Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Short Stay Surgical Unit, University Hospital of Wales, Cardiff and Vale 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.

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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 the University Hospital of Wales, Cardiff and Vale University Health Board on 13 and 14 January 2026. The following hospital wards were reviewed during this inspection:

- Short Stay Surgical Unit - 31 beds and two chairs providing surgical services

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 10 questionnaires were completed by patients or their carers and 13 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Patient feedback about their experience on the unit generally highlighted that staff were respectful, attentive, and supportive. Most individuals reported feeling listened to and treated with dignity. Nonetheless, concerns emerged regarding a drop in cleanliness and delays to treatment during weekends. This mainly attributed to the absence of key teams, such as housekeeping staff and medical staff. They also highlighted the prolonged waiting times for surgical procedures, which occasionally resulted in emergency admissions. The physical environment was described as dated and congested, with limited privacy and insufficient facilities, including the absence of a water dispenser and an appropriate waiting area.

Specialised tools for patients living with cognitive impairment had not been implemented, and signage did not facilitate dementia-friendly navigation, although staff endeavoured to adapt their approach to meet individual needs. Provision for those with sensory impairments or language barriers was restricted, with no 'Meet the Team' board or suitable communication aids available. Staff nevertheless sought to supply information in Welsh and to involve families in patient care whenever possible, although the application of visiting policies was inconsistent.

Additional issues identified included excessive patient allocation to the unit, leading to daily cancellations, the lack of weekend service provision, limited health promotion materials, deficiencies in equipment maintenance, and inadequate privacy surrounding patient information boards. The ward's environment and facilities were also highlighted as requiring enhancement to promote comfort, privacy, and safety. Consequently, it was recommended that weekend staffing and cleanliness should be improved, better communication, person-centred tools adopted, and the physical environment and allocation processes reviewed, with the aim of reducing cancellations and delays.

This is what we recommend the service can improve:

- Use dementia-friendly practices such as "This is Me" and the Butterfly Scheme
- Increase the availability of health promotion materials
- Reduce the frequency of surgery delays and cancellations.

This is what the service did well:

- Staff were consistently respectful, compassionate, and responsive to patient needs
- Welsh-language provision was strong, enhancing patient comfort and communication
- Patients felt involved in decision-making and reported high levels of emotional support.

Delivery of Safe and Effective Care

Overall summary:

The inspection found that the ward environment was largely safe and accessible, with layouts facilitating patient movement, including for those with mobility difficulties. Although most facilities were operational, we identified deficiencies, such as several toilets being out of order and maintenance concerns affecting staff working conditions. Immediate issues, including inadequate decontamination of blood pressure cuffs, broken window blinds, clutter, and inconsistent use of cleaning indicators, were identified and addressed through our immediate assurance process.

Infection prevention and control (IPC) measures were generally observed, including the use of PPE and good hand hygiene, monitored regularly via the AMaT system. However, environmental standards fluctuated, particularly at weekends, and areas were found to be cluttered and dusty, with inconsistent cleaning practices and lapses in sharps disposal. IPC compliance was reduced at weekends, indicating that improved audit sampling and daily IPC oversight were required.

Safeguarding protocols for children and adults were in place, although safety risks arising from broken doors and key card failures required urgent attention. Staff demonstrated awareness of safeguarding responsibilities and had access to policies and mandatory training. Patients reported feeling safe and confident to raise concerns.

Blood management processes were considered safe and well understood, with staff trained and competent in transfusion practices, notwithstanding the infrequency of such procedures on the ward. Medical devices and equipment were well maintained, clearly labelled, and repairs or replacements were managed efficiently with on-site support.

Significant concerns were raised regarding medicines management, including disorganised and unsecured storage, unlocked medicines rooms and fridges, expired controlled drugs, inconsistent monitoring, and a lack of clear accountability for medication oversight. The absence of a dedicated pharmacist

exacerbated these risks, and a sustained pharmacy presence along with immediate remedial action was required.

Pressure and tissue damage prevention relied on initial assessments, but ongoing documentation and reassessment proved inconsistent. Falls risk assessments were completed and prevention measures promoted; however, audit compliance for pressure areas and falls remained unresolved. Nutrition and hydration support was informal, relying on verbal handover, with incomplete fluid balance and nutritional assessments. Hand wipes were not routinely provided to patient prior to mealtimes.

