Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report
(Unannounced)
Minor Injuries Unit, Llandrindod Wells War Memorial 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 of the Minor Injuries Unit (MIU) at Llandrindod Wells War Memorial Hospital, Powys Teaching Health Board on 19 and 20 August 2025.

Our team, for the inspection comprised of two HIW healthcare inspectors, two clinical peer reviewers 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 six questionnaires were completed by patients or their carers and six 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 MIU operated daily from 8am to 8pm daily. Patients were encouraged to arrange an appointment before attending the MIU. However, patients who turned up without an appointment would be seen and treated by staff.

Timeliness of care was mostly good, with many patients seen well within four hours.

Patients were treated with dignity and respect, and confidentiality was generally maintained. However, one instance was observed where a treatment room door was left open during a consultation, and some treatment rooms lacked privacy curtains.

Patients we spoke with were happy with the way that staff interacted with them and provided positive feedback during discussions with members of the inspection team and via the questionnaire. We saw staff speaking with patients and their relatives in a polite, professional and dignified manner.

Patients were involved in treatment decisions. The presence of a multidisciplinary team, including physiotherapists, was noted as a positive aspect.

This is what we recommend the service can improve:

- Review the availability of patient information to ensure that it is relevant and clearly visible within the unit
- Ensure privacy and confidentiality at all times, including provision of privacy curtains in all treatment rooms
- Move ahead with plans to implement a formal triage process
- Ensure that language preference is noted within patient records.

This is what the service did well:

- Treating people quickly
- Patient centred care and involvement in decision-making
- High levels of patient satisfaction
- Kindness and compassion.

Delivery of Safe and Effective Care

Overall summary:
The unit had appropriate systems for recording and managing incidents. Learning from incidents was shared with staff through newsletters and team meetings. However, staff responses indicated that those involved in incidents did not always feel treated fairly by managers outside the MIU, and some did not feel secure in raising concerns about unsafe clinical practice.

Compliance with infection prevention and control procedures was good, and the environment was maintained to a high standard of cleanliness. Safeguarding procedures for children and adults were clearly defined, and staff were trained in these areas.

Medical devices and equipment were generally in good working order. However, there were some gaps in the maintenance records. Similar gaps were found in the emergency resuscitation trolley checks, and some items were out of date. Medication management processes were not fully robust: some medicines were out of date, room temperatures for medication storage were not always checked, and staff had not received training on the safe administration of oxygen from portable cylinders. Blood sugar test bottles and creams were not always checked or dated appropriately. Controlled drugs were securely stored, but not always recorded in an official register, and stock checks were not always signed.

Pressure area and falls risk assessments were not always completed routinely or in a timely way, exposing patients to potential risk. Not all staff were aware of the sepsis screening tool or its use.

Patient records were generally well-maintained, although some inconsistencies needed to be addressed.

Immediate assurances:

- HIW was not assured that medication management processes are sufficiently robust and safe
- HIW was not assured that the process for checking the emergency resuscitation trolley is sufficiently robust and safe
- HIW was not assured that the risks of harm to patients is appropriately managed as staff had not received training on the safe use of portable BOC Oxygen cylinders.

This is what we recommend the service can improve:

- Ensure that staff feel secure when rising concerns and that they are treated fairly when they are involved in incidents or complaints
- Ensure that regular checks are undertaken on consumables and any out-of-date items replaced
- Ensure robust medication management
- Review and improve arrangements for security
- Ensure that falls and pressure area risk assessments are undertaken routinely and in a timely way
- Ensure that staff are aware of the sepsis screening tool and how and when to complete it
- Ensure that pain assessments are completed consistently and that staff offer analgesia to patients who are experiencing pain.

This is what the service did well:

- Clean, tidy and well organised unit with good Infection prevention and control practices
- Safeguarding procedures and staff knowledge were appropriate
- Effective communication
- Incident reporting and management.

Quality of Management and Leadership

Overall summary:
The MIU leadership team was visible, approachable, and committed to service improvement. Staff feedback was mixed, with most staff satisfied with the quality of care and support they provide to patients, and happy with the standard of care for themselves or their families. However, concerns were raised about staffing levels, workload, and support from senior management teams external to the MIU.

We found that staffing levels were acceptable with minimal use of agency staff.

