Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report
(Unannounced)
Cemlyn Ward, Ysbyty Cefni, Betsi Cadwaladr 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 Ysbyty Cefni, Betsi Cadwaladr University Health Board from 28 to 30 July 2025. The following hospital wards were reviewed during this inspection:

- Cemlyn Ward - 13 beds providing mental health services for older people.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of three questionnaires were completed by patients and four by families and carers and 20 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:
The inspection of Cemlyn Ward at the hospital revealed a positive patient experience, with feedback from patients and families highlighting compassionate care, a calm atmosphere and respectful staff interactions. Although the number of responses was limited, comments praised the ward's cleanliness, infection control and the supportive environment, describing it as having an "extended family feel".

The ward was clean, well-maintained and appropriately staffed. Patients had access to private and communal spaces and their dignity was respected during care. However, some incidents of medication administration in communal areas raised concerns about privacy and dignity, prompting recommendations to ensure treatment was delivered in private settings.

Health promotion was evident through accessible information and activities. Patients could use outdoor spaces, though some areas required safety improvements. A sensory garden was planned but not yet usable due to trip hazards. The activities coordinator provided a varied programme, though potential gaps existed during weekends and leave periods.

Communication was inclusive, with bilingual signage and many staff able to speak Welsh. Patients were supported to communicate in their preferred language, enhancing their comfort and engagement. Staff were encouraged to wear the 'iaith gwaith' logo to identify Welsh speakers, though not all did.

Individualised care was promoted, with patients making choices about their activities and personal care. Staff feedback indicated challenges with staffing levels and resources, affecting their ability to meet all patient needs consistently.

Equality and rights were upheld through accessible facilities and respectful care practices. Staff demonstrated awareness of diversity and inclusion, supported by training and policies.

This is what we recommend the service can improve:

- All secure outside areas are made safe and available for patients to use
- Patients' dignity and respect is considered when treatment is given to them which should not be done in a communal area.

This is what the service did well:

- Staff engaged positively with patients
- Patients interacted, in the activities room, with both the activities coordinator and each other
- Individualised care was promoted, with patients making choices about their activities and personal care.

Delivery of Safe and Effective Care

Overall summary:
The ward had a generally safe and effective care environment, with staff demonstrating warmth, respect and professionalism. The ward was clean and well-maintained, though some maintenance issues, such as a broken shower and furniture, required urgent attention. Infection prevention and control (IPC) practices were mostly upheld, but inconsistencies in cleaning schedules and lack of clinical waste bins posed risks.

Safeguarding procedures were robust, with staff knowledgeable and confident in reporting concerns. Families and patients felt supported and informed. Medical equipment was appropriately managed and ligature risks were audited. Medicines management was mostly compliant, though issues with controlled drug storage, unsecured medication trolleys and temperature regulation in the clinic room were noted.

Care delivery was effective, supported by strong multidisciplinary teamwork and a positive ward culture. Staff valued their roles but felt understaffed at times. Restrictive practices were used minimally and appropriately, with clear documentation and post-incident debriefs. Nutrition and hydration needs were well met, with personalised care and dietary assessments in place.

Patient records were comprehensive, reflecting best practice under the Mental Health Measure (Wales) 2010. Care and treatment plans were person-centred, regularly reviewed and included physical, social and spiritual needs. Discharge planning was thorough and collaborative, involving families and community teams.

Mental Health Act monitoring was compliant, though documentation practices could improve. Advocacy services were accessible and active. Paper-based records were well-organised but bulky, staff recommended transitioning to electronic systems for efficiency and data security.

This is what we recommend the service can improve:
- Ensuring maintenance issues on the ward are resolved in a timely manner
- Controlled drugs are secured as required.

This is what the service did well:

- A commitment to safe, effective and person-centred care
- Patient records reflecting best practice under the Mental Health Measure
- Meeting nutrition and hydration needs.

Quality of Management and Leadership

Overall summary:
The inspection revealed a mixed picture of staff satisfaction and operational effectiveness. Whilst most staff felt patient care was a top priority and praised the ward's compassionate culture, concerns were raised about safety, staffing levels and communication with senior management.

Leadership structures were clear, with regular ward visits by the Matron and daily safety huddles were in place. However, visibility and engagement from senior management were limited. Staff felt supported by immediate managers but needed more feedback and involvement in decision-making.

Staffing levels were generally adequate, with efforts underway to recruit more permanent staff and reduce reliance on bank and agency use. Training compliance varied, with mandatory training completion ranging from 67% to 95%. Whilst most staff felt adequately trained, they requested more specialised training in areas, such as palliative care and brain injury. Appraisal rates were low and regular staff meetings were lacking.

The ward demonstrated a positive culture, with staff feeling supported and able to raise concerns. However, formal mechanisms for patient and family feedback were absent. Incident reporting was encouraged, but feedback on outcomes was limited. The Duty of Candour was understood, though training on it was undocumented.

Information governance was mostly secure, though patient notes were not stored in locked cabinets. Quality improvement initiatives, such as the 'Response' system for flexible staffing, were in place but lacked formal documentation. Discharge planning was led by deputy managers due to the absence of a discharge coordinator.

Partnerships with community teams supported patient transitions, aiming to reduce admissions and ensure continuity of care.

This is what we recommend the service can improve:

- Improvements in feedback systems
- Holding appraisals annually and improve compliance
- Keeping patient notes securely in a locked cupboard.

This is what the service did well:

- Strong commitment to patient care
- Partnerships with community teams supported patient transitions
- Training compliance.

3. What we found

Quality of Patient Experience

Patient feedback

We received questionnaire feedback from three patients, responses were generally positive, but due to the low number of replies, we were unable to draw any definitive conclusions.

Patient comments included:

> ***"I enjoy the activities here."***
>
> ***"I don't like the food here."***

We received questionnaire feedback from four members of the family or carers of the patient, most of the comments were positive. They all rated the setting as very good and that infection and prevention control measures were being followed and that the setting was very clean.

We received some positive feedback through the questionnaires from families or their carers who commented:

> ***"This hospital should be praised. Families should be privileged that they can access care here. I think the ward should be recognised for the outstanding quality of care and support provided here to patients and family members. Cefni hospital has saved {relation} and has saved me. The ward manager always explains everything to me in terminology I understand. I always feel listened too."***
>
> ***"I am very pleased with the care here. My {relation} is happy and is calm and relaxed here. I have no concerns and am extremely happy with the care provided here."***
>
> ***"On hearing of so many families being affected by their loved ones being placed so far from their home, we feel very privileged to be able to have a place on the ward. This is then reinforced when all the Staff are extremely kind, helpful and supportive to all patients and their visitors alike, including the cleaners, porters and all admin staff too. It really has an extended family feel about it."***

Patients and families, we spoke with also commented positively and said:

"I felt like I won the lottery."