In terms of effectiveness, early identification and management of sepsis were supported by the NEWS2 system and a sepsis pathway, with staff demonstrating sound awareness of relevant clinical guidelines. Staffing shortages were noted, which impacted supervisory capacity, yet safety processes, such as intentional rounding and audits were in place. Patient records were generally well maintained, though documentation for short-stay patients lagged owing to unavailable templates, and secure disposal of confidential information required improvement.

Efficiency was demonstrated through safe patient movement along care pathways, positive discharge and admission procedures, and positive communication with families. Discharge planning was generally coordinated effectively, with staff ensuring patients departed the unit safely. Overall, the ward was characterised by a strong commitment to patient care, although improvements in weekend staffing, cleanliness, medicines management, documentation, and the physical environment were required to further enhance safety and effectiveness.

Immediate assurances:

- Medication safety concerns: Medication and treatment rooms were left unsecured; expired, unlabelled, and unidentified substances were found; storage areas were cluttered and disorganised. Immediate actions included securing rooms, removing expired stock, and cleaning, with ongoing processes introduced for regular checks, labelling, and pharmacist involvement
- Patient records not securely stored: Records were left unattended in multiple open areas. Actions included ordering lockable trolleys, relocating notes to supervised or locked spaces, displaying reminders for staff, and implementing weekly compliance checks and audits
- Environmental and IPC risks impacting patient safety: Issues include inadequate cleaning, unlabelled or improperly cleaned equipment, broken or dirty windows/blinds, and unresolved estate maintenance requests. Responses involved deep cleaning, strengthened auditing, estate repairs,

and plans for ongoing monitoring and compliance with updated cleaning standards.

This is what we recommend the service can improve:

- Environmental and IPC issues including clutter, cleaning standards, and weekend compliance which need more robust controls
- Documentation, including care plans, pressure-area monitoring, and audit completion, should be made more consistent.

This is what the service did well:

- Staff consistently demonstrated safe practice in blood management and medical device maintenance
- Effective systems for sepsis recognition and escalation were in place and used appropriately
- Patients reported positive interactions with staff, including good communication and pain management.

Quality of Management and Leadership

Overall summary:

The inspection found that governance arrangements within the SSSU were developing, with established escalation pathways, clear accountability, and effective communication mechanisms. Senior nurse support and regular quality and safety reviews were noted. However, staff survey feedback highlighted significant concerns regarding local leadership culture, including reports of unprofessional communication, perceived unfairness, and inconsistent management processes. These issues contrasted with the positive interpersonal care experienced by patients and highlighted the need for organisational attention to address leadership and cultural challenges.

Patients generally described staff as kind and reassuring, expressing confidence in the care provided. Nonetheless, system-level leadership challenges were evident, particularly delays and cancellations of surgery, and reduced responsiveness and cleanliness at weekends. The unit's senior staff were visible and accessible for clinical oversight, with information cascaded effectively and staff demonstrating understanding of risk assessment and quality improvement. Despite positive observations, staff feedback indicated closed-door management, low visibility during busy periods, and distressing interactions, including abrupt communication and inconsistent feedback. Concerns regarding favouritism in rota allocation and allegations of discriminatory behaviours, including racism, were raised, requiring further investigation and action under health board policies.

Workforce pressures persisted, with vacancies, sickness, and reliance on bank and agency staff, especially at weekends. Staff reported variable staffing levels, difficulties securing healthcare support worker cover, and increased redeployment to other wards, affecting wellbeing and care consistency. Staff survey feedback highlighted unsafe weekend working, limited clinical cover, and reduced cleanliness, aligning with patient reports of lower standards and delays at weekends. Despite challenges, staff described strong peer support, high training compliance, and pride in their work. The health board must review staffing arrangements, ensure fair rota allocation, restore staffing establishment, and regularly review workload pressures to support safe patient care and staff wellbeing.

Cultural concerns were identified, with staff survey responses suggestive of bullying, harassment, low morale, and reluctance to speak up. Tensions were reported between nursing and support roles, which arose from workload inequities and leadership inconsistencies. Patient feedback remained largely positive, though some concerns were raised regarding visitor access and delays. The health board must investigate allegations of discrimination, develop a culture improvement programme, strengthen speaking-up mechanisms, and review visitor policy for compassionate application.