The culture within the MIU was generally positive, supportive, and inclusive, with staff working well together. Patients could provide feedback directly to staff, and there were formal systems for managing complaints, aligned with the NHS Wales Putting Things Right process.

There was evidence of good partnership working and collaboration with local services and the Out of Hours GP service.

This is what we recommend the service can improve:

- Allocate dedicated time for clinical development beyond mandatory training, to ensure staff can enhance their professional skills

- Review the staff feedback regarding senior managers and ensure a secure platform is provided to listen to staff and take action to address concerns where appropriate.

This is what the service did well:

- Multidisciplinary team working
- Strong unit leadership
- Staff support and supervision.

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

During the inspection, we saw staff were kind and welcoming to patients and treated them with courtesy and respect. All patients we spoke with during the inspection provided positive comments about their care.

We issued paper and online questionnaires to obtain views and feedback from patients and carers. We received six responses which were generally positive across all areas. Most respondents rated the service as 'very good' or 'good', with the standard of care also scoring well.

Patient comments included:

> *"Excellent service. Never been a problem."*

Person-centred

Health promotion
Health related information was available in various parts of the unit, many of which was bilingual. However, not all the information was immediately visible to patients, and a review of the notice boards was recommended to improve access to information.

The health board should review the availability of patient information to ensure that it is relevant and clearly visible within the unit.

Dignified and respectful care
All patients we spoke with, and those who completed the questionnaire, felt that staff treated them with dignity and respect.

We saw good interactions between staff and patients with staff generally attending to patients' needs in a discreet and professional manner. However, we witnessed one occasion when the door to a treatment room was left open whilst a staff member was speaking with a patient. In addition, there were no privacy curtains fitted within some of the treatment rooms.

The health board must ensure that privacy and confidentiality is maintained at all times and that privacy curtains are provided within all treatment rooms.

Individualised care

Through reviewing a sample of patient records, we found that care was being planned and delivered on a multidisciplinary basis and in a way that identified and met patients' individual needs and wishes. Patients told us that they were involved in decisions about their care.

Timely

Timely care

The MIU was open from 8am until 8pm seven days a week, and the opening hours were listed on the health board website. We found that patients attending the unit were usually seen and treated in a timely manner.

Most respondents to our survey confirmed that they were assessed within 30 minutes of arrival and waited less than four hours in total before receiving treatment.

There was no formal triage process in place at the time of the inspection. Patients were encouraged to contact the unit by phone prior to attending so that staff could manage the flow of patients through the unit and offer advice and signposting to other services where appropriate. We were told that a formal triage process was to be introduced in October 2025.

The health board must move ahead with plans to implement a formal triage process.

Equitable

Communication and language

Patients we spoke with were generally happy with the information provided by staff, and all respondents to the questionnaire felt that staff explained what they were doing and listened to and answered their questions.

All the patients who completed a questionnaire said they were involved as much as they wanted to be in decisions about their healthcare.

We were told that some staff were bilingual (Welsh and English), and that translation services were available for patients who wished to communicate in other languages. Most of the information displayed within the MIU was available in

both Welsh and English. However, patient language preference was not routinely noted within patient records.

The health board must ensure that language preference is noted within patient records.

The NHS Wales 'Putting Things Right' process was displayed in both Welsh and English within patient areas, and there was a bilingual poster displayed, requesting patient feedback about the department. Staff we spoke with were able to confirm how they would deal with feedback, both positive and negative.

The signage to the MIU from the main entrance to the hospital was not very clear resulting in patients being re-directed to the unit from the main hospital reception.

The health board should review the signage to the unit.

Rights and Equality
We saw that staff were striving to provide care in a way that promoted and protected people's rights, regardless of their gender or background. This is aligned to Welsh Governments approach to deliver good quality patient-focused care.

The unit was accessible with wide doorways, clear corridors and spacious treatment rooms.

We were told that equality and diversity training for all staff was mandatory, and we saw training records that indicated a high level of compliance.

Delivery of Safe and Effective Care

Safe

Risk management
The Datix system was used for the logging and managing of incidents and summaries of incidents were reviewed during the inspection. However, staff responses to the electronic survey told us that those involved in incidents were not always treated fairly by managers outside of the MIU and that they did not always feel secure in raising concerns about unsafe clinical practice.