"Calming atmosphere."

"The care is very good here as are the staff."

Person-centred

Health promotion
Patients who used the service were able to access information to help promote and improve their health and lead a healthy lifestyle. Information on healthy eating and smoking was evident alongside relevant health promotion initiatives for patients where appropriate.

There was patient access to a games room with appropriate and well-maintained games, toys and equipment. The outside space used was well-maintained and presentable with evidence of use of a ball game and well-maintained outdoor plants. Staff confirmed the door to access the outside space was open as weather permitted and it was up to patients to decide on when and how they accessed this space. However, the canopy in this space needed repair. There was also a second outside area, we were told there had been a plan to make this a sensory area but was not used due to the risks of tripping and uncertainty as to whether the floor covering was anti-slip. It was a larger outdoor area that should be used by patients.

The health board must ensure that all outside areas are secure, made safe and always available for patients to use as appropriate.

Dignified and respectful care
Staff were noted supporting patients calmly, quietly and with kindness. Staff engaged positively with patients and they were clearly familiar with one another. Where needed, patients were supported with personal care needs in a dignified and sensitive way. Patients were calm and fully dressed during the day.

In the staff questionnaire, all but one respondent felt that patients' privacy and dignity was maintained and most were satisfied with the quality of care and support given to patients.

Not all patients were accommodated in their own rooms, but all patients could personalise their own space with photos and pictures and carrying their own items for comfort. They also wore their own clothes and there were appropriate systems

in place to wash clothes, either by staff using the laundry room or families or carers taking any used clothing home.

The breakfast club run by the activities coordinator was a positive example of promoting independence and developing skills and patients could access a telephone, which we observed was a source of comfort to them.

We observed patients interacting, in the activities room, with both the activities coordinator and each other, painting the windows with a religious design. The activity coordinator felt this was therapeutic and supported patients' spirituality as there was no visiting chaplain or access to religious materials. However, we were told there were plans underway to engage with a local chaplain so patients could access their service.

The activities available were varied with indoor and outdoor games, a television, plants and a timetable to suit patient needs. The activities coordinator also noted the current patient cohort did not enjoy group activity and had worked hard to try to please all patients within the timetable.

The activities coordinator provided a seven-day timetable but worked five days a week. Weekend activities were managed by nursing and healthcare staff. When the activities coordinator was on leave and during weekends, other staff handled the activities, therefore meeting the timetable was inconsistent due to other competing priorities.

A confidential 'patients' safety at a glance board' was kept out of patient and family view in the nurses' station, with information obscured from sight.

Patients we spoke with felt they were treated with dignity and respect, were generally happy with the care received and felt familiar with staff. Whilst not all patients could clearly communicate their feelings or thoughts to us on the care received, we witnessed positive interactions. Family, patients and staff all fed back positively about the care provided and as reflected in the survey responses. Patients noted they felt safe, families felt listened to and staff felt supported and happy within their work.

Staff stated that prior to COVID-19, transport was available at the hospital to take patients out of the setting. However, this was no longer available as the current vehicle was smaller and no longer appropriate. Staff indicated a preference for patients to have the opportunity to leave the facility. We were told that the van was due to be changed and the ward manager planned to request a larger vehicle with more seats, so patients could be taken out of the hospital and to other appointments, without reliance on ambulance transport.

Individualised care
Patients were supported to make their own decisions about how they cared for themselves, promoting their independence and quality of life. They were also supported with walking aids as appropriate. Patients were heard communicating what they felt comfortable with and how they wished to be supported by staff, for example in directing staff which activity they wished to carry out.

In total 65% of staff who responded to the questionnaire agreed they could meet the conflicting demands on their time at work but fewer, 55%, said that they had adequate materials, supplies and equipment to do their job. Additionally, only 30% felt that there were enough staff to do their job properly. Half the staff agreed they were able to access IT systems to provide good care and support for patients, but only a quarter agreed they were involved in deciding on changes introduced that affected their work area. One comment received from staff included::

> ***"Staffing levels need to be reassessed as not enough staff on duty per day to do patients personal care needs, behavioural needs - patient care can be neglected if staff are called to support patients that become challenging and need 3:1 support. Feedback from management for all staff on how their progress is - some staff feel as if they're just a number."***

The health board must reflect on staff feedback regarding staffing and consider reviewing the establishment to ensure patient needs are met in a safe and timely manner.

Timely

Timely care
Patients received care, advice and treatment in a prioritised and timely way. We saw staff providing person centred care with kind, gentle and personalised interactions evident. Prompts and guidance were given by staff to patients to support needs and manage moods and behaviour.

We observed one patient receiving medication in a timely manner and whilst the patient was reluctant to take the medication, the nurse and HCA managed the situation well by providing reassurance and patience. However, this was in the communal dining room in the presence of another patient and a family and carer. There was also another incident observed where a patient's top was raised to administer a medication. Both instances impacting patient privacy and dignity.

The health board must ensure that patients' dignity and respect is considered when treatment is provided and this should not be carried out in communal areas, except in emergency situations.

Equitable

Communication and language

The ward provided information to patients and communicated in a way that was clear, accessible and in a manner appropriate to their individual needs. This enabled them to make informed decisions about their care.

There were appropriate processes in place to enable patients to communicate in a language of their choice and to ensure they were able to make informed decisions about their care. Staff we spoke with understood the importance of speaking with patients in their preferred language supporting the delivery of good care.

There were bilingual signs, posters and reading material available for families and carers. We saw appropriate signage about the 'active offer' and many staff were Welsh speakers or had a knowledge of various Welsh phrases. However, not all Welsh speaking staff wore the 'iaith gwaith' logo to highlight their ability to converse in Welsh. Non-Welsh speaking staff could access Welsh language training and we were told that a health board 'learner of the year' winner worked on the ward.

Sixteen staff responses to the questionnaire were Welsh speakers, but most said they did not wear the 'iaith gwaith' logo or lanyard. Most also said they actively used the Welsh language in everyday conversations and patients were asked to state their preferred language.