Information governance systems were in place, but inconsistent use of electronic tools and lapses in secure record handling were observed, including unsecured patient records and overflowing confidential waste bins. Immediate steps were taken to mitigate risks, yet ongoing monitoring and training are required to ensure compliance with GDPR and secure documentation management.

Quality improvement activities were evident, with regular meetings, audits, and collaborative initiatives. However, barriers to learning included cancelled study days, limited access to competencies, and lack of structured induction for new staff. Staff described reliance on self-directed learning due to insufficient protected time, and reduced confidence in clinical skills. Patient feedback indicated delays in care and cancelled procedures, reflecting systemic constraints. The health board must provide protected time for training, standardised induction processes, establish local concerns log for capturing themes and trends, and embed structured opportunities for shared learning.

Partnership working across surgical pathways was established, supporting patient flow and discharge planning. Nevertheless, systemic pressures, including daily over-allocation of patients to the unit, reliance on rapid turnover assumptions, and recurring delays, negatively impacted patient and staff experience. Limited involvement of ward staff in allocation decisions contributed to feelings of disempowerment. Weekend service provision gaps affected outcomes and standards. The health board must address over-allocation, strengthen weekend

services, involve SSSU staff in cross-service decisions, define escalation pathways, and improve patient-facing spaces for safety and comfort.

Overall, the inspection identified pockets of strong practice and commitment to improvement, but sustainable progress requires strengthened leadership, workforce resilience, equitable access to training, and a proactive whole-systems approach.

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

For our patient survey we received responses from 10 individuals. Patients provided mixed feedback, with strong praise for staff attitudes and interpersonal care, but notable concerns around weekend service provision, cleanliness, delays to treatment, and aspects of the ward environment. Patient comments included:

> *" Very caring hospital staff and students. Helpful treatment and staff were excellent"*
>
> *" Experience of all nursing staff is brilliant BUT [medical] team not available 24/7 when I needed it."*
>
> *"Staff helpful and attentive"*
>
> *"Experiences vary greatly. Staff are under a lot of pressure today. Shortage of beds but appear to be no staff shortages."*
>
> *"Waiting area was ok. Full of mis mash chairs filing cabinets but did have a TV. Needs a water dispenser."*
>
> *"Overall good…"*
>
> *"…Moved from away and visitor travelled down from London was not allowed to sit with me."*
>
> *"Staff are absolutely lovely especially those in theatre."*

Several patient comments describe reduced cleanliness on weekends, including blood and fluids on floors, and delays or harms linked to lack of weekend specialist availability. For example, no team available for [catheter] tube change, leading to a kidney infection. These accounts align with staff concerns about reduced weekend domestic cover and unsafe Saturday provision, which is highlighted later in the report.

Person-centred

Health promotion
The ward provided information aimed at supporting patients' health and wellbeing, although specific hand-hygiene guidance is not displayed within the toilet areas, and there was limited instruction regarding appropriate waste disposal. Handwashing facilities, including soap and paper towels, were readily available.

Patients reported that they were well cared for and spoke positively about the support they received from staff. Most patients were able to manage their own needs independently, with one wheelchair user receiving additional support from his mother, who remained on the ward to assist him. Overall, patient feedback indicated that staff were helpful and that the standard of care provided on the ward was positive.

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

Dignified and respectful care
Overall, no patient concerns were identified regarding the standard of care provided on the ward. Patients consistently reported being treated with dignity and respect, with 90% strongly agreeing with. The inspection found that staff consistently demonstrated respectful, kind, and courteous behaviour towards patients, and this was also highlighted in the patient survey responses.

Patients reported positive interactions with staff and raised no concerns regarding communication, introductions, or the way they were treated. Staff were observed speaking discreetly and sensitively, including during the delivery of personal care. Most respondents felt staff listened to them, answered questions, and provided thorough, sensitive and timely care. Several comments highlighted helpfulness and supportive staff attitudes.