The health board must ensure that staff feel secure when rising concerns and that they are treated fairly when they are involved in incidents or complaints.

Evidence reviewed indicated that incident themes were monitored and reported to senior management through governance mechanisms. Learning from incidents was swiftly shared through newsletters and team meetings.

We were told that there was no designated on-site security team with staff dependent on police assistance in an emergency.

The health board must evaluate and enhance security measures to ensure the safety of both staff and patients.

Infection, prevention and control and decontamination
The unit was found to be clean and tidy and all the patients who completed a questionnaire felt that the environment was very clean.

There were policies and procedures in place to manage the risk of cross infection, and we observed good implementation of infection control practices. However, we found some face masks and hand wash gel that were out of date.

The health board must ensure that regular checks are undertaken on consumables and any out-of-date items replaced.

Safeguarding of children and adults
The staff we spoke with demonstrated a satisfactory knowledge of safeguarding children and adults, and for the deprivation of liberty safeguards and mental capacity.

We found appropriate safeguarding procedures in place for referral, escalation and follow up of safeguarding concerns, and this was supported by the Wales

Safeguarding Procedures. Staff training compliance for safeguarding was appropriate.

Management of medical devices and equipment
There were systems in place to ensure that medical devices and equipment were being serviced annually and maintained to ensure that they were safe to use. However, we found gaps in equipment check records.

The health board must ensure that equipment check records are accurately maintained.

We checked the emergency resuscitation trolley and found gaps in the record of checks. We also found an Ambu Bag stored on the emergency resuscitation trolley that was out of date. **These issues were dealt with under HIW's immediate assurance process and are referred to in more detail within Appendix B of this report.**

Medicines management
We considered aspects of medication management and HIW was not assured that processes were safe.

We looked at the medication storage arrangements and found a box of Buccolam, stored within the controlled drugs cupboard, that was out of date. We also found a GlucaGen pen stored on the Resuscitation trolley that was out of date. In addition, we found that the temperature of rooms where medication was stored were not checked and recorded on a daily basis. **These issues were dealt with under HIW's immediate assurance process and are referred to in more detail within Appendix B of this report.**

We found that staff working at the service had not received training on the safe administration of oxygen from the portable BOC cylinders available to them to use in the event of an emergency. **This issue was dealt with under HIW's immediate assurance process and are referred to in more detail within Appendix B of this report.**

In addition to the above immediate assurances, we found that blood sugar test bottles were out of date and the dates when creams and ointments were opened were not recorded meaning that staff did not know for how long these items were safe to use.

The health board must ensure that blood sugar test bottles are checked regularly and that ointments and creams are clearly marked with the opening dates.

There was no designated pharmacist within the department. Support was available to staff through the pharmacy service based at Neville Hall hospital.

We found that controlled drugs were securely stored. However, we found gaps in the controlled drugs check records. In addition, controlled drug stock was not recorded in an official controlled drug register.

The health board must ensure that controlled drugs are recorded on an official register and that staff sign each time they check the stock of controlled drugs.

Preventing pressure and tissue damage
On review of patient records, we found that skin pressure area risk assessments were not undertaken routinely or in a timely way. This exposed patients to risk of skin pressure damage.

The health board must ensure that pressure area risk assessments are undertaken routinely for patients whose presenting condition warrant such a risk assessment.

Falls prevention
Falls risk assessment were not undertaken routinely or in a timely way for patients when appropriate to do so.

The health board must ensure that falls risk assessments are undertaken routinely and in a timely way for patients whose presenting condition warrant such a risk assessment.

Effective

Effective care
We found that patients in the unit were appropriately monitored. However, not all staff spoken with were aware of the sepsis screening tool or how and when to complete it.

The health board must ensure that staff are aware of the sepsis screening tool and how and when to complete it.

Pain assessments were not completed consistently, and we found one occasion when a patient who was complaining of pain was not offered analgesia with no record of why this was not administered.

The health board must ensure that pain assessments are completed consistently and that staff offer analgesia to patients who are experiencing pain. If pain relief is not administered, then this must be clearly recorded.

There were no ligature cutters available within the unit for use in an emergency.

The health board must ensure that ligature cutters are available within the unit for use in an emergency.

Nutrition and hydration
We found that in general, patients did not stay in the unit for long periods and therefore the provision of food was not an issue. Water was made available to patients on request.

