe use and management NICE guideline RCPYSCH: Standards for Inpatient Mental Health Services	In response to the safe use and management of Controlled Drugs (CDs) which identified areas of concern, the following actions have been identified but some clarity may be required as follows: Issue: Discrepancies in stock levels, including both omissions and surplus stock, with no clear rationale: Response: Some discrepancies have been noted as PTHB were destroying the CDS - these have been added to the CD book and now destroyed, the CD cupboard has also been tidied. However, PTHB would be grateful of clarity/detail from HIW of which medications HIW are referring to in order to provide a robust response. Pharmacy review on 15.06 did not highlight any additional discrepancies. [RESPONSE PROVIDED TO HEALTH BOARD] A rapid review has noted that medication errors within the CD book should be	Pharmacy lead / Ward Manager	June 2025

			recorded with brackets, rather than crossed out, with an asterix to correspond. A memo has been shared with staff reiterating the processes that should be followed. This will be monitored. Issue: Inadequate monitoring of CDs entering and leaving the ward, including patients' own medications brought in on admission. Response: The ward do not normally stock schedule 2 controlled drugs (requiring CD register entry), but a recent patient had been on the ward requiring MST 15mg – both patient's own and stock was found on the ward but wasn't correctly documented in the register. The patient has now left the ward and so the patient's own MST was destroyed (with register entry) and the stock MST 15mg is being removed by Pharmacy to Llewellyn ward, where it is more likely to be used (in the interim it has been added to the Felindre ward controlled drug register). Additionally, staff have been advised that they need to open up TTOs when sent from pharmacy and record these in the CD book also. This will be regularly reiterated. Issue: The use of two CD registers instead of a single, consolidated record. Response: Ward staff and the pharmacist were unable to locate a second CD register - there is a CD register book inside the CD		June 2025 June 2025 June 2025

			cupboard. Within the CD small cupboard, there is a book which is used to record the disposal of any DLMs. There is an additional book which is used for the CD stock check - this is in line with what the policy requires, however Pharmacy have identified that there is potentially more recording than needs be, and that Medicines management colleagues are going to review the headings for this book to streamline it to indicate that a stock check has been undertaken. [CLARIFICATION PROVIDED TO HEALTH BOARD] There are 2 CD ordering books kept in the clinic - this is the recommendation of medicines management, as it allows for continued ordering of CDs, when one book has already been sent to the pharmacy for ordering. Issue: Excessive, unsegregated stock awaiting collection and destruction by the Pharmacy department. Response: All DLMS/CDS have been disposed of by Pharmacist and Ward manager within the meds management team. It is noted that PTHB are keeping all DLMs for destruction (as per medicines management guidance), however there is a		June 2025 June 2025

			potential that they are keeping them all separately, when there may be a means for us to store them in pots where all the same medication is required. This is under review and this action plan will be updated to reflect outcomes/recommendations from the review. The requirements from Medicines management, is that they are able to confirm the number of each of the medications that are required to be destroyed as DLMs. The MH&LD Division have ensured that weekly ward audit and monthly Ward Manager audit review the CD drugs cupboard and book. Issue: The nurse currently overseeing the clinic had only recently assumed this responsibility and was aware of the issues. However, there was a notable lack of pharmacist input on the ward. Although a pharmacy technician attended, their role was limited in scope. The health board had acknowledged this gap in pharmacy support, and the issue had been recorded on the divisional risk register. The health board must undertake a comprehensive review of its processes for managing CDs on the ward. It should also re-evaluate the associated risk on its risk register, particularly the absence of a dedicated pharmacist to support this function and other activities that would benefit the ward and the wider multidisciplinary team (MDT)."		June 2025

			Response: The risk register will be updated in SMT on the 25.06.2025 and will escalate lack of input as part of Directorate oversight requirements. A Pharmacist will work with Ward Managers as escalation is considered in respect of lack of sustainable Pharmacy input.		

Findings

Management of complex patients
Note: Specific patient details have been removed prior to publication to maintain confidentiality.

A review was undertaken of a sample of clinical notes. This [REDACTED] The patient's WARRN risk assessment identified multiple concerns, including a risk of self-harm. Despite these risks and [REDACTED], there was no care plan in place.

Additionally, physical health checks were found to be only partially completed, despite the presence of relevant risks indicated both in the patient's presentation and within the WARRN assessment.

