Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Derwen Ward, Glangwili General Hospital, Hywel Dda 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 Derwen Ward, Glangwili General Hospital, Hywel Dda University Health Board on 2 and 3 September 2025. The ward has 26 beds and provides mainly urology and trauma and orthopaedic services to patients.

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 15 questionnaires were completed by patients or their carers and one was 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 ward demonstrated strengths in supporting patients' rights and equality and generally patient feedback was positive. Improvements were needed in communication, dementia support and timely service delivery to ensure consistently safe and dignified care.

Most of the 15 patients surveyed rated the ward positively, but concerns were raised about staffing levels, inconsistent care and delays in response to call bells. Some patient comments revealed variability in staff compassion and attentiveness and reported they had experienced discomfort due to lack of timely assistance.

Health promotion materials were limited and mainly located in the day room, reducing visibility. However, campaigns, such as "Help Us to Help You" and "Get Up to Get Well" displayed within the main ward areas, promoted patient involvement with their recovery.

Dignified care was generally observed, with staff maintaining discretion during personal procedures. Yet, isolated incidents compromised privacy, such as personal care without curtains drawn. The ward environment lacked private spaces for sensitive conversations and linen shortages were noted due to a new laundry contract.

Individualised care was supported by healthcare assistants encouraging patient mobility, but dementia-friendly practices were lacking. We noted for those who wore them, staff name badges were yellow with black font making them more dementia friendly. However, tools such as "This is Me" and the Butterfly Scheme were underused and ward signage was inadequate for patients with cognitive impairments.

Timely care was mostly delivered, with urgent needs prioritised. However, delays in physiotherapy impacted recovery especially for post-operative patients and discharge planning could be lengthy. Staff were often too busy to respond promptly to call bells, affecting patient dignity and care.

The "Meet the Team" board lacked clarity on staff roles and language capabilities. The day room was cluttered and underutilised, detracting from patient wellbeing.

Welsh-speaking staff were present but not clearly identified, though patients appreciated being spoken to in their preferred language.

Rights and equality were generally upheld, with staff trained in equality and diversity and patients reported no discrimination. Family involvement in care planning was encouraged, especially for vulnerable patients. Flexible visiting arrangements supported patient-centred care.

This is what we recommend the service can improve:

- Ensure clean linen is always available
- Use dementia-friendly practices such as “This is Me” and the Butterfly Scheme
- Response to call bells is improved
- The day room environment is reorganised to make it suitable for patient use.

This is what the service did well:

- Upholding patients’ rights and equality
- Patient feedback was generally positive
- Staff were seen providing discreet and compassionate care.

Delivery of Safe and Effective Care

Overall summary:
Nutrition and hydration practices were generally positive, with systems in place to identify and support patients needing assistance.

Blood management was robust, with adherence to national guidelines and effective communication during shortages. Medical equipment was generally adequate. Medicines management processes were generally structured and aimed at ensuring safety. However, concerns were identified, including the presence of expired medications, unlocked storage areas and inconsistent checking of emergency equipment.

Skin pressure assessments were completed but did not always result in a care. Falls assessment and prevention was generally good with targeted interventions for high-risk patients. However, sepsis management was inconsistent, with gaps in documentation, escalation and use of screening tools.

Patient records were clear but fragmented between paper and electronic systems, complicating access and continuity of care. Care planning and discharge documentation were also inconsistent.

The inspection of the environment revealed multiple concerns impacting patient safety, infection prevention and overall care quality. Risk management issues included inadequate accessibility for patients with mobility challenges, such as low toilets without adjustable options and insufficient availability of walking aids. Fire safety was also compromised by blocked exits and propped-open fire doors. Immediate environmental risks included unclean toilets, clutter and non-functional medical equipment like suction units and oxygen supplies.

Infection Prevention and Control (IPC) practices were inconsistently applied. While hand hygiene and general cleaning scored well in audits, issues like broken / cracked floor tiles, expired hand gel and lack of bathroom cleaning records were noted. Dual roles of domestic staff in cleaning the ward and serving food posed some questions around IPC, prompting a trial to separate these duties. Staff were trained in IPC, but environmental and staffing challenges hindered effective implementation.

Some aspects of safeguarding processes need improvement, such as engagement with families about Deprivation of Liberty Safeguards (DoLS). Advocacy services were available for patients' who lacked capacity to make judgements or decisions.

Staffing shortages impacted on efficient care, particularly in relation to the treatment room, which was used frequently by patients referred in from the community. Staff referred to trauma and orthopaedic patients on the ward as speciality outliers due to bed availability on appropriate wards, which therefore impacted on the ability to admit urology patients.

Immediate assurances:

- We found immediate environmental and health and safety risks relating to poor decontamination of reusable blood pressure, clutter and dust throughout the ward and not all toilets/ bathrooms were clean. Green 'keep me clean' stickers were not used to identify readiness for use, many bed spaces had no oxygen tubing or masks and some wall suction units were not working at full capacity
- Daily checks of the drug refrigerator and the emergency resuscitation trolley were not always completed
  Key risk assessments were not always completed when appropriate

This is what we recommend the service can improve:

- Ensure hand gels on the ward are in date and disposable curtains are dated when hung
- More dementia friendly signage

- Patients' electronic records should be completed promptly and should reflect changes in patient condition and timely action
- Consider full implementation of the electronic patient record system to manage all patient records appropriately.

This is what the service did well:

- Timely provision of nutrition and hydration with support available to patients as required
- Adherence to national guidelines regarding blood product management
- Patient records were clear.

Quality of Management and Leadership

Overall summary:
The ward benefited from structured governance systems and effective team communication. The results of weekly audits, including NEWS2 compliance, were shared with staff via instant messaging and team meetings. Senior ward managers provided daily visible leadership, while higher-level managers engaged virtually. Staff were well-informed through consistent information flows, including updates from regulatory bodies. Policies and procedures were current and accessible.

Roles and responsibilities were clearly defined, with strong staff engagement and alignment to health board values. Despite staffing challenges, such as high turnover, sickness and vacancies, the ward maintained a strong team culture. Staff often covered shift vacancies through overtime, with minimal reliance on temporary staffing. The ward had around six vacancies for Healthcare Support Workers (HCSWs) and despite this, recruitment was paused pending a skill-mix review. Staff felt the ward was under established, with an appropriate skill-mix given patient acuity, dependency and workload.

Training opportunities were available, including specialist training and internal progression. Mandatory training compliance was just under 80%, affected by staff on long term sickness absence. However, some staff were not compliant with basic life support training updates and portable oxygen cylinder training. Appraisal compliance was at 100%.

Quality and safety were monitored via electronic systems and weekly assessments. Complaints and incidents were managed through Datix and discussed in staff meetings. Staff believed there had recently been an increase in complaints related to care related to insufficient staffing and food quality and choices.

The ward fostered a culture of openness, teamwork and pride. Staff felt supported in escalating concerns and contributing ideas within the ward. Staff could access wellbeing services and stress management resources as and when required.

A duty of candour policy was in place, understood by staff and applied in practice. Quality improvement initiatives like hydration plans and seasonal activities enhanced the patient experience. Multi-agency partnerships were in place aimed at improving discharge planning, reflecting a whole-systems approach to patient care and support. However, some record storage issues were noted.

Immediate assurances:

- Paper patient records, including documents due for archive were stored and unattended in various locations throughout the ward. This included an unlocked ward clerk office and patient records trolley.

This is what we recommend the service can improve:

- Ensure staff complete Basic Life Support and portable oxygen cylinder training
- Review the staff establishment and skill-mix taking account of patient acuity and dependency and the flow of patients through the treatment room.

This is what the service did well:

- All staff were in date with their appraisals
- Clear and visible leadership on the ward
- Strong team culture
- Opportunities for additional training to enhance staff knowledge and capabilities.

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

3. What we found

Quality of Patient Experience

Patient Feedback

We received questionnaire feedback from 15 patients. Responses were generally positive with most rating the ward as 'very good' or 'good'. Patient comments included:

> ***"Treated very well…. Answering buzzer depends how busy the staff are."***
>
> ***"Some staff are better than others. Short of staff. No help in toilet, wobbly on feet! Patient has been cold and staff did not supply anything - had to wait for dressing gown to be brought in."***
>
> ***"Staff great, doctors great, food awful."***
>
> ***"Some staff good, some busy, some lack compassion, short staffed. Been without clean sheets and gown, cleaning contract changed. Sometimes left all day and have to sit in chair, not comfortable after op… Not enough physios. I've needed to climb stairs before going home but haven't been given opportunity, not given exercises. Been in hospital 2 weeks some days not even taken down corridor."***

Person-centred

Health promotion

There was limited health promotion information available to patients within the ward and this was primarily displayed in the day room. Materials including posters and visual aids focused on key topics such as sepsis awareness and general self-care.

Campaigns such as "Help Us to Help You" and "Get Up to Get Well" were visible encouraging patients to take an active role in their recovery. There was also a document available to patients in the day room, 'Patient information', with useful tips on what to expect in hospital.

The health board must ensure more health promotion information is available to patients, such as healthy eating, smoking cessation materials and information from charities such as Age Cymru Dyfed to support elderly vulnerable people.

Dignified and respectful care

We observed patient care being administered with discretion, with curtains drawn around beds during procedures. Staff communicated with patients in a discreet, sensitive and courteous manner. All patients appeared well cared for and relatives were allowed to visit out of hours. All but two respondents, in the patient survey felt staff treated them with dignity and respect and almost all said measures were taken to protect their privacy, such as curtains drawn and staff helped them with their toilet needs in a sensitive way. However, patients informed us there had been isolated incidents where privacy was compromised, such as an elderly patient being placed on a bedpan in a four-bed bay without the curtains being drawn. Another patient said curtains were not routinely drawn when patients were on bed pans. This is not acceptable and the health board must ensure that this is addressed promptly.

Further concerns were raised, by patients, about the consistency and quality of care. An elderly patient described being made to walk to the toilet five times in a single day despite expressing fatigue and requesting a bedpan. Several patients commented the standard of care varied depending on which staff were on duty and many felt the ward was generally understaffed, which impacted the overall patient experience and support. The health board stated that as part of the Goal Five Welsh Government initiative: Optimal hospital care and discharge practice from the point of admission, staff were encouraged to promote independence and prevent deconditioning of patients. Utilising the SAFER principles and enablers, patients were encouraged to ‘Get up, Get dressed, Keep moving’.

Patients’ continence needs were recorded electronically and appropriate continence support was provided, including catheter care and discharge planning.