We observed staff and patients speaking in Welsh. Staff were also seen speaking Welsh to visitors, including families and carers. It was evident that Welsh speaking patients benefitted from conversing in Welsh to staff and many of the patients we spoke with chose to speak in Welsh.

The health board must ensure that all Welsh-speaking staff wear the 'iaith gwaith' logo as applicable.

Rights and equality

There were reasonable adjustments in place so that everyone could access and use services on an equal basis. The ward was on one level with equipment available to mobilise patients and wide, open doorways and other spaces further supported this.

Staff treated patients with kindness and respect and in a quiet way, using relevant communication as appropriate.

There was a dedicated visitors room with a pull-out bed that families could use to stay overnight if required. There were also designated places for patients to meet with family and friends away from their bed area. An appropriate room was also available nearby, for patients to meet with their young visitors, such as grandchildren.

Information was available that informed patients of their rights and how to raise any concerns or issues.

Delivery of Safe and Effective Care

Safe

Risk management
There were relevant processes in place to protect the health, safety and wellbeing of all who used the service. The ward appeared to be clean and tidy and the atmosphere quiet and calm. Staff were observed interacting with patients in a warm, patient and respectful manner. Staff were also open and engaging with us during the inspection.

The personal safety alarms available for staff were not used. If staff are not using these, then an appropriate rationale must be provided and documented.

The health board must risk assess the use of personal safety alarms and address non-compliance if appropriate.

Nurse call bells were accessible to patients for those who needed them and were present in bed areas and toilets.

The environment was open plan and staff had good oversight of patients with appropriate fire safety arrangements in place.

Infection, prevention and control (IPC) and decontamination
The environment, policies and procedures, staff training and governance arrangements generally upheld standards of IPC. Equipment was stored and organised appropriately. However, there were no dates present on the disposable curtains, although they appeared to be clean. The bathroom appeared clean, along with patient's individual areas. Most furniture was well maintained, with wipeable chairs in place in the two main social areas.

The health board must ensure that the disposable curtains are marked with a date the curtains were hung, to ensure they are replaced in a timely manner, or sooner if soiled.

Staff explained that one of the two bathrooms was out of order and had been for several months. This was considered unacceptable in an older adult setting with 13 patients, many of whom periodically require increased support. We also noted other minor issues that needed rectifying, which were discussed with the ward manager. This included a broken light switch in a communal toilet and some broken furniture awaiting removal as well as some trim missing between the flooring and wall close to the nurse's office.

The health board must ensure that the shower/ bathroom is repaired promptly and that all maintenance issues are addressed in a timely manner.

Housekeeping and ward staff had access to an adequate supply of cleaning and disinfectant products. There were two separate cleaning schedules in use, though neither was fully completed, however, the ward appeared clean. There was some confusion about which schedule should be completed. This was addressed and resolved during the inspection.

The health board must ensure that a standard cleaning schedule is used and staff are aware of its existence and is completed by staff as appropriate.

We saw evidence that sharps, were disposed of safely in appropriate sharps bins, which were not overfilled.

Staff we spoke with said there was sufficient personal protective equipment (PPE) on the ward and we saw staff wearing PPE during close care with patients. However, in our survey, one member of staff said:

> ***"…. The ward does supply PPE but not [all] around the ward, so unless you have PPE on you, you have to make do, as everyone tends to be on a 1:1 or there's no one around to ask for help…."***

The health board must ensure that staff have easy access to PPE in all areas of the ward.

There were hand hygiene facilities available for staff, patients and visitors, such as sinks and alcohol gels throughout the ward and with bilingual signs displayed above each sink on the correct handwashing procedure. Patients were encouraged and supported by staff to practice good hand hygiene.

We noted appointed IPC leads and a current IPC policy was in place, which staff knew how to access. Staff we spoke with understood their role and responsibility in upholding IPC standards. Staff clearly described IPC issues and action need to minimise infection risk, including segregation of patients, to prevent cross contamination.

In the staff questionnaire only half the respondents felt the organisation implemented an effective infection control policy, though, 75% felt there was an effective cleaning schedule in place. Only 25% of respondents felt the environment allowed for effective infection control. Staff comments included:

"…… Infection control is in place but no adequate bins on Ward due to incident arose on other establishments - therefore staff are having to carry bags with them for soiled items to carry through ward…."

"We need bins back to improve cleanliness of the ward."

"Due to recent changes in policy, we are now unable to have clinical waste bins or rubbish bins in patient facing areas on the ward. Due to the patient group this poses an infection risk as contaminated items are left in inappropriate areas."

"We have no clinical waste bins in any patient areas. this greatly effects the way in which we [can] give personal care. There are ant nests on the ward year after year... I feel the whole ward is not clean. There is only one domestic [staff], trying to do the job of two people. A lot of the furniture should be condemned due to its poor condition."

"The staff here work very hard under some very difficult times, sometimes there is no support. There are no bins on the ward which leaves the place untidy at times and at high risk of infection. There is no place for staff to leave water bottles… and there is nowhere for staff to get a drink, it gets very hot and stuffy on the ward. Sometimes staff get treated like they don't know the patients and it's them who are with them most. A member of the HCA team should be allowed to [attend] the ward round and give their input."

It was noted that risk assessments had been conducted, including the identification of measures to reduce the risk of asphyxiation involving plastic bags. In response, all bin liners and plastic bags were removed from the ward. However, staff have raised several concerns regarding the absence of bins and the ability to appropriately manage IPC

The health board must carefully evaluate both the risks and benefits associated with removing a significant number of bins from the ward, whilst considering potential impacts on infection prevention and control and implement appropriate measures to address both considerations.

Safeguarding of children and adults

Staff we spoke with were fully aware of safeguarding issues and where to find relevant procedures online. The ward team had regular contact with the safeguarding team and could easily contact them for safeguarding advice if necessary. Staff were also made aware of the whistleblowing process as part of the staff induction process.

Families we spoke with said they were encouraged to discuss any concerns with staff and there were notices on the ward highlighting this. We spoke with the family of one patient, who felt very confident the patient was being looked after extremely well. Patients we spoke with were also aware of how to report concerns.

Any safeguarding incidents or referrals were discussed at a ward level on handover. If a referral was made, an electronic Datix incident was also completed and investigated. We were told that senior staff had oversight of safeguarding concerns and the ward shared learning from safeguarding investigations.

Safeguarding issues had also been considered for children and families who may visit.