The physical environment, and particularly the use of disposable curtains and dated facilities, limited the level of privacy, although, staff took reasonable steps to mitigate this, such as using the sister's office for confidential discussions. All respondents in the patient survey felt staff treated them with dignity and respect and were able to speak to staff without being overheard. Almost all said measures were taken to protect their privacy, such as curtains drawn when required.

Patients appeared well cared for, and continence needs were appropriately assessed with referrals arranged as required. Equipment to support patient care was generally available, though some gaps were noted in maintenance records and cleaning arrangements for specific devices.

Individualised care
Widely used initiatives, such as a 'This is Me' document, or the 'Butterfly Scheme', to support people with cognitive impairment, were not used on the unit. The ward manager confirmed that these are not used, because the environment is not intended for patients requiring enhanced cognitive support. Given the unit's throughput of adults with potentially fluctuating cognition, such as those post operative and who may be confused, and people who may present with cognitive impairments, such as those with a learning disability or dementia, adopting these tools opportunistically remains proportionate even in short-stay settings.

We observed that signage on toilet doors and other key areas did not include adaptations designed to support individuals with sensory or cognitive impairment. However, we saw staff supporting patients to mobilise following surgery, as appropriate.

Staff encouraged patient mobility where appropriate, and necessary equipment was available for their support. This included mobility aids, hoists, and the use of patients' own equipment where applicable. Nearly all respondents in the patient survey felt staff listened to them and answered their questions and all felt they were involved as much as they wanted in making decisions about their healthcare.

The health board must ensure that:

- **Person-centred tools such as "This is Me" and the "Butterfly Scheme" are used to support patients with cognitive impairments if required**
- **The signage is improved to ensure a more dementia friendly environment.**

Timely

Timely care
Overall, patients reported timely access to staff support and care throughout their stay. Those in beds had access to call buzzers, and all respondents in the patient survey and those spoken with on the unit, consistently felt that staff responded quickly when assistance was required. We saw staff attending call bells quickly, and postoperative patients reported being pain-free due to effective analgesia and support.

Patients highlighted significant issues on weekends, including lack of specialist teams and reduced responsiveness. In the survey, one patient reported developing a kidney infection due to the unavailability of required clinical support on a Sunday. Others commented that some services appeared to operate only on a five-day basis.

Patients felt they received appropriate emotional support, with adequate information provided during pre-assessment, including anaesthetist review where needed, and relatives were involved in discussions about care and recovery. Patients with urgent or time-critical needs were appropriately prioritised, with medication administered in a timely manner and clear evidence of compassionate and prompt responses to pain or distress.

Whilst patients generally responded positively about the unit staff, several highlighted long waits for surgery. Others reported repeated cancellations, including multiple last-minute postponements.

Some patients commented:

> ***"My care has been thorough and sensitive and timely throughout. I've been fully informed and people have been kind and courteous."***
>
> ***"Transferred from [redacted] hospital. Made to wait and within 24hrs appendix burst. Leading to an infection and long stay."***
>
> ***"Attended via SDEC on Sunday, tube needed changing but no team to do it, leading to a kidney infection and need for longer stay. Totally believe in the NHS but shocked some areas only operate five days a week."***

The ward manager described how the unit is frequently assigned more patients than it can accommodate. For instance, up to 40 patients might be allocated despite the unit having only 31 beds and two chairs. This over-allocation happens because there is an expectation that patients will be discharged following their morning or previous day surgeries, freeing up beds. However, when discharges are delayed for various reasons, daily cancellations often result. Patient feedback described repeated cancellations and long waits, with one patient waiting more than two years, leading to deterioration and emergency admission, this was consistent with staff reports of daily over-allocation versus 31-bed capacity.

The health board must review and address the issues of over allocating patients to the unit, which leads to several patients being cancelled each day.

Equitable

Communication and language

Communication and information on the ward were mixed. Clear signage to the SSSU was available, and patients reported that staff communicated well and took

time to explain their care. However, there was limited evidence of provision for people with sensory impairments, accessible information to support understanding of care, or sepsis information. We found and absence of communication aids, such as a hearing loop system, braille support, or pictorial aids to support patients with hearing, sight, or language barriers.

There was no evidence of a 'meet the team board' displayed in the unit with photographs of staff, accompanying explanation of uniform colours or corresponding staff roles, and not all staff were wearing name badges or had visible identifiers.