The ward environment presented some challenges to patient dignity, including a lack of private rooms for sensitive conversations. We were told by patients that the ward often had to wait until late evening for clean sheets, which was due to the newly implemented laundry contract.

Medical rounds were conducted at each patient’s bedside in line with standard practice and staff across all grades were noted being polite and compassionate in their interactions.

The health board must ensure:

- **The dignity and respect of patients is met consistently including drawing curtains and closing doors whilst staff are administering to patients' personal needs and when patients are using a bedpan**

- **Clean linen is always available for patients on the ward.**

Individualised care
Staff were seen actively helping patients to mobilise throughout the day. Mobility aids, such as walking frames were within easy reach and patients were encouraged to care for themselves as much as possible.

There was limited evidence of dementia-friendly initiatives in place on the ward. There was a "This is Me" section within the electronic patient record, which was not regularly and routinely completed. The use of the "Butterfly Scheme" was not observed where appropriate, for patients with dementia.

Mental capacity assessments were recorded electronically, with no issues noted. Signage throughout the ward was poor, including the absence of clear signs on toilet doors, nor dementia-friendly signs to assist patients with sensory or cognitive impairment.

The health board must ensure that:

- **The signage is improved to ensure it is more dementia friendly**

- **Person-centred tools like "This is Me" and the "Butterfly Scheme" are used to fully support patients with cognitive impairments.**

Timely

Timely care
Patients generally appeared to receive appropriate and timely support for their care and treatment, with nursing staff reporting urgent needs were prioritised and time-critical conditions were managed in a way that minimised risk. Patients approaching end-of-life care were observed to be comfortable and receiving dignified, personalised attention.

In the patient survey, most patients responded that staff were kind and sensitive when they carried out their care and treatment. Whilst most patients said they had access to a call bell, only half agreed that when they used the call bell staff came to them. During the inspection we noted staff were busy, but the lack of

timely response affected patient dignity and care quality. Staff we spoke with felt they did not have time to adequately care for patients.

Some patients commented:

> *"Service is pretty good. Staff helpful. Staff cannot always be understood. Not enough staff to answer the call bell."*

> *"Patient has the care that she wants, though also feels staff are too busy to answer buzzers."*

> *"[Staff should] attend quickly when buzzer goes……"*

The health board must ensure staff answer call bells in a timely manner to maintain patient safety, dignity and quality care.

Patients experienced delays in discharge associated with reduced physiotherapy staffing and some reported limited communication from staff. While there were indications that staffing levels may influence the consistency of care delivery and responsiveness to patient needs, patients were generally observed to have received appropriate care.

Patient feedback indicated difficulties in self-care and health management during hospital stays. Two patients experienced longer admissions after hip surgery due to delayed physiotherapy and others reported that untimely physiotherapy affected their recovery.

The health board must urgently review the provision of physiotherapy services on the ward, to ensure patients receive timely and appropriate assessments and care to support their recovery and prevent delays with discharge.

Equitable

Communication and language

The 'meet the team board' displayed outside the day room was a positive feature, presenting photographs of staff members. However, not all staff were wearing name badges or had visible identifiers on the board and there was no accompanying explanation of uniform colours or corresponding staff roles.

It was noted that the ward did not have provisions such as a hearing loop system, braille signage, or pictorial aids for patients with hearing, sight, or language difficulties. Most patients reported that the ward was accessible for wheelchairs

and included some facilities for visual or hearing impairments. Staff stated that braille treatment consent forms were available.

Translation services were available when needed and bilingual materials were generally present, particularly health board information.

The patient's day room was cluttered and poorly maintained, making it unsuitable for patient wellbeing. Trailing wires, a mop by the door and a notice board on the table made the room seem more like a storage area, than a patient area.

The health board must ensure that the:

- **Ward has the relevant equipment and materials to support patients with hearing, sight and language difficulties**

- **Meet the team board is updated with a description of the uniform colours worn by staff and their roles**

- **The patient day room is decluttered and patients are informed of its availability and purpose to improve access, encourage social interaction and support wellbeing.**

There was limited visual indication of Welsh-speaking staff, due to the absence of 'Iaith Gwaith' badges, although several staff were heard speaking Welsh to patients and relatives. Patients confirmed they were asked about their preferred language and had opportunities to speak Welsh, which was appreciated. Staff understood the importance of speaking with patients in their preferred language, supporting the delivery of good healthcare. The pharmacist reported how helpful speaking Welsh to patients was in gathering drug histories and patients preferred to speak in their first language.

In the patient survey, only 40% said they were able to speak with staff without being overheard by other patients. Just over half of respondents felt staff listened to them and answered their questions and 60% felt they were involved as much as they wanted to be in decisions about their healthcare. One patient we spoke with provided examples where they were not informed about the status of their treatments, additionally, in our survey, one patient commented:

> ***"…The staff on the ward are amazing. However, communication has been an issue previously, when we ask questions not everyone can answer. However, this has improved recently and we have been kept up to date with my mother's care. They are hardworking despite not benefitting***

from extra staff, unfortunately this is a health board / government issue which needs to be addressed for ongoing patient care."

The health board must ensure all staff:

- **Wear name badges and that these clearly display staff who can speak Welsh**

- **Always update patients with their plan of care or treatment**

- **Are reminded they must treat patients in a kind and caring manner.**

There was a 'patient status at a glance' (PSAG) board on the ward corridor. It was positive to note the information listed was relevant to each patient, including dietary and mobility needs, to help with communication across the ward team. The information on the board was also used during the board round. The screen covering patient names on the board was not consistently closed during the initial part of the inspection. This was addressed under our concerns regarding patient safety which were escalated and resolved during the inspection highlighted at Appendix A.

Rights and Equality
Staff were compliant with mandatory training for equality and diversity and there were various policies in place to support staff and we found a general culture of treating people with dignity and respect.

Families were involved in planning hospital care and discharge, especially for patients with dementia or those subject to Deprivation of Liberty Safeguards (DoLS). Religious and cultural needs were considered, with documented assessments in the electronic record.

Visiting arrangements were flexible, allowing relatives to be present outside standard visiting hours, including overnight for some sicker patients.

All patients in the survey confirmed they had not faced discrimination when accessing or using this health service and they could access the right healthcare at the right time.

Delivery of Safe and Effective Care

Safe

Risk management
The ward environment presented several concerns regarding accessibility, cleanliness, safety and suitability for patient care. Whilst the ward was wheelchair accessible and mobility aids were available, patients were not consistently provided with other appropriate aids. Toilet areas had support rails but one patient noted the toilets were too low and there was no variety in height options.

The health board must ensure the relevant equipment is made available to support patient mobility when required.

Fire safety concerns were noted, including stairs blocked by a metal pole outside of a fire exit following some remedial works and automatic closure fire doors were propped open with boxes or bins. Other doors marked as 'fire doors, keep shut' were also propped open with boxes, including doors to the storeroom containing intravenous fluids and the cleaning room where hazardous chemicals had been left out on a worktop. We informed the ward manager and this was addressed during the inspection.

We also noted that there were shelving materials stored in the ward clerk's office, cluttering the environment, which were awaiting installation for several months. These concerns were addressed under our concerns regarding patient safety which were escalated and resolved during the inspection highlighted at Appendix A.

We found several other issues across the ward which required immediate attention, which included:

- Blood pressure cuffs not decontaminated between patients
- Clutter and dust throughout the ward and not all toilets were clean
- Green 'keep me clean' stickers were not used to show that the equipment had been cleaned and was ready for use
- Not all beds had oxygen tubing and oxygen masks readily available for patients use
- Some wall suction units were not working at full capacity.

These issues were addressed under our immediate assurance process highlighted in Appendix B.

The ward was considered a Urology Ward and during inspection accommodated 10 urology patients and 16 trauma and orthopaedic patients. The relatively high number of orthopaedic cases, some of whom were considered outliers, could present a risk to patient safety and/ or their recovery where staff are not adequately trained in that speciality.

Infection, prevention and control (IPC) and decontamination
Infection rates were monitored through the Audit Management and Tracking (AMaT) system, with results discussed centrally and actions cascaded to the ward. Monthly audits were conducted, with hand hygiene scoring 92% and general cleaning 96%. However, Credits for Cleaning scores were not visibly displayed and some IPC principles were inconsistently applied.

Infectious patients would be managed in the single side rooms when available, prioritising those with more transmissible conditions. However, during inspection, one isolated patient's door was left open despite signage indicating it should be closed, raising concerns about adherence to protocols. Staff were trained in IPC, including aseptic non touch techniques and personal protective equipment was used appropriately, with correct donning and removal observed. Hand hygiene facilities were accessible.

There were broken tiles and cracked floors in some rooms, hindering effective cleaning. Cleaning schedules existed, but toilets lacked visible records. In addition to cleaning, domestic staff also served food. Although they changed aprons, concerns were raised about IPC due to the dual role. A trial separating cleaning and food service roles had previously been conducted, with ongoing work in the hospital hotel services to implement this change.

Occupational health support was available and staff were aware of procedures for incidents like needlestick injuries. Staff understood IPC policies and their roles, but practical implementation was hindered by environmental issues and staffing shortages. For example, expired hand gel was found in the day room and there were no dates present on the disposable curtains, although they appeared to be clean.

The health board must ensure that:

- **Damaged areas, such as broken tiles and cracked floors are repaired to limit potential IPC issues**

- **Cleaning records are displayed in the toilets on the ward**

- **Hand gel on the ward is in date to maintain its effectiveness**

- **Disposable curtains are marked with a date the curtains were hung, to ensure they are replaced in a timely manner, or sooner if soiled**

- **There is a separation of duties between domestic staff cleaning the ward and serving food**

- **The relevant precautions are taken when treating isolated patients including closing doors.**

In the patient questionnaire all respondents felt the setting was 'very clean' or 'fairly clean' and most respondents felt that IPC measures were being followed.

Safeguarding of children and adults
We considered patients subject to Deprivation of Liberty Safeguards (DoLS). The senior sister reported that when patients are subject to a DoLS appropriate steps are taken for this, which includes, family engagement and support team involvement and the provision of information leaflets as appropriate, in addition, that advocacy arrangements are considered for patients lacking capacity. For one patient, we identified in communication, where one family member we spoke with felt inadequately informed about the DoLS arrangement.

The health board must ensure that where appropriate, family members, such as next of kin or those with Health and Welfare Lasting Power of Attorney are kept fully informed of decision relating to care of the patient, such as patient subject to a DoLS.

Staff safeguarding training was mandatory and staff highlighted that safeguarding officers provide further updates during team meetings. Despite the ward having links with the safeguarding team and access to corporate policies, record keeping, particularly with mental capacity and DoLS, was poor.