Patient records
We found that nursing records were generally completed to a good standard. However, there were some inconsistencies noted in the detail on some patient notes.

The health board must undertake regular audits of patient records and address any inconsistency.

Efficient

Efficient
We spoke to several staff members, and all demonstrated a desire to provide patients with a good standard of care. We also found that the MIU leadership was good.

We witnessed effective responses to patients presenting at the unit and good communication between staff. However, some staff were critical of staffing levels and that, on occasions, there is only one Emergency Nurse practitioner and one health care assistant on duty. Staff comments included:

> *"The staffing model that has been followed for the past 6 months is unsafe and compromises patients care. 1 qualified ENP and 1 HCSW is not enough to manage a unit with unpredictable patient attendances. It compromises patient care and staff wellbeing."*

The health board must review the staffing establishment to ensure the MIU always has the right number of staff available each shift and with an appropriate staff skill mix.

Quality of Management and Leadership

Staff feedback

We spoke with staff during inspection and obtained their feedback through online questionnaires, which generated six responses. Responses were mixed, with most saying they were satisfied with the quality of care and support they give to patients, and that they would be happy with the standard of care provided by the hospital for themselves or for friends and family. However, concern was expressed about staffing levels, workload and support from senior management teams external to the MIU.

Leadership

Governance and leadership

We found good leadership within the MIU, and it was evident that staff were committed to providing a good experience for patients.

Clear lines of reporting and accountability were described and demonstrated, and suitable governance systems were in place.

Most of the staff we spoke with were generally positive about working in the unit and were committed to improving the quality of care provided. Staff told us they were well supported by the unit manager. However, some felt unsupported by the senior managers outside of the unit. Staff comments included:

> *"Immediate line management is excellent, and support is unquestionable. Senior management is very much lacking with often an attitude of blame first then look into the facts of the matter, staff often feel not listened to by senior management particularly in relation to staffing levels."*

> *"Senior manager reprimand staff for complaints without having gathered all the knowledge. Any complaint is treated as 'patient is right, staff are wrong', even when all policies and guidelines have been adhered to and staff worked within vicarious liability."*

> *"We are never consulted on our wellbeing, cannot ever take a wellbeing break and are overlooked in terms of keeping us safe and well."*

Workforce

Skilled and enabled workforce

We found a committed and skilled workforce amongst all disciplines in the MIU. Staff we spoke with were knowledgeable of their roles and responsibilities and how this relates to providing quality patient care for minor injury patients. We saw a range of positive and effective communications in place, both formal and informal, which ensured that patients were prioritised in line with their presenting condition, to ensure appropriate and timely care.

We reviewed training data, which indicated a high compliance rate with mandatory training (over 85%), and an appropriate system in place to monitor this. It was positive to note that appraisals were up to date.

Most respondents to the staff survey confirmed they had received appropriate training to undertake their roles. Although some felt it was not always possible to achieve timely professional development, due to the increasing patient demands on the unit. Staff comments included:

> *"We are due to increase our scope of practice to see children over the age of 1 (when currently we see 2+ years and cannot request x-rays for <5years). We feel further paediatric teaching would be beneficial."*
>
> *" More face-to-face training instead of E learning and teams"*
>
> *"I feel we should be able to complete the red dot training as part of our role."*

Staff also told us that they would benefit from training on autism and administration of Entonox.

The health board must allocate dedicated time for clinical development beyond mandatory training, to ensure staff can enhance their professional skills.

Culture

People engagement, feedback and learning

We found the culture within the MIU to be generally positive, supportive and inclusive, with staff working well together. However, some staff who completed the survey told us that there was a blame culture within the health board and that they did not feel supported by senior managers outside of the unit.

The health board must review the staff feedback regarding senior managers and ensure a secure platform is provided to listen to staff and take action to address concerns where appropriate.

Patients and their representatives had opportunities to provide feedback on their experience of services provided.

There were formal systems in place for managing complaints, and this aligned to the NHS Wales Putting Things Right process.

The management of incidents and concerns was appropriate.

Information

Information governance and digital technology

Staff had received training on information governance and were aware of their responsibilities when dealing with confidential information.

Learning, improvement and research

Quality improvement activities

Quality and safety audits were conducted on the unit and yielded detailed findings. Audit results and any learning from incidents were communicated at staff meetings and via the unit's governance channels.