Staff reported positive Welsh language practice and were visibly wearing 'Iaith Gwaith' identifiers. Whilst some patients appreciated the opportunity to use Welsh for their stay, the patient survey contained no responses to Welsh language questions. Staff had access to Welsh language training and bitesize courses to ensure basic Welsh language needs are met. All patients spoken with confirmed they were offered to speak in the medium of Welsh.

Identifying the patient language also formed part of the pre-assessment form. Translation services were available when needed, such as 'Language line', for Welsh and other languages. Bilingual materials were available but were limited. Staff demonstrated appropriate communication practices, including speaking with patients in their preferred language and involving other disciplines when necessary to assist with communication needs. Although specific examples of support for sensory loss were not provided, staff indicated a willingness to adapt communication methods.

The patient's waiting room was clean, and a temporary partition separated patient chairs, however, the area was cluttered with storage units and chairs of various size and shape. Patients also described the space as "mismatched" and lacking a water dispenser. However, we acknowledge the risks associated with patient access to water in this area, where people may be 'nil-by-mouth' prior to surgery. Secure storage and the removal of general office equipment, such as the photocopier from patient areas would support a calmer waiting environment.

The health board must ensure that:

- **The implementation of a 'Meet the Team' board is considered to support patient understanding of staff and their roles**
- **The patient waiting room is reviewed to make it appropriate for those awaiting surgery, and should include a solution for the secure storage of patients' personal belongings**
- **The unit has the relevant equipment and tools to support patients with hearing, sight and language difficulties.**

There was a centrally located ‘patient status at a glance’ (PSAG) board on the unit. 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. However, the information on the board was visible to everyone, potentially impacting patient privacy.

The Health Board must ensure that all patient-identifiable information is appropriately concealed or removed from public view to maintain compliance with GDPR requirements.

Rights and Equality
Staff were compliant with mandatory training for equality, diversity and inclusion, and there were various policies in place to support staff. We found a general culture of treating people with dignity and respect, and this was confirmed by patients.

The ward had limited space and lacked a dedicated relatives’ room, reducing privacy for conversations. Patients said they felt comfortable raising concerns with staff who were perceived as supportive during the complaints process.

Shared decision making is integrated into the ward’s short-stay model, with care plans and expectations discussed before admission. Families and carers are encouraged to participate in patient care, and staff were seen involving relatives in discussions, such as discharge planning. While most patients felt involved in decisions about their care, some disagreed, indicating variation in practice.

Although the ward typically cares for lower-acuity patients, staff can accommodate relatives overnight when patients require additional support, and efforts are made to reduce inequalities, such as providing a cubicle to allow relatives to stay with patients living with dementia. However, this contradicts the patient comment highlighted earlier that their visitor from London was not allowed in to visit out of hours.

Overall, staff displayed respectful attitudes and awareness of diverse needs, though the ward’s physical environment limits privacy and the ability to enhance family involvement further. All patients in the survey confirmed they had not faced discrimination when accessing or using this health service, although only 70% said they could access the right healthcare at the right time. One patient commented:

> ***“Can't access appropriate healthcare after Friday lunchtime no matter what your age”***

Some patients also highlighted discomfort due to cold temperatures, insufficient pillows, lack of handwipes provided before eating, and an inadequate waiting area described as containing “mismatched chairs” as highlighted earlier and lacking a water dispenser for hydration.

Delivery of Safe and Effective Care

Safe

Risk management
The environment was generally safe, accessible and conducive to patient care. Ward layouts provided sufficient space for patients, including those using mobility aids or wheelchairs, to move around safely. The environment was generally clean, although some areas were noted to be very dated, and cosmetic improvements, including paintwork were identified, though patient and staff comments contradicted the cleanliness at weekends.

Facilities such as toilets were accessible, however three of the five toilets on the unit were 'out of use' for repair work. Staff raised concerns about environmental maintenance, including blocked toilets impacting their working conditions.

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

- Blood pressure cuffs not decontaminated between patients
- Some window blinds were broken, missing, or unable to be sufficiently cleaned, requiring removal or repair
- 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.