Any conflict between patients would be managed on the ward by using the 'response' observation levels. Staff outlined a recently implemented initiative involving the release of staff from one-to-one observations when the patient was settled, using a process referred to as ‘response’. This allowed the staff member to participate in other activities or administrative duties when observation was not required. This approach was currently being trialled on Cemlyn Ward with the agreement of the hospital Matron.

Each patient’s observation level was assessed and time spent not under close observation was considered equally important. Enhanced patient independence gave the patient space and time, whilst ensuring the patients were checked regularly and changes in behaviour could result in increased observations.

Management of medical devices and equipment
Shared equipment and reusable medical devices were decontaminated appropriately and appropriate cleaning labels were used to identify clean equipment.

Staff had access to specialist patient equipment like hoists, slide sheets and pressure relieving items, such as air mattresses.

A comprehensive ligature risk audit had been completed, with the next one due in September 2025. All staff we spoke with knew the location of ligature cutters for emergencies.

Oxygen storage complied with regulations and guidance. Records showed that maintenance checks of oxygen supply occurred, along with weekly checks documenting available oxygen in the medication room.

Medicines management
Medication was stored in a clinical room, known as the clean utility. Adequate emergency drugs and equipment were in date and regular checks were recorded. There was a system in place to replace expired drugs and equipment.

The patient cohort had limited capacity, therefore, staff were observed talking to them sensitively about their medication. Patients had individualised medication management plans, which were discussed weekly during ward rounds.

All Wales Drug Charts were completed and the sample of four patient records checked were completed appropriately. All drug charts had a picture of the patient to identify them and had their legal status also recorded on the front page. The administration of medicines were recorded consistently and contemporaneously during medication rounds. Medications were taken to individual patients and signed on return to the medication room.

The health board medicine management policy was overdue its review at the end of December 2023.

The health board must ensure that the medicine management policy is reviewed in the appropriate designated timescale.

All medications, including controlled drugs (CDs), were kept in a locked clinical room. However, CDs were placed in an unlocked internal cupboard inside a larger locked cupboard, as the internal lock was missing. The outer cupboard contained drugs exempt from CD storage requirements, though local policy mandated secure storage. Storing CDs in an unlocked cupboard violated legislation, However, all CDs were accurately tracked in the CD register, correctly signed and subject to regular stock checks.

Temperature records showed the clinical fridge occasionally exceeded safe medication storage limits in line with pharmaceutical recommendations. In addition, the clinical room's ambient temperature records showed this often rose above 25°C but lacked air conditioning to cool it. Installing temperature control would help maintain appropriate conditions for both the room and fridge.

The health board must ensure that:

- **Controlled drugs are securely in line with legislation**

- **An appropriate system is installed in the room containing medication to ensure that the fridge and room temperatures stay within appropriate ranges to maintain the viability of medications.**

We noted that the keys to the medication cupboards and containers were kept securely by the nurse in charge.

We noted that there was medication dispensing equipment, known as 'Mediwell' stored in the hospital, for the ward but was not installed and with no known installation date. The installation of this would maintain the security of medications and may also help with appropriate temperature regulation of medication, depending on model installed.

The health board must ensure that the work to progress the installation of the 'Mediwell' medication dispensing equipment is prioritised to support the management of medications on the ward.

Effective

Effective care

The ward had systems in place to support safe, effective care and staff generally had time to deliver care safely, particularly since the implementation of the new 'response' system. However, staff still felt there was not enough time for effective care or complete documentation to a high standard and believed more registered nurses were needed. All staff spoken with said how they valued their team and took pride in their work.

All staff that we spoke with said there was effective team working and collaboration. The patient had a nominated nurse known as a 'primary care nurses' who attended ward rounds for their patients. Staff were grateful for their multidisciplinary team (MDT), which they said worked particularly well. There was a strong sense of team spirit among ward staff and other staff assigned to the ward. One staff commented:

> ***"Betsi Cadwaladr University Health Board treats staff and patients very well."***

We noted that the responsible clinician (RC) regularly attended MDT meetings and case reviews for patients and was evidenced in patients' notes.

Clinical audits had taken place on the ward to improve clinical practice.

Safe and therapeutic responses to challenging behaviour

Patient’s individual needs were considered in the prevention, planning and use of restrictive practices in response to challenging behaviour. The ward clearly upheld standards of safe and effective care in-line with national guidance and the Code of Practice.

There were measures in place to reduce the need for restrictive practices, these included therapeutic activities, access to outside space, exercise, quiet areas and patient involvement in care and treatment plans.

The patients had a 'This is Me' booklet which contained information about the patient as a person in their everyday life. This was effective in providing person-centred care and minimising behaviours that communicated distress. The care and treatment plans included strategies for managing challenging behaviour which were regularly reviewed.

There was an in date restrictive practices policy, observation policy and restraint policy.

From our observation and review of patient records, we found staff only used physical restraint as a last resort. Occasions involving restraint generally occurred in response to violence and aggression, which were sometimes triggered during the provision of personal care to patients, who were unable to understand why staff were attending to their personal needs. The patients' notes clearly documented physical interventions, which were reviewed regularly by the MDT.

All staff were trained in carrying out safe and supportive observations and the ward did not use seclusion. Where restraint had been used, staff and patients received a de-brief where practicable. Staff received managerial supervision and regularly engaged in peer support.

All clinical incidents and episodes of physical restraint were reviewed weekly in an Integrated Concerns Operational Panel sub meeting where lessons learned were discussed and cascaded to ward staff.

Nutrition and hydration

Our patient records review showed that patients’ nutritional and hydration needs were assessed, documented and managed, with an Adult Nutritional Risk Screening Tool (WASSP) implemented for all patients. Patients received diets tailored to their medical needs, with modified diets and fluids provided when swallowing was compromised. Noteworthy areas of practice were consistent assessments for all patients and prompt referrals to Speech and Language Therapy (SaLT) and dietician.

Patients were able to choose what, where and when they ate and they could choose from a menu which was explained to them. The menu provided variety and healthy options, including fruit and vegetables. The food looked appetising and patients had access to a communal dining room, should they choose. Patients spoke positively about the range of food on offer and the opportunity to provide input to the menu. During the lunch meals we observed patients being promoted to feed themselves.

Names were printed on patients opened food items but not the date opened, otherwise food items were stored appropriately and in date.

The health board must ensure that opening dates of food items are included on patients own food including their name.