The health board must strengthen the safeguarding processes on the ward which includes robust documentation and accessibility to safeguarding policies and Wales Safeguarding Procedures.

Blood management
There were systems in place to ensure the safe management of blood and blood products and the nurse had a designated lead for safe blood product management. Staff complied with national guidelines and health board policies and completed blood transfusion training every three years. Patient identification and blood component checks were conducted appropriately throughout all stages of the process. Staff we spoke with were knowledgeable about the transfusion process and action required for adverse reactions.

Management of medical devices and equipment
Equipment was serviced appropriately, however, whilst equipment was generally in good condition and sufficient to meet patient care needs, we noted issues with the accessibility of air mattresses.

The health board must ensure that the relevant medical devices, such as air mattresses are accessible in a timely manner.

Medicines management
Medication charts were appropriately completed, signed and dated. A dedicated pharmacist and pharmacy technician supported the ward and those we spoke with felt they had a good working relationship with the ward team.

Any non-stock medication needed out-of-hours was accessed through a central stock supply or accessible via the on-call pharmacist. Oxygen was appropriately prescribed and staff were aware of incident reporting procedures if applicable. The medication room was always locked during inspection.

Medication rounds appeared well-organised, and staff communicated with patients in a kind and compassionate manner.

Intravenous fluids were prescribed appropriately and the volume was also recorded on fluid balance charts. However, we found an example of one urology patient post-urosepsis, did not have a fluid balance chart in place when it was appropriate to monitor their fluid balance.

The health board must ensure that fluid balance charts are completed for all applicable patients.

Medicines were generally stored securely in locked cupboards and controlled drugs were checked daily with accurate records in place. However, we found a medicine trolley and a medication fridge unlocked during the inspection. We highlighted this to ward staff and this was promptly addressed during the inspection. When

checking some medication expiry dates we noted they had expired in May 2025. The ward manager immediately removed the medication from the stock for appropriate disposal. These were addressed and resolved during the inspection and are highlighted at Appendix A.

Checks of the drug refrigerator temperatures were not completed daily in line with local procedures. In addition, we found checks of the emergency resuscitation trolley were not completed daily in line with local policy and the standards set out by the Resuscitation Council UK. These issues were addressed under our immediate assurance process highlighted in Appendix B.

Preventing pressure and tissue damage
Skin pressure risk assessments were completed on patient admission and were recorded electronically. However, there was no evidence of care plans implemented nor turn charts where appropriate to do so. The electronic records appeared to be updated regularly, but changes in patient conditions were not always appropriately recorded where appropriate.

The health board must ensure a clear process is implemented that captures changes in patient condition and the need for skin pressure reassessment.

Falls prevention
Falls risk assessment had been completed as appropriate in all six patient medical records we checked.

Staff discussed the considerable emphasis on fall prevention, particularly among patients who may be confused post-operatively or at risk of tripping over catheter tubing. The Quality and Assurance team conducted a ward mapping exercise to identify high-risk areas. Following this assessment, an action plan was developed that included grouping higher-risk patients for easier observation, utilising bed alarms where appropriate, encouraging suitable footwear and providing enhanced support to further reduce fall incidents.

Effective

Effective care
Registered nurses and healthcare support workers had a general understanding of sepsis, with mandatory sepsis training covering sepsis awareness, the updated National Early Warning Score (NEWS2) and Immediate Life Support. However, we noted some incomplete documentation and inconsistent escalation of care where appropriate.

A sepsis display board was outside the day room and outlined key steps for assessment and escalation. Staff reported knowing where to access sepsis policies and guidelines via the intranet and having time and access to do so.

The ward used the NEWS2 tool for recording observations. However, escalation protocols were not reliably followed. The use of the sepsis six care bundle was inconsistent and while sepsis forms were available on the resuscitation trolley, they were not found in patient notes where appropriate and the folder designated for archived sepsis forms was empty, indicating a lack of audit trail.

There was no fluid warmer on the ward to heat intravenous or irrigation fluids to an optimal temperature when required, to minimise risk of hypothermia. However, we were told that if one was required, this would be provided by the theatre department if directed by a doctor.

The health board must ensure that there is a robust system in place for timely escalation of care, consistent use of screening tools and adherence to best practice guidelines, including sepsis.

When we checked a sample of six patient records, one record highlighted that a NEWS score of seven was not acted upon as appropriate. In addition, Venous Thromboembolism (VTE) risk assessments had not been completed for any of the patient records checked. This was addressed under our immediate assurance process highlighted in Appendix B.

Nutrition and hydration

Nutrition and hydration practices were appropriate and a red tray and red lid initiative was in place to identify patients needing assistance with eating and drinking.

We observed meals being served promptly by housekeeping staff, however, we were told that staff shortages prolonged the process therefore affecting food temperature and timely service. This was supplemented by nursing staff on occasionally however, this impacted sometimes impacted on timely clinical duties.

Food preferences were recorded digitally, but we were told the system had limitations, requiring staff to call the kitchen for updates. Most patients appeared satisfied with their meals and the menu seemed nutritious and healthy, though food was not always visually appealing. However, two patients expressed dissatisfaction, citing poor presentation and taste, with one suggesting they had lost weight due to inability to eat the food.

Nutritional risk assessments were being completed for all patients within 24 hours of admission, with documentation generally well maintained on the electronic record system. However, assessments within the emergency department pathway document were not consistently completed and a few were slightly out of date.

The health board must ensure that nutritional risk assessments are completed and ensure patients are offered alternative meals where appropriate to meet their nutritional needs.

Nutritional assessments were completed and care plans were developed as appropriate and referrals made to dietitians or speech and language therapy (SALT) where indicated, reflecting a responsive approach to individual nutritional needs. Oral care plans were also in place, supporting overall patient wellbeing.

Most patients said in the questionnaire, they had time to eat their food at their own pace and they always had access to water on the ward. We saw that all patients had water jugs at their bedside.

Patient records
Electronic risk assessments were completed and up to date, with clear, legible and timely documentation. However, the combination of both electronic and paper records made navigation of records difficult. Medical records were also arranged in date order but split between the front and back of files, complicating access to recent medical history.

The health board must consider fully implementing electronic patient record system to access and manage patient records appropriately.

Care planning to promote independence was inconsistent, only half of care plans were documented and few reflected individual needs. Discharge planning was noted verbally and on whiteboards, but supporting documentation was limited. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were present, though copies were not always provided to patients in line with the national policy.

Pain management was robust, with regular assessments completed and appropriate analgesia administered as prescribed. Patient needs were promptly assessed on admission, including language preferences. Handover sheets and MDT involvement were documented, but “What matters to me” and care plans were inconsistently completed. Catheter records were also sometimes missing from e-notes.

The health board must ensure that:

- **Care planning to promote independence is completed consistently and reflects individual patient needs**

- **There is supporting documentation to support discharge planning**

- **Copy of DNACPR forms are provided to patients**

- **Catheter records are completed in full**

- **There is greater integration between paper and electronic records.**

Efficient

Efficient
Services were arranged to support movement through care and treatment pathways. This included timely referrals into and out of other services, effective multidisciplinary working, involvement of third-party providers, integration with social care and collaboration with primary care. Staff worked across services to coordinate care and engaged with families and carers to achieve the best possible outcomes for patients.

We noted that there was a standard operating procedure to define and formalise the movement of emergency and elective patients through the treatment room at the end of the ward. This was to ensure pathways of care for urology patients via the Emergency Department could be avoided. Patients requiring admission would be transferred to the next available ward bed, to provide a constant flow within the treatment room. Although we were told that an assistant practitioner would manage this area, they often had to work across the wider ward due to staffing issues. This therefore meant that the treatment room was understaffed, placing additional pressure on ward staff.

The health board must ensure that both the ward and the treatment room are appropriately staffed as intended to maintain safe and timely care.

The ward sister reported that discharge support was adequate, with access to a discharge lounge, physiotherapy and occupational therapy services. A “How Can We Help?” board had been placed at the ward entrance to encourage relatives to participate in discharge planning. Despite these measures, delays persisted due to patients awaiting community services and care packages, which the ward sister believed should be improved to reduce discharge delays.

The health board must ensure hospital staff work closely with social care teams to ensure that patients are discharged promptly when medically fit.

We were told that patients were referred for trial without catheter to the district nursing team. Although the district nurses had received training to reinsert catheters, the complexity of some patients meant that some were referred back to the ward team for re-catheterisation, which often increased pressure due to workload on ward staff.

We were informed that some district nursing teams were not sufficiently skilled to manage urology patients, therefore were unable to accommodate them on the community case load. This impacted on ward staff where patients may need to attend from the community for dressing renewal or change of catheter. This also impacted on patients, where some had to travel for long distances for this.

The health board stated that the District Nursing team have the sufficient skills to manage the urology patients and catheter management and care, within the community setting. The community have a robust training development system set up with an online training session that all band four HCSW and Registered Nurses complete. All staff complete a clinical competency booklet before they were deemed safe to care for urology patients. There were Trial without Catheter (TWOC) clinics set up in the Carmarthenshire Community and they were run by highly skilled professionals.

The health board must complete a training needs analysis for its community nursing staff, to appropriately support them to adequately manage urology patients at home and minimise the need for patients reattending the ward for less complex nursing care procedures.

Quality of Management and Leadership

Staff feedback

HIW issued staff questionnaires to obtain their views on Derwen Ward. However, only one member of staff completed a questionnaire, so we could not draw key conclusions from this about staff experiences on the ward..

Leadership

Governance and leadership
Governance and leadership on the ward were supported by structured systems and regular communication. Weekly audits were conducted and results shared via instant messaging and team meetings. Senior nurse managers were present daily, providing visible leadership, whilst higher-level managers engaged primarily through virtual platforms. Information flows between senior management and staff ensured updates and safety notices from regulatory bodies were cascaded effectively.

Staff were clear on their roles, escalation procedures and accountability, with a shared commitment to health board values and patient-centred care. Leadership was evident and staff felt supported. Governance structures worked well, with effective interaction and clear processes for identifying and managing risks. Staff engagement was strong and there was a collective understanding of the ward's vision to deliver quality care efficiently. There was good teamwork evident.

Overall, governance arrangements were good, communication was effective and staff demonstrated a clear understanding of their responsibilities and the ward's goals.

Senior nurses were consistently present at daily flow meetings and were available for advice, support to staff throughout the day. The ward manager and ward sisters were also active and visible on the ward. Staff had easy access policies and procedures, which were in date.