Whole-systems approach

Partnership working and development

The Out of Hours GP service is based in the hospital, and staff described positive and effective partnership working in place that benefited the patients.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.			

Appendix B – Immediate improvement plan

Service: Minor Injuries Unit, Llandrindod Wells War Memorial Hospital

Date of inspection: 19 and 20 August 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.

Findings

HIW was not assured that medication management processes are sufficiently robust and safe.

We looked at the medication storage arrangements and found a box of Buccolam, stored within the controlled drugs cupboard, that was out of date. We also found a GlucaGen pen stored on the Resuscitation trolley that was out of date. In addition, we found that the temperature of rooms where medication was stored were not checked and recorded on a daily basis.

This meant that we could not be assured that the risks of harm to patients was appropriately managed.

1. Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure: That measures are in place to identify when medication is close to its expiry date, and once passed this date, that it is disposed of and replaced promptly. That the temperature of rooms where medication is stored is	Delivery of Safe and Effective Care	• Medication replaced 21.8.25 • Pharmacy team engaged to support checking process for expired medication. Awaiting onboarding of new staff/	Team Lead MIU Lead – Head of nursing has liaised with Meds Management lead.	Completed November 2025

monitored and recorded on a daily basis.		• Unit team to ensure that expiry dates are conducted on daily CD checks & appropriate action taken.	Team Lead	Completed
		• Ambient checking forms implemented, and team updated 20.8.25	Team Lead	Completed
		• Plan to conduct a weekly audit and when compliance is achieved to conduct monthly as departmental safety KPI	Team Lead & Oversight from Management Lead	30.09.25
		• Exception reporting to be taken through community services group (CSG) Quality, safety, patient experience and governance meetings bi-monthly.	Management Lead reporting	6.10.25

Findings

HIW was not assured that the process for checking the emergency resuscitation trolley is sufficiently robust and safe.

We checked the emergency resuscitation trolley and found gaps in the record of checks. We also found an Ambu Bag stored on the emergency resuscitation trolley that was out of date.

This meant that we could not be assured that the risks of harm to patients was appropriately managed.

2. Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that the resuscitation trolley is checked regularly and an accurate record of checks is maintained That equipment passed its expiry date is disposed of and replaced promptly.	Delivery of Safe and Effective Care	• Communication with the team occurred prior to the HIW inspection and has been reinforced	Team Lead MIU	22.8.25 Completed
		• Items with expired date immediately removed and replaced	Team Lead MIU	22.8.25 Completed
		• Daily safety checking process is embedded but there was a lack of understanding around the one date and symbol on the bag which was mistaken for a production date – all team members have been updated on this, and monthly monitoring will be undertaken by team lead.	Team Lead MIU	30.08.25
		• Exceptions to be reported through CSQ Quality and safety meeting and through Professional Heads of Nursing and Midwifery meetings.	Service Lead Management Lead oversight	Update to be shared 30.08.25

		• Discussion with Resus officer to be undertaken as current system builds delays with stock replacement.	Team Leader	October 2025

Findings

Staff had not received training on the safe use of portable BOC Oxygen cylinders.

This meant that we could not be assured that the risks of harm to patients was appropriately managed.

3. Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that the any staff who use portable BOC Oxygen cylinders receive training on the safe use.	Delivery of Safe and Effective Care	• Welsh health circular shared with all MIU teams. • System rechecked to ensure that all alerts reach all departments from one confirmed source. • All staff in MIU have BOC accounts and have been asked to undertake the required training. • Assurance will be provided through Community Service group quality and safety group meeting. Aiming for 85% compliance by September 30th.	Head of Nursing Head of Nursing Team Lead for MIU Llandrindod Management Lead	22.8.25 Completed 22.8.25 Completed Completed 30.9.25

		• To be followed up and implemented in all MIU	MIU clinical transformation lead	29.08.25

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: Professional Head of Nursing