Patient records
The patient records showed evidence of comprehensive mental health assessments. This incorporated the criteria set out in the Mental Health Measure (Wales) 2010, with all risks and needs identified within the Clinical Assessment Tool. There was also evidence of complete physical health assessment on admission, including a care plan, ongoing physical treatment if required.

Other physical health assessments were completed, including falls assessment and tissue viability. All assessments were up to date regularly reviewed and reflected best practice.

Where the patient was at risk of falls, there was an up-to-date care plan, tailored to the patient. The falls risks assessments in place were frequently reviewed and up to date. The ward had access to specialist advice and the falls service. Pressure ulcer risk assessments were conducted upon admission and routinely thereafter. Patients' risk assessments and wound charts were regularly reviewed during their ward stay. Ongoing wound treatment plans were routinely evaluated and revised during ward rounds. Intentional rounding ensured continuous pressure area monitoring, with referrals to the tissue viability nurse documented as needed in weekly checks.

The patients had current and personalised care and treatment plans (CTPs) that corresponded to their assessed needs and supported their safety. A care coordinator had been identified in the CTP, which was person centred, outcome focused with clear achievable goals and planned review dates. This clearly highlighted contributions from the full MDT including community staff where relevant, which reflected the current and future needs of the patient.

Care interventions were appropriate and met patients' needs. The CTP considered the patient's social, cultural and spiritual needs, such as language choices, engagement or re-engagement with a religion of choice or tradition. It also drew on patient's strengths and focussed on recovery, rehabilitation and independence

There was evidence of discharge and aftercare planning, with patient and carer views also recorded. Relevant members of the MDT were present when discharge planning was discussed and recorded under 'Discharge Arrangements' in the patients record. The community mental health team were also actively involved in the discharge and aftercare process.

There were arrangements in place to ensure Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) discussions and decision making was undertaken appropriately and sensitively. The DNACPR status was confirmed for each patient during handover and was also recorded in relevant patients' notes.

Mental Health Act monitoring
There were 13 patients receiving treatment on the Ward and one patient was on extended section 17 leave to a nursing home, for a trial period. All were detained under the Mental Health Act 1983.

We reviewed the records of four detained patients' and found no irregularities affecting their detention. The nearest relatives were involved during their inpatient stay.

Patients were informed of their rights, although improvement was needed in documenting regular updates. Through the MDT process, patients' treatment was subject to weekly monitoring and review, with plans being adjusted accordingly. There were records of patients' capacity and consent to treatment and treatments appropriately certificated.

In one patient record, we found a Section 62 (Urgent Treatment) form for a different patient, thus compromising data protection and risk of confusion over treatment for both patients. The form was removed from the file during inspection and a DATIX incident form was completed. Details can be found in Appendix A.

Mental capacity assessment undertaken by the RC were discussed in the MDT meeting as appropriate. Patient capacity was assessed on admission, prior to administering medication and regularly throughout their admission / detention.

Leave of absence authorisation forms were signed appropriately following the appropriate risk assessment and inclusion of patient family members as

appropriate. Any plans to support the leave were documented on the leave form and/or in the patient's notes.

There was an independent advocacy service available, the contact details and information about the service was readily available and clearly displayed for patients and their families. The advocates regularly visited the ward to see the patients.

Monitoring the Mental Health (Wales) Measure 2010: care planning and provision

The records we reviewed were paper based and were generally well-maintained, organised and easy to navigate. However, some patients' files contained a high volume of documentation making them bulky, with some pages unsecure, risking loss or incorrect filing. To help manage the volume of patient records, an additional filing system was implemented containing records accessed daily, such as observation charts, risk assessments and care plans. It would likely be more efficient and less of a risk if an electronic record system was implemented. One staff also highlighted their concerns in the survey and commented:

> ***"… IT systems - need total update. Other establishments complete all paperwork on iPads and can access patient information at any time which would be so beneficial. Equipment on [the] ward is dated, needs repairing, not suitable for patients we support. We as staff give 110% to the patient's we support each shift but feel deprived of equipment and a dated setting. Management support is given, but not enough and staff don't feel they are listened to……"***

The health board must consider the use of an electronic patient record system and provide additional resources to the staff to manage the paper records appropriately on the ward.

There were recurring themes of good practice with regards to timely care plan reviews and weekly ward rounds, which were well documented. For one patient, the nursing risk assessment was a good example of a thorough and comprehensive assessment of a patient with complex needs. The quality of the assessment was considered exceptional by the ward team, and this level of detail was being rolled out for all patients as a quality improvement initiative introduced by the deputy ward manager.

Efficient

Efficient

Thorough records of patient discharge planning were evident in-patient notes. Staff worked across services to coordinate involvement with patient families and carers to help ensure the best outcomes. Community Psychiatric Nurses (CPNs) would also attend ward rounds for their patients to discuss discharge planning back to the community team.

Quality of Management and Leadership

Staff feedback

HIW issued a staff questionnaire to obtain their experience of care and working on the ward, and we received 20 responses. Responses were mixed throughout and most felt that patient care was the organisation's top priority. However, only half agreed that they were content with the efforts of the organisation to keep them and patients safe. 75% said they would recommend the ward as a place to work and said they would be happy with the standard of care provided for themselves, friends or family. Some of their comments included:

> ***"…We feel as Cemlyn Ward is getting left behind - feedback from patients' families is fantastic and we as staff see this with their cards and gifts to the team, so please let's get the ward up to this present century to enable us to carry on providing excellent support to patients and their families."***
>
> ***"I will say the staff are lovely, most of us go above and beyond to support patients and give our all. The patients are well cared for and we all care so much about them and their family."***
>
> ***" …Being able to care and feel happy that you have been able to make a positive impact for that patient to have the best treatment/life possible and that they are safe…"***

Leadership

Governance and leadership
There were processes in place to support effective governance, leadership and accountability, to sustain the delivery of safe and effective care. There was a clear management and leadership structure in place and leaders were available and accessible.

We were told that the hospital Matron visited the ward on a weekly basis and that the ward manager had daily contact with the Matron. There were daily safety huddles taking place and the ward manager also attended acute care meetings twice a week to discuss patients, safeguarding, Mental Health Act status, therapeutic discharge barriers and weekly patient flow meetings.

There was clear information shared with staff through the safety huddles, emails, memos and notices. We were also told about the restricted items notice, which

informed families or carers about what they could not bring onto the ward to maintain patient safety.

Any changes to health board policies or procedures were shared with staff. We saw that the ward managers were visible and approachable and had a clear understanding of the staff and patients and any issues they had.