Workforce

Skilled and enabled workforce
We were told that the ward had faced staffing challenges, with regular turnover and sickness. Several staff members had recently resigned. Despite these difficulties, there was a strong culture of teamwork, with staff describing the ward

as a good team environment where everyone worked together for patients. Staff felt able to escalate concerns to ward sisters, but there was less clarity or confidence about escalating issues beyond the ward. Health board-wide staff support services were available and employees could access counselling where appropriate.

There were just under six whole time equivalent vacancies for HCSWs on the ward. This greatly impacted the ward, as staff reported ongoing issues with the ability to recruit temporary staff to fulfil shifts. Although filling shifts were easier on nights. Agency staff were rarely used, instead, substantive staff often covered unfilled shifts through overtime.

Acuity levels on the ward varied, especially based on the proportion of urology to trauma and orthopaedic patients, as the latter were generally higher in acuity and dependency and required more staff resource. HCSWs were at times also reassigned to cover shifts on other wards, which further impacted resource availability. Whilst staff could request additional support, this was often limited impacted by vacancies on other wards.

Staff reported that recruitment for HCSWs was paused, pending a skill-mix review for the ward, therefore delaying recruitment for unfilled vacancies. Staff perceived the establishment as insufficient, particularly due to the need for day-to-day management of varying dependency and acuity of patients on the ward and the flow of patients through the treatment room. This was impacted further when acuity and dependency increased, or there was a need for additional support for some cognitively impaired patients.

Ward staff we spoke with reported mixed views on their ability to maintain safe care, which predominantly related to insufficient staff numbers based on patient acuity and dependency, therefore impacting patient care. We were told that staff shortages and unfilled shifts were often reported on Datix and band two HCSW absences were often filled by band three or four staff.

The health board must consider the staff feedback around the patient speciality, their acuity and dependency in line with the establishment and the ongoing impact of vacancies and unfilled shifts, impacting both patients and staff. Consideration should also be given to the staffing required to manage attendances through the treatment room.

Staff received regular supervision, appraisals and opportunity to attend staff meetings. Communication was facilitated through online measures, although staff absences could make information sharing challenging. Learning from incidents and

good practice was cascaded through meetings and digital platforms, with senior staff attending wider meetings to share learning across the hospital.

Training and development opportunities were available to all staff, which included additional training opportunities, such as for stoma care, wound care, pain management. Additionally, some staff were supported to undertake a master's degree and diploma programmes. The ward also facilitated student nurse placements, which included a robust induction and valuable learning experiences, which facilitated the 'grow your own' initiative that helps encourage development, recruitment and retention of staff.

Mandatory training was tracked via the electronic staff record and compliance was overall, just under 80% for the ward. Although this included the staff with low compliance due to long term sick absence. However, a key area that needed improvement was staff compliance with portable Oxygen cylinder training, with very few staff having received this, despite previous patient safety alerts circulated across NHS Wales around portable oxygen cylinder safety ((WHC/2024/036) Oxygen cylinders: regulation 28 report and patient safety notice 041 reminder).

We checked a sample the mandatory training of five members of staff. Some were not complaint with receiving up to date basic life support training. We were told there had been difficulties in arranging face to face training in the health board. It was, positive to find that the compliance with annual appraisals for staff was 100%.

The health board must ensure that:

- **All relevant staff complete portable oxygen cylinder training in line with national patient safety alerts**
- **Ensure all staff are supported to attend mandatory training in a timely manner.**

Staff were recruited and employed centrally by the health board once all the relevant pre-employment documentation had been completed. Copies of various documents were available to ward management.

Whilst there was no visible information about Llais, to support patients in raising concerns, there were leaflets available for the NHS Wales Putting Things Right process within the day room. Verbal and informal concerns are captured, with communication and treatment being common complaint themes.

Complaints and incidents were shared with staff through ward meetings and online applications. Lessons learned were discussed in assurance meetings and cascaded to staff. Incidents were investigated at ward level with MDT involvement.

Culture

People engagement, feedback and learning
There was a strong culture of openness and honesty, with staff working collaboratively to try and support early recovery and timely discharge. Daily board rounds involved multidisciplinary input, including physiotherapists, occupational therapists, discharge liaison nurses and social workers, with an external wellbeing provider occasionally involved for care packages.

Staff at all levels were encouraged to raise ideas or concerns. HCSWs typically escalated issues to a designated band five nurse or the ward manager. Staff were aware of the line management structure, the whistleblowing process and a no-blame culture was evident.

Staff consistently reported pride in their work and a strong team ethos. Nursing staff frequently picked up overtime and student nurses expressed a desire to remain with the health board, reflecting a positive and supportive training environment. There was a focus on wellbeing with staff knowing how to access support services. Stress risk assessments, occupational health referrals and human resource-led sickness meetings were in place. Managers told us they maintained contact with staff on sick leave, offering one-to-one meetings and phone support.

Staff feedback mechanisms included informal initiatives. Patient feedback was centrally gathered and acted upon, with one example leading to quieter night-time practices.

The health board had a clear Duty of Candour (DoC) policy accessible to staff electronically which also included training materials. Staff understood the principles of DoC and were encouraged to discuss any incidents with patients as appropriate. Examples were provided where staff had exercised the DoC, including written communication and apologies following investigations.

We spoke with occupational therapy staff who covered multiple wards. They discussed the handover process being held at the PSAG board, due to a lack of dedicated space for MDT discussions. They stated that there were enablement HCSWs on the ward whose role it was to mobilise patients regularly. However, due to staff vacancies and unfilled shifts they were often unable to do this to carry out other HCSW responsibilities.

Information

Information governance and digital technology

There were systems in place to support the effective collection, sharing and reporting of data within a sound information governance framework. Staff used individual logins to access systems and sensitive information, such as safeguarding reports were shared securely using password protection. The service monitored the quality of care through regular audits, which helped identify areas for improvement and drive changes in practice.

Data submission to external bodies was managed centrally, although no specific examples were provided. Internally, the service used dashboards to track key performance indicators (KPIs), training compliance, audit outcomes, staffing levels and patient feedback. These tools supported the delivery, planning and monitoring of the service. Regular meetings and reviews of incident reporting systems such as Datix also contributed to continuous quality improvement.

We found paper patient records, including documents for archive were left unattended in the various locations throughout the ward. This included an unlocked ward clerk office and the patient records trolley (where staff did not know the keycode to lock it). We were subsequently told that digilocks had been ordered during inspection including new locks for the patient records trolley. This was addressed under our immediate assurance process highlighted in Appendix B.

Learning, improvement and research

Quality improvement activities

The ward had implemented several quality improvements and wellbeing initiatives to enhance patient safety and experience.

In terms of quality, safety and wellbeing, the ward introduced a hydration plan featuring a red trolley stocked with extra drinks to prevent dehydration and to supplement nutritional needs. Other initiatives included the “Thinking Umbrella” project, which provided signposting for both patients and staff to access wellbeing support.

Seasonal initiatives such as “lolly rounds” during summer helped keep patients cool and hydrated, while festive activities like a Christmas decoration competition and themed events, such as “Winter Wonderland” created a positive and inclusive atmosphere. The ward also celebrated International Nurses Day, winning a competition for best themed ward and hosted events like cake-sharing to promote staff and patient morale.

Whole-systems approach

Partnership working and development

The service engaged with a range of system partners to support patient care and discharge planning. Carers Wales was available to speak with relatives who may need support, offering a link to third-sector services.

General Practitioners (GPs) communicated directly with speciality doctors to agree admissions, particularly in relation to assessments. In addition, a service level agreement had been implemented with social services, to maintain care packages for up to seven days, instead of being cancelled after 48 hours, to minimise discharge delays.

Internally, the service collaborated with district nurses for specialist advice, such as managing patients with nephrostomies. Discharge planning was supported by the involvement of social workers, the discharge liaison team and an external provider, who focused on prevention and early intervention, ensuring a coordinated approach to patient transitions and ongoing care needs. These interactions reflected a multi-agency approach aimed at improving outcomes and supporting patients and families throughout their hospital journey.

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 summaries 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
There was a patient status at a glance (PSAG) board on the corridor on the ward. The confidentiality screen on the board was not closed during the initial part of the inspection. consistently.	Confidential information about patients on the ward could be seen by other patients or visitors when they passed the board.	We informed the senior ward staff.	Senior ward staff informed all other staff, including medical and MDT staff aware of the need to ensure the confidentiality screen was closed, when not in use.
Safety concerns included the stairs on the outside of a fire exit from the ward were blocked with a metal pole following some remedial works on the previous weekend.	Patient and staff safety could be put at risk due to tripping hazards and IPC risks.	We informed the ward manager.	We informed the ward manager about these and these were rectified during the inspection.

Some of the automatic closure fire doors were also propped open with boxes or bins. Doors marked as ‘fire doors, keep shut’ were propped open with boxes on the floor, these included the storeroom for intravenous (IV) fluids and the cleaning room with hazardous chemicals on a worksurface.			
We checked the use by dates of medication in the general medication stock cupboard and we noted that the lipid medications had expired at the end of May 2025.	Overdue medication loses its efficacy and may not be meeting the patients’ medication needs.	The ward manager was made aware of the issue.	The ward manager immediately removed the medication for destruction.
One medicine trolley and one fridge were found unlocked during the inspection	Medication could be taken and misused by patients or visitors.	The senior ward staff were made aware of the issue.	Medication trollies and fridges were noted to be locked for the remainder of the inspection.

Appendix B – Immediate improvement plan

Service: Derwen Ward, Glangwili Hospital

Date of inspection: 2 and 3 September 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.	HIW was not assured that the ward was undertaking consistent, daily checks of the drug refrigerator in line with local procedures. Furthermore, that the ward was undertaking, daily checks of the emergency resuscitation trolley in line with local procedures and the standards set out by	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	Delivery of Safe and Effective Care	• To remind all ward clinical staff of the requirement to consistently record the date and temperature reading in the dedicated logbook located in the clinical room, confirming completion of daily temperature checks. • To undertake spot checks the over the next month.	Senior Ward Sister Senior Ward Sister	Complete 30th September 2025

	the Resuscitation Council UK. We reviewed the checks of the temperature of the drug refrigerator in the clinical room and noted that there was no evidence to show that checks had been completed. During discussion with staff, we were told that checks had been completed and that the records of these checks had been kept but had been removed, when an old refrigerator was disposed of over the weekend 30-31 August 2025. A folder with checks is now in place.			• To conduct weekly spot checks to verify compliance with daily medication checks as outlined in the medication policy. Any discrepancies or missed entries to be documented and escalated to the Senior Nurse Manager within 24 hours for prompt resolution. • To undertake spot checks of the results monthly to ensure sustained compliance. • To review the training attendance and requirements of staff for Medication Safety & e-learning module and report and	Senior Ward Sister/designated team member Senior Nurse Manager Senior Nurse Manager	With immediate effect - complete 31st October 2025 31st October 2025

				report findings, with improvement actions if required, at the Medication Scrutiny Meeting. • To further sharing and dissemination of learning within wider Health Board forum: 1. Community & Integrated Medicine Clinical Care Group Integrated Governance Group (Quality, Health & Safety); 2. Senior Nurse Management Team (SNMT) and 3. Medication Events Review Group (MERG). • To undertake the medication audit, which is recorded on	Deputy Head of Nursing Senior Nurse Manager	30th September 2025 17th November 2025 26th September 2025 31st October 2025.