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

Equipment and furniture were in good working order, and bed spaces were adequately equipped to support patient care. While the ward was considered fit for purpose, opportunities for improving bed and ward layout to enhance patient observation were identified, and the staff survey received comments suggesting insufficient bed spacing between beds two and three. The ward magnetic access lock was reported as not functioning at the time of inspection, but this had already been escalated to estates.

Clutter was observed during the inspection although corridors, despite containing equipment and patient notes, remained navigable with adequate space. Call bells were accessible to all patients. Environmental hazards related to medicines were noted, but these were addressed separately in the medication section of the report, and no broader environmental safety concerns were raised by staff.

Housekeeping cupboards were located away from public areas; their positioning reduced the risk of unauthorised access. Most patients reported satisfaction with the cleanliness and general environment of the ward, apart from the weekends.

Infection, prevention and control and decontamination

The inspection found that personal protective equipment (PPE) was widely available, accessible and used appropriately, with staff routinely changing PPE between tasks and patients. Correct donning and doffing were observed throughout the unit. Hand hygiene facilities were well stocked and accessible, and staff described appropriate hand hygiene practice.

Infection rates were monitored through the Audit Management and Tracking (AMaT) system, with results discussed centrally and actions cascaded to the ward. Infectious patients would be managed in the single side rooms when available, prioritising those with more transmissible conditions.

Environmental standards varied significantly; many areas were cluttered, dusty, and poorly organised, including the sluice, treatment and medication rooms, with some expired items identified. Shared equipment was often inadequately decontaminated, with outdated or absent green-clean labels and inconsistent cleaning practices.

Estates issues were widespread, with tired décor, maintenance delays, and areas requiring refurbishment. Housekeeping staff understood their roles and cleaning routines, though some equipment shortages were reported. Observations identified several IPC risks that require attention to ensure the ward environment is safe, well maintained and conducive to effective infection control. Many of the identified issues were addressed under our immediate assurance process highlighted in Appendix B.

The ward had a good number of single rooms to help maintain IPC and safe sharps systems were mostly adhered to. However, isolated lapses included used needles and syringes left unsecured awaiting disposal.

The health board must ensure staff dispose of sharps and syringe waste appropriately and in a timely manner.

Staff demonstrated a generally sound understanding of infection prevention and control (IPC), including policy access and equipment decontamination, although some staff, particularly students, required further support in areas such as needle-stick injury procedures.

Patients spoken to reported that the environment was clean and accessible, and mostly all survey respondents rating a very clean or clean unit. However, in the survey, several patient responses described reduced cleanliness and infection-control compliance at weekends, including reports of blood and fluids on floors, and poor hygiene standards. These accounts, and staff reports of no domestic cover on Saturdays indicate a weekend IPC performance gap, that is not fully reflected in weekday audit data. Audit methods should explicitly sample weekends and bank-staffed shifts.

The health board must ensure that compliance with infection prevention and control (IPC) procedures is maintained every day, particularly at weekends, where the unit is often managed by bank staff.

Safeguarding of children and adults

During the inspection, it was noted that the ward environment presented several safety risks due to broken doors, including the main ward access door and the medicines storage room door. This resulted in unrestricted access between the ward and the main corridor, an issue that staff reported had been raised with estates but remained unresolved.

The issue of the medicine's storage room broken door lock and failure of the key card access system required immediate attention. These issues were addressed under our immediate assurance process highlighted in Appendix B.

At the time of the visit, no patients were under constant supervision, and staff reported they rarely manage patients requiring Deprivation of Liberty Safeguards (DoLS), as such individuals are usually admitted to the main wards rather than remaining overnight. Staff demonstrated general awareness of DoLS processes and safeguarding responsibilities, with relevant policies accessible if required. Staff safeguarding training was mandatory and staff highlighted that safeguarding officers provide further updates during team meetings. Patients spoken to reported feeling safe on the ward and comfortable raising concerns with staff, stating they would seek help or follow formal procedures if needed.

Blood management

Staff described the process to support the safe and appropriate transfusion of blood and blood products. Most staff were trained and competent in blood transfusion and were further supported by a training board within the ward office, and clear expectations for maintaining up-to-date competencies. Although transfusions are not routinely undertaken on this ward, staff were consistently able to explain safe practice, including patient identification, component checking and the required monitoring throughout the transfusion process.