In the staff questionnaire 65% felt their immediate manager could be counted on to help with a difficult task at work, but only 55% said they received clear feedback on their work. Half said their immediate manager sought their opinion before making decisions affecting their work. While 45%, felt senior managers were visible, 65%, felt they were committed to patient care and just 35% felt that communication between senior managers and staff was effective.

Workforce

Skilled and enabled workforce
There was a plan in place to ensure an appropriate skill mix and establishment of competent staff. Recruitment was in progress for an additional two registered nurses and three HCA staff, to fulfil the ward establishment. Currently, each day shift needed three registered nurses and seven HCA on duty to manage the patients and two registered nurses and six HCA on nights.

Some shifts were impacted by unplanned staff absences and these were supplemented by temporary staff where possible. Ward managers were in the process of completing a review of staffing and had completed an exercise using the Situation, Background, Assessment and Recommendation (SBAR) model to help their case to increase core staffing numbers permanently, in line with the ongoing acuity of patients.

Staff reported that, except for occasional absences, there were generally enough employees with the necessary skills to run the ward safely. Most staff said they had enough time for documentation, though one noted frequent understaffing. Heavy reliance on bank staff was mentioned, but these staff felt included and had access to required training. However, some tasks could not always be completed due to staffing shortages.

Annual appraisals compliance was low at 60%, however, we were told there was a plan in place to improve on this.

There was regular senior nursing team, and housekeeping meetings held, however, there had not been any regular ward team meetings. This prevented staff from

attending a forum to discuss relevant topics related to patients, staffing, training or other issues.

The health board must ensure that:

- **The ward is in compliance with annual staff appraisals**

- **Regular ward staff meetings are held with a planned agenda and minutes are captured including any actions to share key information with all staff formally.**

Any compliments or comments from families or carers would be to the quality assurance team and these would be shared with the senior leadership teams and with staff at the ward.

There were induction processes in place for new staff, including bank and agency staff. Newly appointed registered nurses would be given a two-week supernumerary period, although their mandatory preceptorship programme can last up to 18 months. Any new bank staff would complete a supernumerary shift to familiarise themselves with the ward and patients.

Staff had access to training and development opportunities to support them in their role, this included training in the Mental Health Act and Measure, as well as training in restrictive practices. We were told that staff had attended health board blood management training and some HCA staff had been supported to attend level four NVQ training and phlebotomy training. Additionally, three HCAs had been sponsored and supported to complete nurse training to become qualified and registered nurses.

Staff compliance with mandatory training varied, from 67% for IPC to 95 % for safeguarding. We checked a sample of four staff records and the compliance varied from 67% to 92%. All registered staff had completed training on oxygen cylinders. Compliance with the mandatory training was overseen by ward managers through the electronic staff record and reported compliance to the Head of Nursing monthly.

In our staff survey, all but one respondent felt that they had received appropriate training to undertake their role and half said they have had an appraisal in the last 12 months. Some staff highlighted in the survey that they would benefit from additional training. Their comments included:

> ***"Palliative care."***

"Brain injury training."

"Training specific to my safety and restraint and restrictive intervention (RPI) training would be useful…."

"Therapeutic training."

"…training that is specific for patients here."

"Classroom courses for knowledge of [skin pressure damage]…, and taking patient vital [signs] and recognising when to escalate."

Staff we spoke with felt that the level of supervision available was sufficient and was better than 12 months ago. They felt that the number of staff on the ward was appropriate for the patients, when fully staffed and there was enough time to give patients the care they needed safely. They had suitable support, with access to deputy ward managers or the ward manager and described a positive ward culture, supportive colleagues and fair handling of reported concerns.

Culture

People engagement, feedback and learning
Senior staff reported that feedback and complaints were managed centrally by the patient advisory liaison service (PALS), but none have been received in the past year. They also highlighted a process to ensure staff were supported through any complaint procedure. Any verbal complaints would be captured and addressed in the patient notes. Learning from complaints would be shared in daily huddles.

In relation to reporting incidents, all but two staff survey respondents felt their organisation encouraged them to report errors, near misses or incidents and when reported, the organisation took action to help prevent recurrence. However, few felt they were given feedback about changes made in response to reported incidents. All said they would know how to report unsafe practice and 70% agreed their organisation treated staff involved in an incident fairly. Whilst 85% of staff felt secure raising concerns, only half were confident that the organisation would address their concerns. One member of staff commented that:

"You are presumed guilty before proven innocent by [the health board]... [senior managers] do not check the wellbeing of staff when incidents occur."

Only 15% of staff survey respondents said patient experience feedback was collected and 45% did not know. Additionally, 15% said they received regular updates on patient experience feedback and 25% did not know.

There were no feedback mechanisms for patients or any patient specific meetings. However, we were told and observed continuous engagement between staff, patients and families in providing suggestions for improvements.

The health board must ensure there is a formal process in place for patients and their families or carers to provide their feedback about the ward.

The NHS Wales 'Putting Things Right' process was displayed at the ward entrance and in numerous areas of the ward. Patients were provided with details of other organisations and advocacy for support to raise concerns if needed.

The health board provided Duty of Candour guidance, staff we spoke with described their roles and responsibility in compliance with the duty. However, there was no evidence that staff had received Duty of Candour training. In our survey, 80% of staff said they knew and understood the Duty of Candour and their role in meeting the duty.

A positive culture was observed among staff, characterised by strong teamwork between ward and MDT members to deliver patient-centred care.

In our staff survey, most said their job was not detrimental to their health and all felt that the organisation took positive action on health and wellbeing. Additionally, most staff said their current working pattern allowed for a good work-life balance and that they were aware of the occupational health support available.

Information

Information governance and digital technology

Data was generally managed in a safe and secure way. Staff files were stored securely in the ward managers office. Patient notes were kept in the nurses' station, which was secured by keypad entry, although they were stored in an unlocked filing cabinet.

The health board must ensure that patient notes are kept securely in a locked cupboard.

All computer systems used were password protected and any correspondence emailed between wards or to other care settings, such as nursing homes was completed securely and were password protected.

Learning, improvement and research

Quality improvement activities
Some initiatives were in place to support quality improvement, this included the recently implemented initiative involving the release of staff from one-to-one observations when the patient was settled, using a process referred to as 'Response'.

We reviewed a document outlining the roles and responsibilities of the HCA co-ordinator, indicating that they would be on response for the duration of each shift where possible. Although, the process was incomplete and still required formal documentation.