				AMAT, in accordance with the medication policy. (The audit was last completed in June 2025 and is usually repeated six-monthly. Actions arising from the audit will be developed in an improvement plan and reviewed within one month to ensure compliance and continuous improvement.)		
2.	HIW was not assured that the ward was undertaking consistent, daily checks of the drug refrigerator in line with local procedures. Furthermore, that the ward was undertaking,	The health board must ensure that daily checks of the emergency resuscitation trolley are completed and documented daily.	Resuscitation Council UK Guidelines	• To remind all ward clinical staff that they must perform and document daily checks of the emergency resuscitation trolley in line with the resuscitation policy.	Senior Ward Sister	Complete

	daily checks of the emergency resuscitation trolley in line with local procedures and the standards set out by the Resuscitation Council UK. We further reviewed the record of the daily checks of the emergency resuscitation trolley for the months of July and August and noted inconsistent daily checks. This was an on-going failure by the ward to ensure that the resuscitation trolley was checked and maintained in line with local and national guidelines. For the two months we noted that the checks had not been completed on 35			This includes verifying the presence and expiry dates of emergency equipment and medications and ensuring the trolley is clean, secure and ready for use. • To conduct weekly spot checks to verify compliance with daily resuscitation trolley checks as outlined in the resuscitation policy. Any discrepancies or missed entries will be documented and escalated to the Senior Nurse Manager within 24 hours for prompt resolution. • To undertake spot checks of the	Senior Ward Sister or designated team member Senior Nurse Manager	With immediate effect - complete 31st October 2025

	of the 62 days. The instruction on the paperwork states weekly if locked and daily if opened, as the trolley was open on the day of the inspection, we could not be assured whether this was a regular feature. A tag is now in place on the trolley.			results to ensure sustained compliance. • To inform all relevant staff of the updated emergency readiness procedures through a scheduled team meeting led by the Senior Nurse Manager. The importance of maintaining emergency preparedness to be reinforced during the session and attendance to be recorded. • To undertake the medication audit, which is recorded on AMAT, in accordance with the medication policy.	Senior Ward Sister Senior Nurse Manager	10th October 2025 31st October 2025

				(The audit was last completed in June 2025 and is usually repeated six-monthly. Actions arising from the audit will be developed in an improvement plan and reviewed within one month to ensure compliance and continuous improvement.)		
3.	HIW was not assured that the ward was maintaining patient safety at all times. During the inspection, HIW considered the environment of the ward. We found immediate environmental and health and safety risks including:	The health board must ensure that sufficient domestic staff are available to clean the ward to maintain appropriate infection prevention and control (IPC)	Delivery of safe and effective care – Environment and IPC.	• To undertake spot checks of domestic staff compliance with hand hygiene and PPE when in clinical areas. Findings and remedial actions to be reported to the Infection Prevention Strategic Steering Group.	Head of Facilities and site supervisors	31st October 2025

	• The cuffs on the blood pressure (BP) monitor were not decontaminated between patients. We were told that the cuffs would be cleaned with Clinell wipes in between patients, but we also did not see evidence of this during inspection • There was clutter and dust throughout the ward, additionally, not all toilets were cleaned, including the underside of toilet seats. We were told by staff that there was a lack of storage space and limited domestic support for periods during the day			• Synbiotix audits to be aligned with the existing improvement plan including a review of the audit criteria to ensure they reflect current priorities and actions outlined in the plan. • To monitor audit outcomes and address any gaps identified through targeted actions within 2 weeks of each audit cycle. • To continue to report and review the findings from Synbiotix audits at each monthly Carmarthenshire System Infection Prevention and Control Locality Meeting. Any	Senior Nurse Manager Senior Nurse Manager Deputy Head of Nursing	30th September 2025 31st October 2025 31st October 2025

	• Not all clean equipment had been labelled with green 'keep me clean' stickers, to show that the equipment had been cleaned • On the first day of the inspection, only two beds out of 26, had oxygen tubing and there were no oxygen masks readily available for patients use. Oxygen tubing and masks are essential for delivering oxygen to patients who require it. We were told that this had been rectified on the second day of the inspection. However, we noted that tubing was only available per bay and			identified issues will be discussed with agreed actions recorded and monitored for progress at subsequent meetings. To note: the Facilities Team will be implementing a new model of cleaning provision across all acute hospital sites. This will include the recruitment of additional staff to improve cleanliness standards and the introduction of revised rotas and shift patterns tailored to each site's operational needs. A Task & Finish (T&F) Group will be established to support		

	not at each flow meter, this posed a risk to patient safety if needed promptly in an emergency. • Some wall suction units were not working at full capacity; these are essential medical devices used to manage oral and airway secretions in patients. Particularly relevant in emergency situations. We were told that arrangements had been made to have these units tested HIW could not be assured that the health, safety and welfare of patients, staff and visitors was			the Facilities and Nursing Teams during the implementation phase of the new cleaning and catering model. The group will meet monthly to review progress, identify challenges and coordinate solutions. Membership will include representatives from both teams, with meeting outcomes documented and shared. The group will remain active until full implementation is achieved. Interviews for a Facilities Manager (Band 8a) to support the Facilities Team during the implementation phase of the new cleaning		

	being actively promoted and protected at all times.			and catering model will start week commencing 22nd September 2025. The recruitment process to fill the 8.63 WTE vacancies in the domestic team has commenced. The Hotel Services Manager will provide fortnightly updates on recruitment progress, including shortlisting, interview dates and onboarding timelines. Full staffing levels are expected to be achieved by 30 November 2025, with impact on service delivery reviewed monthly thereafter.		
4.	The cuffs on the blood pressure (BP) monitor	The health board must ensure that multi patient		• To remind all ward clinical staff of	Senior Ward Sister	Complete

	were not decontaminated between patients. We were told that the cuffs would be cleaned with Clinell wipes in between patients, but we also did not see evidence of this during inspection,	use items such as BP cuffs, are appropriately decontaminated between use and that clean equipment is correctly labelled.	Delivery of safe and effective care – Environment and IPC.	the requirement to decontaminate reusable equipment between each patient use, in line with the decontamination policy. This includes the use of approved cleaning products and adherence to IPC standards (including hand hygiene). The guidance will be reinforced during scheduled team meetings, with attendance recorded and key messages circulated within 3 working days. • To review training attendance and requirements of staff for IPC e-learning module. Training compliance	Senior Nurse Manager/Deputy Head of Nursing	29th October 2025

				will be monitored via Carmarthenshire System Infection Prevention and Control Locality Meeting. • To conduct weekly spot checks to verify compliance with routine decontamination of equipment, as per decontamination policy. Any discrepancies or missed entries will be documented and escalated to the Senior Nurse Manager within 24 hours for prompt resolution. • To undertake spot checks of the results to ensure sustained compliance.	Senior Ward Sister or designated team member Senior Nurse Manager	With immediate effect - complete 31st October 2025

				• To ensure that decontamination wipes are routinely stocked and visibly available in all observation trolleys across clinical areas. To check the availability of the wipes during weekly environmental checks, with 100% compliance expected. Any shortages will be reported to the Team and replenished to support staff adherence to decontamination guidance.	Senior Ward Manager Senior Ward Manager	With immediate effect - complete 31st October 2025
5.	On the first day of the inspection, only two beds out of 26, had	The health board must ensure that oxygen tubing and face masks are easily	Delivery of safe and effective care – Environment and IPC.	• To review each bed space to ensure oxygen tubing and	Senior Ward Sister	Complete

	oxygen tubing and there were no oxygen masks readily available for patients use. Oxygen tubing and masks are essential for delivering oxygen to patients who require it. We were told that this had been rectified on the second day of the inspection. However, we noted that tubing was only available per bay and not at each flow meter, this posed a risk to patient safety if needed promptly in an emergency.	accessible for all bed areas on the ward.		face masks are available, as per resuscitation policy and stored in a consistent, easily accessible location. • To ensure oxygen delivery equipment including availability and readiness for use is included in daily ward checks. Any missing or damaged items to be reported or replaced promptly. • To undertake spot checks the over the next month. The findings will be reported to the Senior Nurse and 100% compliance will be expected.	Senior Ward Sister Senior Ward Sister or designated team member	Complete 31st October 2025

				• To remind staff the importance of ensuring emergency and routine oxygen equipment is always accessible, as per resuscitation policy. This will be reinforced through staff meetings.	Senior Ward Sister	Complete
6.	Some wall suction units were not working at full capacity; these are essential medical devices used to manage oral and airway secretions in patients. Particularly relevant in emergency situations. We were told that arrangements had been made to have these units tested.	The health board must ensure wall suction units are fully operational	Delivery of safe and effective care – Environment, IPC and Health and Safety	• To review of each bed area and ensure wall suction units are fully operational and adequate suction available. • To ensure a check of the suction delivery units (availability and readiness) in daily ward checks. Any missing or damaged	Senior Ward Sister Senior Ward Sister	Complete - No failures found to any suction units. With immediate effect - complete

				items are reported or replaced promptly. • To undertake weekly spot checks to ensure compliance with the daily checks. The findings will be reported to the Senior Nurse. • Staff to be reminded of the importance of ensuring bedside suction is always adequate and accessible. This will be reinforced through staff meetings.	Senior Ward Manager or designated team member Senior Ward Sister	With immediate effect - complete Complete
7.	HIW was not assured that patient records were always stored securely.	The health board must ensure that patient records are stored securely at all times.	General Data Protection Regulation (UK GDPR) and the	• To remind all ward staff of the requirement to store patient records in	Senior Ward Sister	Complete