Name (print): Linzi Shone

Job role: Professional Head of Nursing

Date: 26.08.2025

Appendix C - Improvement plan

Service: Minor Injuries Unit, Llandrindod Wells War Memorial Hospital

Date of inspection: 19 and 20 August 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.	Not all the information was immediately visible to patients.	The health board should review the availability of patient information to ensure that it is relevant and clearly visible within the unit.	Person Centred Care	Patients are to have access to information that is relevant to their injury/illness and also to other literature that may support their personal circumstances. PTHB has a compendium of literature available online which can be made available on an individualised basis. And, will also ensure	MIU Leads	Completed

				that commonly used literature is available to people in the entrance to each unit.		
2.	The door to a treatment room was left open whilst a staff member was speaking with a patient. In addition, there were no privacy curtains fitted within some of the treatment rooms.	The health board must ensure that privacy and confidentiality is maintained at all times and that privacy curtains are provided within all treatment rooms.		Privacy curtains must be used as a part of daily standard practice. Privacy curtains are available in each unit. Doors must be closed during care delivery to ensure that confidentiality is maintained. In addition, there is now a poster on the door to remind staff. Senior manager for USC has completed a visit to ensure these are in place and will add to their audit visits to ensure practice is being	MIU Leads Senior Manager Unscheduled care (USC)	Completed

				maintained. Spot audit completed on the 13th November 2025 and remains in place. It will be reported to the community service group quality and safety group (Q&S) via MIU report on a bimonthly basis. It will also become a long-standing agenda item on the local team MIU meeting.		Evidenced through Bi-Monthly reporting commencing with December 2025 report
3.	There was no formal triage process in place.	The health board must move ahead with plans to implement a formal triage process.	Timely Care	All MIU teams will undertake triage to assess and prioritise patient care needs. Triage training has been completed in Q2 25/26 and implementation is being conducted in Q3 25/26 with urgent care transformation lead.	MIU Leads Senior manager USC Urgent care transformation lead.	Completed, 100% compliance achieved.

				Update expected via Community Service group (CSG) Quality and safety meeting (QSG) in Q4 25/26.		
4.	Patient language preference was not routinely recorded.	The health board must ensure that language preference is recorded.	Equitable Care	All those who attend MIU will have their preferred language recorded in their clinical records. Language of choice has been added to clinical document. Language of choice has been added to the current clinical documentation. Each month the unit will complete a documentation audit. Findings will be shared via local MIU practitioners, team meetings locally, and team leaders meeting for all 4 units and any breeches will be	MIU Leads Senior Manager USC	Completed

				escalated through CSG and Q&S Senior manager to continue to oversee and provide spot check reviews bi-monthly New APP for MIU being Implemented for electronic record keeping and this will be a standard field. (Urgent and Emergency care App – Welsh Emergency care dataset (WECDS)		Reporting through Bi-Monthly Q&S meeting to commence in December 2025 In Progress, working group established. Implementation Q3 2026/2027
5.	The signage to the MIU from the main entrance to the hospital was not very clear.	The health board should review the signage to the unit.		This action has been escalated to estates colleagues for review. New signage upstairs in the building has been completed.	Estates Lead	Clear Signage for MIU completed.

				External and lower floor signage to be renewed. This will be monitored through CSG operational group meetings		In Progress, no date for completion with internal site works ongoing. Tacking through CSG Operational meetings from January 2026
6.	Staff told us that those involved in incidents were not always treated fairly by managers outside of the MIU and that they did not always feel secure in raising concerns about unsafe clinical practice.	The health board must ensure that staff feel secure when rising concerns and that they are treated fairly when they are involved in incidents or complaints.	Safe Care	Nursing in PTHB will promote a culture of compassionate leadership, learning from events and CPD in a psychologically safe environment. The Professional Head of Nursing will attend the MIU in person on a monthly basis and also attend key meetings to align the professional support	Professional head of Nursing (PHON) Health board wide	Monthly reviews

				that is accessible to everyone. Staff encouraged to complete staff survey, and we receive 1:1 feedback from Workforce on a quarterly basis. We encourage the use of Speaking Up Safely an anonymous method and Framework in the organisation to raise concerns about unsafe clinical practice. A learning event will be facilitated via workforce with all staff to ensure understanding of all pathways policies and guidelines available. This will be supported		To be achieved by Q4 To be achieved in Q4.