The health board must document the HCA 'Response' process, to ensure there is clarity when the 'Response' process can be used safely.

Deputy ward managers were responsible for discharge planning related to nursing home placements and funding applications, including best interest decisions for patients, due to the absence of a discharge coordinator.

Discussions with senior ward staff highlighted challenges related to discharging patients when bed availability at alternative settings was delayed due to other cases being given priority. Such instances were escalated to the senior management team for review, ensuring that any unmet patient needs were addressed appropriately.

We were told that a therapy dog had visited the ward in the past and hospital volunteers called 'Robins' attended the ward twice a week to befriend patients, taking the time to stop and talk to people. In addition, there were psychology students who attended the setting to provide one to one contact with patients and supporting with activities.

Whole-systems approach

Partnership working and development
Staff interacted with the Home Treatment Team (HTT) and Community Mental Health Team (CMHT) at the hospital. The HTT supported people in their own homes to prevent hospital admission, or to facilitate early discharges from the inpatient setting.

It was explained that the purpose of involving the teams was to reduce hospital admissions by providing enhanced home treatment for a specified period. If this intervention was unsuccessful, patients would be admitted to the ward with continued support from the relevant teams.

Upon discharge, the Home Treatment Team (HTT) would deliver wrap-around support. Additionally, for patients discharged to care homes, initial discharge would occur under section 17 leave to ensure continued wrap-around assistance, serving as a safety net for timely intervention by the designated team.

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
On the record of one patient, there was a Section 62 (Urgent Treament) form that belonged to a different patient.	This compromised data protection.	The issue was reported to the ward manager.	The ward manager dealt with this by making a DATIX report. The patient records were paper based, with most individuals having large files that run into several volumes. Moving to an electronic system of record keeping would eliminate this re-occurrence.

Appendix B - Immediate improvement plan

Service: Cemlyn Ward, Ysbyty Cefni

Date of inspection: 28 to 30 July 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.	No immediate assurance issues.					

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):

Job role:

Date:

Appendix C - Improvement plan

Service: Cemlyn Ward, Ysbyty Cefni

Date of inspection: 28 to 30 July 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.	The canopy in the garden is in need of repair. There was also a second outside area, we were told there had been a plan to make this a sensory area but was not used due to the risks of tripping and uncertainty as to whether the floor covering was anti-slip. It was a larger outdoor area that should be used by patients.	The health board must ensure that all outside areas are secure, made safe and always available for patients to use as appropriate.	Health and Care Quality Standards (H&CQS) - Health Promotion	Repair of canopy, including discussion regarding warranty with company. Review of all external patient areas with Health and Safety and Estates to establish any issues and progress any works required to make safe	Ward Manager and Clinical Operational Manager Ward Manager and Clinical Operational Manager	30 November 2025 31 January 2026

2.	Staff comment on staffing	The health board must reflect on staff feedback regarding staffing and consider reviewing the establishment to ensure patient needs are met in a safe and timely manner.	H&CQS - Individualised care	Ensure safe care is updated as directed and staffing discussed at twice daily safety huddles aligned to safe care	Ward Manager Head of Nursing for locality and Assistant Director of Nursing	31 October 2025
				Continue Roster Meetings twice weekly, to discuss and review feedback regarding staffing		31 October 2025
				Continue support to the Ward Manager from the Senior Leadership Team and Workforce colleagues in relation to absence management and prompts aligned to absences. Progress Divisional inpatient staffing establishment review.	Assistant Director of Nursing	31 March 2026

				Ensure monthly staff meetings are progressed, with minutes shared with all staff.	Ward Manager	30 November 2025
3.	We observed one patient receiving medication in a timely manner. However, this was in the communal dining room in the presence of another patient and a family and carer. There was also another incident observed where a patient's top was raised to administer a medication.	The health board must ensure that patients' dignity and respect is considered when treatment is provided and this should not be carried out in communal areas, except in emergency situations.	H&CQS - Timely care	Ensure 85% compliance with Dignity and Respect training by all staff. Learning reflected with staff member in supervision.	Ward Manager Ward Manager	30 November 2025 Complete
4.	Not all Welsh speaking staff wore the 'iaith gwaith' logo to highlight their ability to converse in Welsh	The health board must ensure that all Welsh-speaking staff wear the 'iaith gwaith' logo as applicable.	H&CQS - Communication and Language	Escalate the issue regarding embroidered badges to senior management for any further escalation and resolution and ensure	Ward Manager	31 October 2025

				there are sufficient appropriate uniforms available. Liaise with Welsh Language Team regarding any themes for support Remind all staff to wear the Iaith Gwaith logo if they are able to converse in Welsh.	Ward Manager	31 October 2025
5.	The personal safety alarms available for staff were not used. If staff are not using these, then an appropriate rationale must be provided and documented.	The health board must risk assess the use of personal safety alarms and address non-compliance if appropriate.	H&CQS - Risk Management	Use of personal safety alarms needs to be informed by a robust risk assessment with the outcome documented.	Ward Manager	31 October 2025
6.	There were no dates present on the disposable curtains, although they appeared to be clean.	The health board must ensure that the disposable curtains are marked with a date the curtains were	H&CQS - IPC	Housekeeper to add dates to when the disposable curtains were hung.	Ward Manager	31 October 2025

		hung, to ensure they are replaced in a timely manner, or sooner if soiled.		Add checking dates of disposable curtains to weekly job list checked by the Deputy/Ward Manager.	Ward Manager	31 October 2025
7.	Staff explained that one of the two bathrooms was out of order and had been for several months. We also noted other minor issues that needed rectifying, which were discussed with the ward manager. This included a broken light switch in a communal toilet and some broken furniture awaiting removal as well as some trim missing between the flooring and wall close to the nurse's office.	The health board must ensure that the shower/ bathroom is repaired promptly and that all maintenance issues are addressed in a timely manner.	H&CQS - IPC	Escalate the repair of one of the bathrooms with senior Estates to ascertain update on the outstanding schedule of works. Additional minor work request to be completed for:	Ward Manager and Clinical Operational Manager	31 October 2025
				Repair of broken light switch with Estates.	Ward Manager	Completed
				Arrange for the removal of broken furniture.	Ward Manager	31 October 2025
				Request repair of broken flooring trim outside nurses' office.	Ward Manager	31 October 2025