The health board must ensure that all patients, particularly those with complex physical health needs, have a care plan in place from the point of admission. These care plans must be appropriately developed and maintained to address the individual needs of each patient.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
3.	The health board must ensure that all patients, particularly those with complex physical health needs, have an appropriate care plan in place that considers both physical and mental health needs of patients.	Safe / Person Centred Care	For the patient identified on the ward in relation to the improvement stated as needed, an immediate review has been undertaken and there is clear evidence [they were] reviewed regarding [their] mental and physical health regularly. [REDACTED]	June 2026	

			… these had not been integrated into the CTP care plan. On admission or when indicated a physical health care plan will be completed within 24 hours and physical health complexity and co-morbidity inclusions will now be included as part of care plan audits (monthly)		

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): **Paul Hanna**

Job role: **Head of Nursing MH**

Date: **18 06 25**

Appendix C - Improvement plan

Service: Felindre Ward, Bronllys Hospital

Date of inspection: 10-12 June 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.	Page 10 of report	The health board should reflect on the access and time restrictions for patients when using certain ward areas, such as the garden and other communal areas, to ensure equitable and appropriate access to areas, such as the garden and games room.	Patient experience	Increased access to the Garden and Game Room has been agreed. A member of staff will be allocated to enable observed garden access between the hours of 6am (except for protected mealtimes) and midnight. The observational aspect of the garden is in reflection of recent procedural and relational safety	Ward managers Service Managers	September 2025

				incidents; this is also supported by CCTV. Work is being undertaken to review the structure of the furniture and the anti-climb fixtures to ensure that these risks are mitigated.		
2.	Page 11	The health board should ensure that every effort is made to facilitate [Section 17] leave when planned.	Patient experience	Standard operational procedure in relation to section 17 leave across the mental health service will be agreed. A daily process to ensure patients are aware of their section 17 status, and availability to access section 17 leave and how this may be facilitated will be agreed. This will additionally form part	Service Managers. Ward managers. Responsible clinician.	September 2025

				of the weekly 1:1 named nurse sessions. Safe staffing will be considered to support section 17 leave safely. Monthly audits will be used to review compliance with section 17 leave.		
3.	Page 14	The health board must ensure that medication charts are fully completed.		Safety notice shared with all medical and registered nursing staff to remind them of the need to ensure that medication charts are fully completed. Charts will be reviewed weekly in ward round and any issues immediately rectified. The need for a dedicated Mental	Ward managers. Responsible clinician. Pharmacy Clinical Director for Mental Health	August 2025

				Health Pharmacist is on the Divisional risk register and the Assistant Director for Mental Health is meeting with Pharmacy colleagues to consider how this can be taken forward.		
4.	Page 15	The health board should ensure that its clinical psychology workforce provision is closely monitored to ensure patients are able to receive timely psychological interventions, as required.	Patient experience	Strategic Workforce planning for Psychology services is ongoing but recent recruitment success to what have been long term vacancies will improve the current position. Mental Health and Learning Disability (MH&LD) Division has developed an investment business case seeking additional capacity for complex emotional needs workers to in reach to	Asst Dir MH&LD/Head of Psychology	Sept 2025

				inpatient settings. It will be submitted to the Investment Business Group panel in August 2025 and if successful will then move forward for Executive decision.		
5.	Page 16	The health board must ensure that continued efforts are made to ensure WCCIS is implemented in a seamless, safe and effective manner for all staff to record patient care and maintain effective communication.	Safe care	The WCCIS digital system is fully integrated on all of the mental health inpatient facilities. All staff have completed the online training and are evidencing competency in the use of the system. There is a responsive system in situ to assign regular agency staff members access to WCCIS, however additional work is required to facilitate seamless access for Ad	WCCIS lead. Head of MH Operations.	Complete September 2025

				hoc agency staff members.		
6.	Page 18	The health board must ensure that its divisional policies and procedures are prioritised and reviewed according to their clinical need.	Safe care	The mental health Quality and Safety team Chair monthly Clinical Policy Advisory Group (CPAG) which includes Team leads and relevant service managers to review and implement policy documents. There is a policy tracker in place which is utilised by CPAG to ensure policies are developed or reviewed in order of priority. Following the HIW inspection the tracker was reviewed from the perspective of divisional policies specific to Felindre to re-prioritise where appropriate.	Quality and Safety lead Senior Management Team	Complete.

				SMT receive a Monthly update in the Quality, Assurance, Integrated Learning and Safety (QUAILS) meeting		
	Page 19	The health board should consider if any additional informal methods of engaging with patients are required, alongside existing formal concerns and complaints processes.	Patient experience	The mental health quality and safety team hold monthly putting things right meetings (PTR). PTR supports services to address concerns, early resolutions and Datix, so themes and trends are acted upon, and service improvements are implemented. The Patient's Council (facilitated by PAVO) attend Felindre unit on a monthly basis providing a confidential space for patients to discuss any issues, raise concerns	Quality and safety lead. Ward managers. Mental health partnership lead.	September 2025

				and provide feedback on their experience. IMHAs attend the ward on a weekly basis to offer support and Advocacy to patients. The ward managers hold a 'catch up and a cuppa space' weekly to enable patients to discuss concerns and feedback any issues or ideas. Staff will offer patients time to 'debrief' following any incidents or altercations on the unit to capture any concerns and offer reassurance. Patients debrief to be included within the development of a		

				standard operational procedure. Felindre unit also use PROMS. A Recovering Quality of life (ReQoL – Patient Reported outcome measure PROM) is offered for completion at the point of admission and prior to discharge.		

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): Louisa Kerr

Job role: Assistant Director MH&LD

Date: 28/07/2025