				by our Professional nursing advocate who provides restorative supervision.		
7.	There was no designated on-site security team with staff dependent on police assistance in an emergency.	The health board must evaluate and enhance security measures to ensure the safety of both staff and patients.		The Health Board have undertaken a review of site security following an incident in 2024. CCTV is now in place to support staff in and out of hours. We recommend the use of police and have implemented a site security policy with a site security manager appointed to the Health Board to monitor service needs. The MIU has a local risk assessment for site security stored in the health and safety	Site security manager	Completed and ongoing

				folder that was developed in 2024 and kept in the unit, where all staff have access. Team leader will discuss in local team meetings as a rolling agenda, and ensure any concerns are escalated to the site security officer. This will be reported through CSG Q&S meetings commencing in December 2025.		December 2025 reporting
8.	Some face masks and hand wash gel that were out of date.	The health board must ensure that regular checks are undertaken on consumables and that any out-of-date items replaced.		Team to add to daily checks and ensure that no out of date stock is present in MIU's throughout PTHB Quality walkthrough to be undertaken quarterly as a minimum standard by	Team Lead MIU Service manager USC PHON	Completed

				PHON and Quality and safety (Q&S) Lead.		
9.	We found gaps in equipment check records.	The health board must ensure that equipment check records are accurately maintained.		The team will embed a culture of daily compliance with safety checks This will be monitored and reported through community services group quality and safety meetings. We will add this to senior quality assurance visits. Updated clinical checking records in place. Senior manager has completed a spot check on 13/11/25 and will continue to do so monthly. All staff have been informed in the local	Team Lead MIU	Completed

				team meeting and will remain on the rolling agenda, reported via CSG Q&S meetings from December 2025.		
10.	We found that blood sugar test bottles were out of date and the dates when creams and ointments were opened were not recorded.	The health board must ensure that blood sugar test bottles are checked regularly and that ointments and creams are clearly marked with the opening dates.		All affected items removed from service on day of visit. All staff advised of the process for adding dates to opened tubes and bottles. 2 stage process in place to ensure good practice. This will be monitored monthly by the MIU lead This will be reviewed during quality assurance visits and will be monitored	Team Lead MIU	Completed

				through the CSG Q&S meeting structure.		
11.	We found gaps in the controlled drugs check records. In addition, controlled drug stock was not recorded in an official controlled drug register.	The health board must ensure that controlled drugs are recorded on an official register and that staff sign each time they check the stock of controlled drugs.		Central book is in place – however, due to limited use, PTHB use a lot of books for daily checking and sign off; to remove this need a change was implemented by the PTHB medicines management team and therefore the daily checks are in a separate register with approved headings. (see supporting document) Quality walkthrough to be undertaken quarterly as a minimum standard by PHON and Q&S Lead. This will be reported through CSG Q&S meeting structure.	Team Lead MIU Senior Manager USC PHON	Completed

12.	Skin pressure area risk assessments were not undertaken routinely or in a timely way.	The health board must ensure that pressure area risk assessments are undertaken routinely for patients whose presenting condition warrant such a risk assessment.		People will be offered a pressure area risk assessment on attending MIU and this decision will be recorded in their inpatient notes. If someone is not ambulatory, we would complete a skin bundle and refer to District nursing colleagues for onward monitoring. Where a risk is identified we would recommend a mattress and order pressure relieving devices for that person where applicable. During their time on the unit, pressure relief would be implemented including regular	MIU Lead Senior Manager USC	Completed Ongoing monitoring through datix and CSG QSG meetings.

				offloading and the use of repose inflation devices where required. Skin bundles will be completed. Any Pressure areas found on attendance to MIU would be reported on Datix and monitored through PTHB pressure learning panels. Tissue Viability champion has been identified to undertake specialist training in tissue viability and will then lead on this area of expertise within the MIU's throughout Powys. This has been communicated via		

				local team meeting and also discussed at the team leader meeting for all MIU's 19/11/25. This will be picked up via documentation audits and reported via CSG Q&S meetings		
13.	Falls risk assessment were not undertaken routinely or in a timely way for patients when appropriate to do so.	The health board must ensure that falls risk assessments are undertaken routinely and in a timely way for patients whose presenting condition warrant such a risk assessment.		Where people are identified as having a risk of falls, MIU teams refer to Physiotherapy for a holistic assessment of needs. In addition, where there is a concern about falls risk, we will refer to the community falls team to undertake a comprehensive geriatric assessment and falls risk assessment.	MIU Leads Senior Manager USC PHON	In progress Due at end of Q3