	The inspection team saw paper patient records, including documents due for archive, stored and unattended in the various locations throughout the ward, including in an unlocked ward clerk office and the patient records trolley (where staff said did not know the keycode to lock it). We were subsequently told that digilocks have now been ordered and new locks for the trolley.		Data Protection Act 2018 Health and Care Quality Standard – Governance	locked notes trollies as per Record Keeping policy. This will be reinforced through staff meetings. • To review the training attendance and requirements of staff for Information Governance e-learning and report the findings to the Carmarthenshire Integrated Performance and Business Management Care Group, with a clear plan for improvement if required. • To ensure that the daily environmental checks include verification that patient records	Senior Nurse Manager Senior Ward Sister	31st October 2025 Complete

				are stored securely and appropriately, in line with information governance standards. Any breaches will be reported to the Ward Manager immediately and addressed within 24 hours.		
				• To undertake weekly spot checks to ensure compliance with 100% adherence expected. The findings will be reported to the Senior Nurse.	Ward Manager	31st October 2025
				• To progress with recruitment of Ward Clerk to support with timely return of notes for patients who are no longer admitted onto the ward.	Deputy Head of Nursing	30th November 2025

				• To undertake a site review of notes trollies and develop a replacement programme.	Deputy Head of Nursing	31st October 2025
8.	HIW was not assured that key risk assessments are completed when appropriate, therefore patient safety was not always being maintained. During our inspection we checked a sample of six patient records and noted that: • In one patient record, a National Early Warning Score (NEWS) was not acted upon where it was	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance and document this in patient records. This includes: • Taking appropriate action when NEWS scores are 3 or above • Completing and documenting sepsis Screening for those at	Delivery of safe and effective care – Managing Risk and Health and Safety	• To remind all ward clinical staff of their responsibility to document all risk assessments and associated actions in the patient record, in line with the Monitoring, Recording of Adult Physiological Observations and Response to Physical Deterioration Policy. This includes initial assessments, reassessments and any interventions taken. The requirement will	Senior Ward Sister	Complete

	appropriate to do so. The NEWS was 7, meaning the patient was high risk and likely to deteriorate rapidly. However, the patient observations were not repeated for 4.5 hours instead of every 30 minutes as per protocol. The score of seven should also have prompted an action to inform the rapid response team for assessment, however, there was no evidence to suggest this had occurred • As the NEWS score was seven this should also have prompted a sepsis screen. However, there was no evidence this had taken place.	risk of sepsis, such as a NEWS score of 5 or above • Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.		be reinforced through staff meetings and mandatory training sessions, with attendance recorded and compliance monitored through monthly documentation audits by the Senior Ward Manager. • To review the current training compliance of staff for NEWS 2 e-learning module and develop a plan to ensure timely completion of the e-learning module. Training compliance will be monitored via RADAR scrutiny meeting. • To review the current training	Senior Nurse Manager Senior Nurse Manager	13th November 2025 13th November 2025

	We noted a sepsis safety display on the ward and easily accessible to staff, yet there was no evidence to suggest health board's sepsis screening process was followed • Venous Thromboembolism (VTE) risk assessments had not been completed for the patient records checked. NICE guidance stated that all patients should be risk assessed for VTE on admission to hospital and reassessed within 24 hours of admission or a change in clinical condition. Therefore, HIW was not assured			compliance of staff for classroom ILS/BLS and develop a plan to ensure timely completion of the learning. Training compliance will be monitored via RADAR scrutiny meeting. • To arrange additional training to support the early recognition of a deteriorating patient. • To undertake weekly spot checks to verify compliance accurate NEWS scoring and escalation of sepsis as per guidance. Any	Senior Ward Sister Senior ward manager / designated team member	Complete (The dates for the additional training are 25th, 27th and 29th September 2025) With immediate effect - complete

	that all patients are assessed for their risk of developing VTE on Derwen Ward, meaning consequently their safety may be compromised.			discrepancies or missed entries are documented and escalated to the Senior Nurse Manager within 24 hours for prompt resolution. To note: the Health Board is implementing E-Observations (Electronic NEWS recording) throughout the hospital site. • To reinforce to medical staff the requirement to complete and document the VTE Risk Assessment. • To promote the Hospital Acquired Thrombosis SharePoint page which is available with current	Deputy Medical Director Deputy Medical Director Quality Improvement VTE Lead	30th September 2025 30th September 2025 Complete

				resources and information. • To review the VTE Site Improvement plan currently in place to ensure it covers the findings of HIW. • To review of VTE risk assessment compliance findings to be discussed within the Carmarthenshire System Quality and Safety Governance meeting (feeding into our Clinical Care Group) Monthly spot checks of VTE (Venous Thromboembolism) risk assessments are carried out on the Surgical, Medical and Trauma &	Deputy Head of Nursing / Medical Director	30th September 2025

				Orthopaedic ward areas by the Quality Improvement VTE Lead or designated clinical lead. Findings are reported to the governance team and any gaps in compliance will be addressed through targeted staff feedback and re-education.		
9.		The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	Delivery of safe and effective care – Environment, IPC, Managing Risk and Health and Safety	• To share the immediate actions with all Heads of Nursing across the health board and request that spot checks be undertaken. • To share the immediate actions through the Community and	Assistant Director of Nursing, Assurance and Safeguarding Deputy Head of Nursing	Complete 31st October 2025

				Integrated Medicine Professional Nurse Forum. • To share the immediate actions findings at other forums such as the: 1. Community and Integrated Medicine Clinical Care Group Integrated Governance Meeting 2. Senior Nurse Management Team and 3. Integrated Quality, Finance, Performance and Delivery Group • To support with individual ward review to monitor and ensure compliance with actions. Where	Assistant Director of Nursing, Quality and Patient Experience Head of Nursing Assistant Director of Nursing, Quality and Patient Experience Quality improvement team	18th September 2025 22nd September 2025 24th September 2025 1st October 2025

				compliance is found to not be in place, immediate remedial activity to commence. • To present the Quality Improvement audit results for all wards (inclusive of actions at the Care Group Quality and Safety Group for assurance.	Deputy Head of Nursing	16th October 2025

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): Anna Chiffi

Job role: Assistant Director of Nursing

Date: 10/09/2025

Appendix C - Improvement plan

Service: Derwen Ward, Glangwili Hospital

Date of inspection: 2 and 3 September 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.	There was limited health promotion information available to patients within the ward and this was primarily displayed in the day room. Materials including posters and visual aids focused on key topics such as sepsis awareness and general self-care.	The health board must ensure more health promotion information is available to patients, such as healthy eating, smoking cessation materials and information from charities such as Age Cymru Dyfed to support elderly vulnerable people.	Health promotion	Assign a team of staff from the ward to lead the development and implementation of a visual display board in a communal area of the ward. Collaborate with the Health Board's Public Health Team and external partners (e.g., Age Cymru Dyfed). Remind staff via staff meeting, of the 'every contact counts' principles and reinforce communication of	Senior Ward Manager Senior Ward Manager	30th November 2025 30th November 2025

				health promotion topics during routine care interactions. Work commenced to scope local project to embed health promotion at ward level along Making Every Contact Count principles with Assistant Director of Public Health Directorate. This will include scoping appropriate literature, wider training and strengthening sign posting, advice and guidance.	Assistant Director of Public Health Strategic Business and Operations.	31st January 2026
2.	Further concerns were raised, by patients, about the consistency and quality of care. An elderly patient described being made to walk to the toilet five times in a single day despite expressing fatigue and requesting a bedpan. Several patients	The health board must ensure: • The dignity and respect of patients is met consistently including drawing curtains and closing doors whilst staff are administering to	Dignified and respectful care	Ensure staff consistently maintain patient dignity by drawing curtains and closing doors during personal care activities, including when patients are using a bedpan. Senior ward manager or a designated team member will conduct weekly spot checks to verify compliance in line	Senior Ward Manager	30th November 2025

	commented the standard of care varied depending on which staff were on duty and many felt the ward was generally understaffed, which impacted the overall patient experience and support. The ward environment presented some challenges to patient dignity, including a lack of private rooms for sensitive conversations. We were told by patients that the ward often had to wait until late evening for clean sheets, which was due to the newly implemented laundry contract.	patients' personal needs and when patients are using a bedpan • Clean linen is always available for patients on the ward.		with Health Board Values and Behaviours Framework. All staff to be reminded of the Health Board Values and Behaviours Framework. The framework will be reinforced during scheduled team meetings, with attendance recorded and key messages circulated to all staff. Review of training compliance and requirements of staff for Equality, Diversity and Human Rights e-learning module to be undertaken. Training compliance will be monitored, with 100% compliance of all staff, currently attending work, expected. Review of current Service Level Agreement for linen provision on Derwen Ward to be completed. Increase linen order as per needs of service	Senior Ward Manager Senior Ward Manager Hotel Services Manager	30th November 2025 31st December 2025 31st December 2025

				due to increased demand and activity on the ward. As part of the Goal Five Welsh Government initiative: Optimal hospital care and discharge practice from the point of admission, staff were encouraged to promote independence and prevent deconditioning of patients. Utilising the SAFER principles and enablers, patients were encouraged to 'Get up, Get dressed, Keep moving'.		
3.	There was limited evidence of dementia-friendly initiatives in place on the ward. There was a "This is Me" section within the electronic patient record, which was not regularly and routinely completed. The use of the "Butterfly Scheme" was not	The health board must ensure that: • The signage is improved to ensure it is more dementia friendly • Person-centred tools like "This is	Individualised care	Review of signage has been completed following recent refurbishment of Derwen ward. New signage has been ordered to support all patients, including dementia friendly. Escalate order of signage and support facilities team to place new signage.	Deputy Head of Nursing	30th November 2025

	observed where appropriate, for patients with dementia. Signage throughout the ward was poor, including the absence of clear signs on toilet doors, nor dementia-friendly signs to assist patients with sensory or cognitive impairment.	Me" and the "Butterfly Scheme" are used to fully support patients with cognitive impairments.		Discuss the 'What Matters to Me' initiative and 'Butterfly Scheme' during a ward meeting and provide all staff with a copy of the presentation. Monitor the above compliance through undertaking WNCR monthly audits. Findings to be shared in HB documentation steering group.	Senior Ward Manager Senior Nurse Manager	30th November 2025 31st December 2025
4.	Whilst most patients said they had access to a call bell, only half agreed that when they used the call bell staff came to them.	The health board must ensure staff answer call bells in a timely manner to maintain patient safety, dignity and quality care.	Timely Care	All staff to be reminded to ensure all patients have access to call bells and that staff answer the bells in a timely manner. This will be reinforced during scheduled team meetings, with attendance recorded and key messages circulated to all staff.	Senior Ward Manager	30th November 2025