8.	There were two separate cleaning schedules in use, though neither was fully completed, however, the ward appeared clean. There was some confusion about which schedule should be completed. This was addressed and resolved during the inspection.	The health board must ensure that a standard cleaning schedule is used and staff are aware of its existence and is completed by staff as appropriate.	H&CQS - IPC	Ensure correct cleaning schedule form is used by staff.	Ward Manager	Complete
9.	Staff comment on access to PPE.	The health board must ensure that staff have easy access to PPE in all areas of the ward.	H&CQS - IPC	Liaise with Infection Prevention and Control (IPC) team for advice aligned to providing easy access to PPE in all areas of the ward. Progress actions based on advice received.	Assistant Director of Nursing	30 November 2025
10.	In response to ligature and asphyxiation risk concerns, all bin liners and plastic bags were removed from	The health board must carefully evaluate both the risks and benefits associated with removing a	H&CQS - IPC	Review current position in regard to use of bins on dementia wards	Head of Nursing for locality and Assistant	30 November 2025

	the ward. However, staff have raised several concerns regarding the absence of bins and the ability to appropriately manage IPC.	significant number of bins from the ward, whilst considering potential impacts on infection prevention and control and implement appropriate measures to address both considerations.		aligned to Infection Prevention risks.	Director of Nursing	
11.	The health board medicine management policy was overdue its review at the end of December 2023.	The health board must ensure that the medicine management policy is reviewed in the appropriate designated timescale.	H&CQS - Medicines Management	Progress with the review of Medicine Management policy and progress through divisional and Health Board process.	Assistant Director of Nursing	30 November 2025
12	CDs were placed in an unlocked internal cupboard inside a larger locked cupboard, as the internal lock was missing. Temperature records showed the clinical fridge occasionally exceeded	The health board must ensure that: • Controlled drugs are securely in line with legislation • An appropriate system is installed in the	H&CQS - Medicines Management	Fix internal lock of Controlled Drug cupboard Review environment and ventilation of clinic room with	Ward Manager Ward Manager	Complete 31 October 2025

	safe medication storage limits in line with pharmaceutical recommendations. In addition, the clinical room's ambient temperature records showed this often rose above 25°C but lacked air conditioning to cool it. Installing temperature control would help maintain appropriate conditions for both the room and fridge.	room containing medication to ensure that the fridge and room temperatures stay within appropriate ranges to maintain the viability of medications.		Pharmacy and Estates colleagues to ensure temperatures stay within appropriate ranges.		
13.	We noted that there was medication dispensing equipment, known as 'Mediwell' stored in the hospital, for the ward but was not installed and with no known installation date. The installation of this would maintain the security of medications and may also help with	The health board must ensure that the work to progress the installation of the 'Mediwell' medication dispensing equipment is prioritised to support the management of medications on the ward.	H&CQS - Medicines management	Progress the installation of the "Mediwell" medication dispensing equipment	Clinical Operational Manager	31 January 2026

	appropriate temperature regulation of medication, depending on model installed.					
14.	Names were printed on patients opened food items but not the date opened, otherwise food items were stored appropriately and in date.	The health board must ensure that opening dates of food items are included on patients own food including their name.	H&CQS - Nutrition and hydration	Reaffirm to all staff the need to place opening dates of any food items. Food item check added to weekend job/checks. Ensure 85% compliance with food hygiene training.	Ward Manager Ward Manager Ward Manager	Complete 31 October 2025 30 November 2025
15.	Some patients' files contained a high volume of documentation making them bulky, with some pages unsecure, risking loss or incorrect filing.	The health board must consider the use of an electronic patient record system and provide additional resources to the staff to manage the paper records appropriately on the ward.	H&CQS - Care Planning and Provision	Whilst progress is being made with the Digitisation of health records, reaffirm the responsibility to the ward clerk that patients' files do not exceed the	Ward Manager and Ward Clerk	30 November 2025

				recommended thickness before an additional volume is created.		
16.	There was regular senior nursing team, and housekeeping meetings held, however, there had not been any regular ward team meetings.	The health board must ensure that: • The ward is in compliance with annual staff appraisals • Regular ward staff meetings are held with a planned agenda and minutes are captured including any actions to share key information with all staff formally.	H&CQS - Skilled and enabled workforce	Reminder to all Line Managers regarding need to undertake staff appraisals Report PADR compliance at weekly Operational Leadership Meetings (OLM). Develop an action plan to ensure consistent improvement to achieve 85% compliance and continue to monitor via OLM. Ensure ward/staff meetings are	Ward Manager Ward Manager Ward Manager Ward Manager	30 November 2025 30 November 2025 30 November 2025 31 October 2025

				scheduled on a continual basis.		
17.	There were no feedback mechanisms for patients or any patient specific meetings.	The health board must ensure there is a formal process in place for patients and their families or carers to provide their feedback about the ward.	H&CQS - People engagement, feedback and learning	Ensure CIVICA posters are displayed in ward areas to seek feedback. Ensure CIVICA post cards are easily accessible to hand out to families and carers who visit the ward. Monitor CIVICA feedback forms at the monthly Service Quality Delivery Group. Report West Area CIVICA data into the Divisional Patient, Carer and Experience meeting.	Ward Manager Ward Manager Ward Manager Head of Nursing	Complete 30 November 2025 31 October 2025 30 November 2025

18.	Patient notes were kept in the nurses' station, which was secured by keypad entry, although they were stored in an unlocked filing cabinet.	The health board must ensure that patient notes are kept securely in a locked cupboard.	H&CQS - Information governance and digital technology	Reaffirm with all staff thought the team meeting and written correspondence the requirement to keep the filing cabinet storing patient notes locked whilst not in use. Ensure 85% Information Governance Mandatory Training compliance.	Ward Manager Ward manager	31 October 2025 31 December 2025
19.	Some initiatives were in place to support quality improvement, this included the recently implemented initiative involving the release of staff from one-to-one observations when the patient was settled, using a process referred to as 'Response'.	The health board must document the HCA 'Response' process, to ensure there is clarity when the 'Response' process can be used safely.	H&CQS - Quality improvement activities	Develop clear guidance regarding the 'Response' process and approve through local and Divisional Governance.	Ward Manager	31 December 2025.

	We reviewed a document outlining the roles and responsibilities of the HCA co-ordinator, indicating that they would be on response for the duration of each shift where possible. Although, the process was incomplete and still required formal documentation.					

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): **Fiona Sera-Hughes**

Job role: **Head of Nursing (West) Mental Health & Learning Disabilities**

Date: **7th October 2025**