				We will work with the MIU teams during Q3 of 25/26 to determine the applicability of the Multi Factorial Falls risk assessment document in MIU's and the onward referral pathways available. The Falls risk assessment will be agenda item on the Team leaders meeting on the 19/11/2025. This will form a rolling agenda on local MIU meetings. This will be picked up via documentation audits and reported via Q&S meetings		
14.	Not all staff spoken with were aware of the sepsis screening	The health board must ensure that staff are aware of the sepsis	Effective Care	All staff are trained in Resuscitation and NEWS2 which includes Sepsis screening.	Team Leads Senior Manager USC	Completed

	tool or how and when to complete it.	screening tool and how and when to complete it.		When someone is considered to have sepsis during their assessment, teams will implement the sepsis screening tool to support the care needs of the individual. This will be picked up at the Team leader meeting on 19/11/25. Outcomes will be reported via the documentation audit and fed into the Q&S meetings and health board Resus meetings. Team leader has added to rolling team meeting agenda to ensure staff have access to training. Senior manager has		

				completed a walk around discussion with staff around sepsis management and sepsis toolkits.		
15.	Pain assessments were not completed consistently, and we found one occasion when a patient who was complaining of pain was not offered analgesia and there was no record of why this was not administered.	The health board must ensure that pain assessments are completed consistently and that staff offer analgesia to patients who are experiencing pain. If pain relief is not administered, then this must be clearly recorded.		All staff in MIU will undertake pain scores for each patient, document clinical reasons for administration or non-administration of analgesia. Team leads will undertake monthly audit of pain scores and associated clinical actions. Monitoring will be undertaken through CSG QSG meeting structure by exception	Senior Manager USC	Completed

16.	There were no ligature cutters available within the unit for use in an emergency.	The health board must ensure that ligature cutters are available within the unit for use in an emergency.		Ligature cutters to be sourced and placed on each MIU resuscitation trolley. Safe use of ligature cutter training available via ESR. All staff to complete by end of Q3 Monitoring to be undertaken via Electronic Staff records Exception reporting to be carried through CSG quality and safety meeting Risk assessment for ligature point recording to be completed for each MIU by end of Q3 and confirmed through CSG Q&S meeting in January 2026.	Team Lead MIU	Completed End of Q3

17.	There were some inconsistencies noted in the detail on some patient notes.	The health board must undertake regular audits of patient records to address any inconsistency.		Monthly audits of patient records to be undertaken by MIU team lead. Learning to be shared with MIU teams in PTHB Exception reporting to be carried through CSG Q&S meeting structure.	Team Lead MIU	Completed
18.	Some staff were critical of staffing levels and that on occasions, there is only one Emergency Nurse practitioner and one health care assistant on duty.	The health board must review the staffing establishment to ensure the MIU always has the right number of staff available each shift and with an appropriate staff skill mix.	Efficient Care	Current staffing levels were determined on the outcome of a demand and capacity review. PTHB are currently reviewing urgent care delivery and undertaking future workforce planning in this area. Recent temporary service change to the	Senior Manager USC	Completed Q1 26-27

				MIU operational hours from 7am to midnight, to the new hours of 8am –8pm has allowed for additional resource of staffing during the operational hours.		
19.	Some felt unsupported by the senior managers outside of the unit.	The health board must review the staff feedback regarding senior managers and ensure a secure platform is provided to listen to staff and take action to address concerns where appropriate.	Leadership	Senior managers are attending monthly team meetings with MIU leads to listen to feedback, support learning & address concerns where appropriate. In addition, senior managers will visit MIU's in person to increase visibility and engaged with staff.	Senior Managers PHON	Completed and ongoing.
20.	Some staff felt it was not always possible to achieve timely professional development, due to the increasing patient demands on the unit.	The health board must allocate dedicated time for clinical development beyond mandatory training, to ensure staff	Workforce	Rosters will be reviewed to ensure that time for CPD is built into practice hours.	MIU Leads Senior Manager USC	Completed

		can enhance their professional skills.		All staff have rostered time allocated for Mandatory CPD. An application process for non-mandatory training is available for all staff. Monitoring and reporting through CSG QSG structure. Monthly ESR review of mandatory training % will be monitored through Q&S meetings to enable escalation of barriers to desired outcome.		

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): Linzi Shone

Job role: **Professional head of Nursing**

Date: **19/11/2025**