5.	Patients experienced delays in discharge associated with reduced physiotherapy staffing and some reported limited communication from staff. Patient feedback indicated difficulties in self-care and health management during hospital stays. Two patients experienced longer admissions after hip surgery due to delayed physiotherapy and others reported that untimely physiotherapy affected their recovery.	The health board must urgently review the provision of physiotherapy services on the ward, to ensure patients receive timely and appropriate assessments and care to support their recovery and prevent delays with discharge.	Timely care	Recruitment into 2 whole time equivalent (WTE) band 6 physiotherapy posts for Trauma & orthopaedics & surgical to be completed – these posts had been vacant for a significant amount of time. Support return of band 7 following long-term absence period. Returned in the middle of September on phased return. Clinical prioritisation tool to be developed for a consistent approach to prioritising patient care / those at risk of deterioration. Rehabilitation currently on the Therapies risk register (2145)	Physiotherapy Service Lead – Acute Services GGH & PPH Physiotherapy Service Lead – Acute Services GGH & PPH Physiotherapy Service Lead – Acute Services GGH & PPH Physiotherapy Service Lead – Acute Services GGH & PPH	31st October 2025 31st October 2025 31st October 2025 Completed and reviewed monthly

				Physiotherapy team to continue engagement with Ward Board Rounds, to support Goal 5 Optimal Flow. Central recruitment for Band 3 deficits across the whole site has commenced in October, with first cohort of staff due to start induction end of November. This will reduce deficits on the ward and release Assistant Practitioner and rehab support workers to work within the expected role to support with Rehabilitation delays.	Physiotherapy Service Lead – Acute Services GGH & PPH Deputy Head of Nursing	Completed and ongoing attendance 30th November 2025
6.	The 'meet the team board' displayed outside the day room was a positive feature, presenting photographs of staff members.	The health board must ensure that the: • Ward has the relevant equipment and	Communication and language	Ensure the ward is equipped with appropriate tools and materials to support patients with sensory and communication needs, including hearing aids, visual	Senior Ward Manager	15th December 2025

	However, not all staff were wearing name badges or had visible identifiers on the board and there was no accompanying explanation of uniform colours or corresponding staff roles. It was noted that the ward did not have provisions such as a hearing loop system, braille signage, or pictorial aids for patients with hearing, sight, or language difficulties. The patient's day room was cluttered and poorly maintained, making it unsuitable for patient wellbeing. Trailing wires, a mop by the door and a notice board on the table made the room seem	materials to support patients with hearing, sight and language difficulties • Meet the team board is updated with a description of the uniform colours worn by staff and their roles • The patient day room is decluttered, and patients are informed of its availability and purpose to improve access, encourage social interaction and support wellbeing.		aids, large-print materials, and translation or interpretation resources. Work with the Health Board's Equality and Diversity Team, Speech and Language Therapy, and Audiology departments to source appropriate materials. Engage ward staff in identifying common patient needs and practical solutions. 10% of Derwen ward staff to attend Hearing Loss Bitesize Webinar and RNIB Vision Friends training in line with Sensory Loss Awareness Month in November. Staff who have attended the training to share learning through staff meeting and GGH Assurance Scrutiny Meeting. Liaise with the Diversity and Inclusion team to arrange bespoke Sensory Loss Training for the ward.	Senior Ward Manager Deputy Head of Nursing	31st January 2026 28th February 2026

	more like a storage area, than a patient area.			A poster will be displayed on the ward entrance outlining staff uniform colours and corresponding staff grades. To promote clarity and reassurance for those accessing the ward	Senior Ward Manager	15th December 2025
				In collaboration with the ward team, undertaken a thorough decluttering of the day room. This will involve the removal of unnecessary items, ensuring appropriate storage of essential equipment, and reorganisation of the space to enhance safety, accessibility, and the overall environment for patients and staff.	Senior Ward Manager	15th December 2025
				To establish a practice of daily environmental checks to ensure that the day room remains clutter-free, promoting a safe, welcoming, and therapeutic environment	Senior Ward Manager	15th December 2025

				for patients, staff, and visitors.		
7.	There was limited visual indication of Welsh-speaking staff, due to the absence of 'Iaith Gwaith' badges. One patient we spoke with provided examples where they were not informed about the status of their treatments.	The health board must ensure all staff: • Wear name badges and that these clearly display staff who can speak Welsh • Always update patients with their plan of care or treatment • Are reminded they must treat patients in a kind and caring manner.	Communication and language	Reinforce the importance of wearing name badges to staff. This will be discussed in the staff meeting. New name badges have been ordered for staff, those who can speak Welsh will have the 'Iaith Gwaith' emblem included. Arrange bespoke training with the Welsh Language team to support staff to be able to make the initial meet and greet in Welsh. Arrange with the Welsh Language team for additional Welsh resources to be delivered to the ward e.g. lanyards.	Senior Ward Manager Senior Ward Manager Deputy Head of Nursing Deputy Head of Nursing	30th November 2025 30th November 2025 31st December 2025 30th November 2025

				See actions for recommendations 2 and 3 with regards to – treating patients with dignity.		
8.	Toilet areas had support rails but one patient noted the toilets were too low and there was no variety in height options.	The health board must ensure the relevant equipment is made to support patient mobility when required.	Risk Management	The ward has different height sized toilets and has seat raisers if required. Staff to be reminded via staff meeting the importance of completing manual handling assessments on patients on admission, and documenting if amendments are required e.g. toilet heights. Monitor the compliance through undertaking WNCR monthly audits. Outcome of assessment to be communicated and discussed with the patient.	Senior Ward Manager	31st December 2025
9.	There were broken tiles and cracked floors in some rooms, hindering	The health board must ensure that:	IPC	Derwen ward has had a recent full refurbishment, new flooring included. Review	Senior Ward Manager	15th December 2025

	effective cleaning. Cleaning schedules existed, but toilets lacked visible records. In addition to cleaning, domestic staff also served food. Although they changed aprons, concerns were raised about IPC due to the dual role. A trial separating cleaning and food service roles had previously been conducted, with ongoing work in the hospital hotel services to implement this change. Occupational health support was available and staff were aware of procedures for incidents like needlestick injuries. Staff understood IPC policies and their roles, but practical implementation was hindered by	• Damaged areas, such as broken tiles and cracked floors are repaired to limit potential IPC issues • Cleaning records are displayed in the toilets on the ward • Hand gel on the ward is in date to maintain its effectiveness • Disposable curtains are marked with a date the curtains were hung, to ensure they are replaced in a timely manner, or sooner if soiled		of tiled areas to identify broken tiles and Minor Works request to be completed to support repairs. Synbiotix audits will be fully aligned with the existing improvement plan. The Senior Nurse Manager will review audit criteria and ensure they reflect current priorities and actions outlined in the plan. Audit outcomes will be monitored monthly, and any gaps identified will be addressed through targeted actions within 2 weeks of each audit cycle. The findings from Synbiotix audits will continue to be reviewed at each monthly Carmarthenshire System Infection Prevention and Control Locality Meeting. The Hotel Services Manager will ensure audit outcomes are submitted at least 3 working	Deputy Head of Nursing Deputy Head of Nursing	31st December 2025 31st December 2025

	environmental issues and staffing shortages. For example, expired hand gel was found in the day room and there were no dates present on the disposable curtains, although they appeared to be clean.	• There is a separation of duties between domestic staff cleaning the ward and serving food • The relevant precautions are taken when treating isolated patients including closing doors.		days in advance, and any identified issues will be discussed with agreed actions recorded and monitored for progress at subsequent meetings. The Facilities Team will begin implementing a new model of cleaning provision (that includes split catering and cleaning) across all acute hospital sites. This will include the recruitment of additional staff to improve cleanliness standards and the introduction of revised rotas and shift patterns tailored to each site's operational needs. IP&C precautions will be reinforced in staff meeting, in line with the Standard Infection Prevention and Control Precautions Policy. Attendance will be monitored and minutes shared with the team.	 Head of Facilities Senior Ward Manager	 PPH – Jan 8th 2026 GGH – Jan 8th 2026 WGH – Apr 1st 2026 BGH – Apr 1st 2026 30th November 2025

10.	For one patient, we identified in communication, where one family member we spoke with felt inadequately informed about the DoLS arrangement.	The health board must ensure that where appropriate, family members, such as next of kin or those with Health and Welfare Lasting Power of Attorney are kept fully informed of decision relating to care of the patient, such as patient subject to a DoLS.	Safeguarding of children and adults	Review of current training compliance and requirements for staff for Mental Capacity E-learning module, with 100% compliance of all staff, currently attending work, expected. Staff to be reminded via staff meeting the importance of communication with patients and families regarding decision relating to the care of a patient.	Senior Ward Manager Senior Ward Manager	31st December 2025 30th November 2025
11.	Staff safeguarding training was mandatory and staff highlighted that safeguarding officers provide further updates during team meetings. Despite the ward having links with the	The health board must strengthen the safeguarding processes on the ward which includes robust documentation and accessibility to safeguarding policies and	Safeguarding of children and adults	Review of current training compliance and requirements for staff for Level 2 Adult Safeguarding E-learning module, with 100% compliance of all staff, currently attending work, expected.	Senior Ward Manager	31st December 2025

	safeguarding team and access to corporate policies, record keeping, particularly with mental capacity and DoLS, was poor.	Wales Safeguarding Procedures.		Staff to be reminded via staff meeting the availability of safeguarding resources via the HB Safeguarding intranet page. Icon to be added to ward computer desktop to support accessibility.	Senior Ward Manager	30th November 2025
12.	Equipment was serviced appropriately, however, whilst equipment was generally in good condition and sufficient to meet patient care needs, we noted issues with the accessibility of air mattresses.	The health board must ensure that the relevant medical devices, such as air mattresses are accessible in a timely manner.	Management of medical devices and equipment	Staff to be reminded via staff meeting, accessibility of air mattresses are via Synbiotix request. Encourage staff to escalate any delays in receiving such equipment.	Senior Ward Manager	30th November 2025
13.	We found an example of one urology patient post-urosepsis, did not have a fluid balance chart in place when it was	The health board must ensure that fluid balance charts are completed for all applicable patients.	Medicines management	Fluid balance training is covered in ILS training, see actions for recommendation 15.	Senior Ward Manager	Complete

	appropriate to monitor their fluid balance.					
14.	There was no evidence of care plans implemented nor turn charts where appropriate to do so. The electronic records appeared to be updated regularly, but changes in patient conditions were not always appropriately recorded where appropriate.	The health board must ensure a clear process is implemented that captures changes in patient condition and the need for skin pressure reassessment.	Preventing pressure and tissue damage	All clinical staff will be reminded of their responsibility to document all risk assessments and associated actions in the patient record, in line with the Prevention and Management of Pressure Ulcer Policy. This includes initial assessments, reassessments, and any interventions taken. The requirement will be reinforced through staff meetings and mandatory training sessions, with attendance recorded and compliance monitored through monthly documentation audits by the Senior Ward Manager.	Senior Ward Manager	31st December 2025

				Review training attendance and requirements of staff for Pressure Ulcer Risk Assessment E-learning module, with 100% compliance of all staff, currently attending work, expected.	Senior Ward Manager	31st December 2025
15.	The use of the sepsis six care bundle was inconsistent and while sepsis forms were available on the resuscitation trolley, they were not found in patient notes where appropriate and the folder designated for archived sepsis forms was empty, indicating a lack of audit trail.	The health board must ensure that there is a robust system in place for timely escalation of care, consistent use of screening tools and adherence to best practice guidelines, including sepsis.	Effective care	All clinical staff will be reminded of their responsibility to document all risk assessments and associated actions in the patient record, in line with the Monitoring, Recording of Adult Physiological Observations and Response to Physical Deterioration Policy. This includes initial assessments, reassessments, and any interventions taken. The requirement will be reinforced through staff meetings and mandatory training sessions, with	Senior Ward Manager	31st December 2025

				attendance recorded and compliance monitored through monthly documentation audits by the Senior Ward Manager. Review training attendance and requirements of staff for NEWS 2 e-learning module. Training compliance will be monitored via RADAR scrutiny meeting. Review training attendance and requirements of staff for classroom ILS/BLS. Training compliance will be monitored via RADAR scrutiny meeting. Arrange additional training to support the early recognition of a deteriorating patient.	Senior Ward Manager Senior Ward Manager Senior Nurse Manager	31st December 2025 31st December 2025 31st December 2025
16.	Nutritional risk assessments were being completed for all patients within 24 hours	The health board must ensure that nutritional risk assessments are completed and ensure	Nutrition and hydration	Review training attendance and requirements of staff for All Wales Nutrition Risk Screening Tool E-learning	Senior Ward Manager	31st December 2025

	of admission, with documentation generally well maintained on the electronic record system. However, assessments within the emergency department pathway document were not consistently completed and a few were slightly out of date.	patients are offered alternative meals where appropriate to meet their nutritional needs.		module, with 100% compliance of all staff, currently attending work, expected. All patients' meals are aligned via Synbiotix System, which is signed by the nurse in charge of the patient. Spot audit of Synbiotix System, in line with patients' nutrition assessment, to be completed by Senior Ward Manager.	Senior Ward Manager	31st December 2025
17.	Electronic risk assessments were completed and up to date, with clear, legible and timely documentation. However, the combination of both electronic and paper records made navigation of records difficult. Medical records were also arranged in date order	The health board must consider fully implementing electronic patient record system to access and manage patient records appropriately.	Patient records	Electronic flow system planned launch in November 2025, for whole of HB. Electronic Observations to be piloted on Towy Ward (GGH) in December 2025, with a plan to launch early 2026 HB wide.	Senior Clinical Informatics Nurse Senior Clinical Informatics Nurse	30th November 2025 28th February 2026

	but split between the front and back of files, complicating access to recent medical history.			Electronic Prescribing (ePMA) system planned launch April 2026 for HB wide. Implementation of Cito Digital Health Document Repository programme to store digital patient health records. Phase 1 of external scanning is due for final completion in November 2025.	Senior Clinical Informatics Nurse Programme Manager Digital Health Records	31st October 2026 Phase 1 – 30th November 2025
18.	Care planning to promote independence was inconsistent, only half of care plans were documented and few reflected individual needs. Discharge planning was noted verbally and on whiteboards, but supporting documentation was limited. Do Not Attempt	The health board must ensure that: • Care planning to promote independence is completed consistently and reflects individual patient needs	Patient records	All clinical staff will be reminded of their responsibility to document all risk assessments and associated actions in the patient record, in line with all care plans including discharge planning. This includes initial assessments, reassessments, and any interventions taken. The requirement will be	Senior Ward Manager	31st December 2025

	Cardiopulmonary Resuscitation (DNACPR) forms were present, though copies were not always provided to patients in line with the national policy. Handover sheets and MDT involvement were documented, but "What matters to me" and care plans were inconsistently completed. Catheter records were also sometimes missing from e-notes.	• There is supporting documentation to support discharge planning • Copy of DNACPR forms are provided to patients • Catheter records are completed in full • There is greater integration between paper and electronic records.		reinforced through staff meetings and mandatory training sessions, with attendance recorded and compliance monitored through monthly documentation audits by the Senior Ward Manager. All clinical staff will be reminded of their responsibility to provide patients with a copy of DNACPR form, in line with the All Wales Policy for DNACPR. The requirement will be reinforced through staff meetings, with attendance recorded and compliance monitored through monthly documentation audits by the Senior Ward Manager.	Senior Ward Manager	31st December 2025
19	We noted that there was a standard operating procedure to define and	The health board must ensure that both the ward and the treatment room	Efficient	Central recruitment to be engaged re Band 3 deficits across the whole site has	Deputy Head of Nursing	30th November 2025

	formalise the movement of emergency and elective patients through the treatment room at the end of the ward. This was to ensure pathways of care for urology patients via the Emergency Department could be avoided. Patients requiring admission would be transferred to the next available ward bed, to provide a constant flow within the treatment room. Although we were told that an assistant practitioner would manage this area, they often had to work across the wider ward due to staffing issues. This therefore meant that the treatment room was understaffed, placing additional pressure on ward staff.	are appropriately staffed as intended to maintain safe and timely care.		commenced in October, with first cohort due to start induction end of November. This will reduce deficits on the ward and release Assistant Practitioner and rehab support workers to work within the expected role. Nurse Staffing Level review to be completed for the Autumn cycle, to support the current Nurse Staffing Levels on Derwen. Staff to be reminded in ward meeting to raise Red Flags on the Safe Care system when staffing is not met and not appropriate. Review of Red Flags completed by Senior Nurse Manager and staff redeployed dependant on whole system review of staffing.	 Nurse Staffing Programme Lead Senior Ward Manager Senior Nurse Manager	 31st October 2025 30th November 2025 Completed and ongoing task

20.	The ward sister reported that discharge support was adequate, with access to a discharge lounge, physiotherapy and occupational therapy services. A "How Can We Help?" board had been placed at the ward entrance to encourage relatives to participate in discharge planning. Despite these measures, delays persisted due to patients awaiting community services and care packages, which the ward sister believed should be improved to reduce discharge delays.	The health board must ensure hospital staff work closely with social care teams to ensure that patients are discharged promptly when medically fit.	Efficient	Weekly 'Deep Dive' meetings in place, attended by Local Authority, Therapies and Nursing Teams. Action focussed meeting to support timely discharges.	Senior Nurse Manager	Completed and ongoing task
				Weekly escalation meetings of complex patients and long stay patients – meeting supported by Local Authority colleagues and lead nurses for discharge.	Deputy Head of Nursing	Completed and ongoing task
				Discharge workshop arranged in collaboration with external stakeholders involved with discharge support.	Senior Nurse Manager	31st October 2025
				Discharge SharePoint page available with current resources and information. All staff will be encouraged to review the resource page via staff meeting.	Senior Ward Manager	30th November 2025

				Delayed pathways of care are the subject of performance review for the Health Board and Local Authority partners. They are measured and reported on a national basis monthly using an agreed set of criteria to identify the delay. Community Management Teams (CMT) ensure that arrangements are in place for the census to be undertaken on a monthly basis and the outcome validated in collaboration with Local Authority (LA) partners.	Head of Integrated Community Services	Complete
21.	We were informed that some district nursing teams were not sufficiently skilled to manage urology patients, therefore were unable to accommodate them on the community case load.	The health board must complete a training needs analysis for its community nursing staff, to appropriately support them to adequately manage urology patients at home and minimise the	Efficient	The District Nursing team have the sufficient skills to manage the urology patients and catheter management and care, within the community setting. The community have a robust training development system		

	This impacted on ward staff where patients may need to attend from the community for dressing renewal or change of catheter. This also impacted on patients, where some had to travel for long distances for this.	need for patients reattending the ward for less complex nursing care procedures.		set up with an online training session that all band four HCSW and Registered Nurses complete. All staff complete a clinical competency booklet before they were deemed safe to care for urology patients. There were Trial without Catheter (TWOC) clinics set up in the Carmarthenshire Community and they were run by highly skilled professionals. Lack of staff awareness within acute setting regarding community services available to support admission avoidance for catheter care. Clinical Lead Nurse for Community to present in GGH Professional Nurse Forum, to raise awareness of services available in the community, reinforce importance of COBWEB referral process and strengthen handover	Clinical Lead Nurse Community	30th November 2025

				processes to the community teams.		
22.	Ward staff we spoke with reported mixed views on their ability to maintain safe care, which predominantly related to insufficient staff numbers based on patient acuity and dependency, therefore impacting patient care. We were told that staff shortages and unfilled shifts were often reported on Datix and band two HCSW absences were often filled by band three or four staff.	The health board must consider the staff feedback around the patient speciality, their acuity and dependency in line with the establishment and the ongoing impact of vacancies and unfilled shifts, impacting both patients and staff. Consideration should also be given to the staffing required to manage attendances through the treatment room.	Skilled and enabled workforce	See actions for recommendation 19.		
23.	A key area that needed improvement was staff compliance with portable Oxygen cylinder training,	The health board must ensure that:	Skilled and enabled workforce	Support all staff to complete E-learning module for the safe use, storage and set up of medical gas cylinders, with	Senior Ward Manager	31st January 2026

	with very few staff having received this, despite previous patient safety alerts circulated across NHS Wales. We checked a sample the mandatory training of five members of staff. Some were not complaint with receiving up to date basic life support training. We were told there had been difficulties in arranging face to face training in the health board. It was, positive to find that the compliance with annual appraisals for staff was 100%.	• All relevant staff complete portable oxygen cylinder training in line with national patient safety alerts • Ensure all staff are supported to attend mandatory training in a timely manner.		100% compliance of all staff, currently attending work, expected. Introduce information posters to the areas of the ward that store medical gas cylinders, outlining the importance of safe storage, in line with the Medicines Policy. This information will be shared via staff meeting. Further sharing and dissemination of learning within Medication Events Review Group (MERG).	Senior Ward Manager Senior Nurse Manager	15th December 2025 31st January 2026

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Louisa Standeven

Job role: Interim Deputy Head of Nursing Unscheduled Care GGH

Date: 31st October 2025