Management of medical devices and equipment
Maintenance arrangements for medical equipment were found to be effective. All items of equipment sampled during the inspection were clearly labelled, up to date, and indicated when the next safety or service checks were due. Staff reported that on-site medical engineers were available to support with repairs and equipment replacement when required. Staff demonstrated good general awareness of processes for obtaining replacement equipment from medical stores and demonstrated generally strong oversight of medical devices, with equipment well-maintained and staff able to access support when needed.

Medicines management
Overall, significant concerns were identified regarding medicines management on the ward. While the ward has recently transitioned to the ePMA system, with electronic charts generally completed correctly and patient identifiers clearly recorded, numerous issues were noted in the wider management, storage, and governance of medicines. The key issues reported within this section were managed under our immediate assurance process, which can be found in Appendix B.

Staff were able to demonstrate that medication administration, oxygen usage, and IV fluid prescribing were recorded appropriately on the electronic system. Staff confirmed they knew where to access relevant policies on the health board intranet site and reported having completed online training related to oxygen management.

The organisation and safety of the medicines room were of considerable concern. The room itself was unlocked, with internal cupboards also left unlocked, providing unrestricted access to medicines for anyone entering. The medicines fridge was not locked and was found to be disorganised, with no separation of medicines and at least two unlabelled containers containing unknown fluid. Staff were unable to identify the contents of these containers. The general clutter and lack of workspace in the medicines room presented clear risks to safe preparation of medicines, including IV antibiotics.

Controlled drug (CD) management also raised concerns. The CDs were signed out appropriately with two signatures, however, the CD cupboard contained numerous expired medications, with some expired in May 2025. Staff reported that these issues had been repeatedly raised with pharmacy but had not been removed. We found that CD checks had not been completed for four days prior to inspection, to ensure the contents and balances were correct, which does not comply with policy. This therefore highlights concerns about the effectiveness of monitoring processes and safe management of CDs.

Further issues were observed in respect of medicines storage on the ward. Patients did not have bedside lockers, and their medicines were stored in open baskets within the medicines room or, in one case, left unattended on a patient's chair. The system for safe and uninterrupted administration of medicines was not evident, likely due to the nature of the ward as a day-case and overnight stay area, where patients arrive and leave at variable times. Staff were also unable to identify who was responsible for oversight of medication dispensed for patients being discharged.

During inspection, oxygen cylinders were found free-standing rather than secured safely, although staff could describe the process for reporting damaged or faulty cylinders.

The Health Board must ensure oxygen cylinders are secured or returned to the theatre storage area immediately after use is ceased.

Staff reported that they did not have a dedicated pharmacist, despite being due a visit from pharmacy every Tuesday, no pharmacist had attended on the day of the inspection, and the medicines room had become disorganised due to the absence of the Healthcare Support Worker responsible for medicines-related tasks.

In conclusion, inspectors noted significant deficits in the safe storage, organisation, and oversight of medicines on the ward. The cluttered environment, absence of secure storage, poor fridge organisation, absent CD checks, and lack of clear accountability for medication represent substantial risks to medicines security, and potentially patient safety. This requires a sustained oversight and pharmacy presence. This was dealt with under our immediate assurance process highlighted in Appendix B.

Preventing pressure and tissue damage

Skin pressure risk assessments were completed on patient admission. However, reassessments were not consistently recorded, additionally, there was no evidence of turn charts where applicable. Staff reported that continued monitoring was prioritised for patients with longer stays. 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 medical records we checked. Staff discussed the considerable emphasis on fall prevention, particularly among patients who may be confused post-operatively. Suitable footwear was encouraged and enhanced support to further reduce fall incidents.

Audits related to pressure areas and falls were not completed.

The health board must ensure compliance with audit requirements in a timely manner.

Nutrition and hydration
Overall, the ward did not have a formal system to identify patients requiring assistance with eating, although staff relied on verbal handover to ensure awareness. While no patients currently required support, staff reported that help is provided when needed by staff. The All-Wales Nutrition Pathway was not in use due to the ward's short-stay nature. Mealtime observations showed that food was served promptly once the trolley arrived, with lunchtime consisting of sandwiches and soup and hot meals offered in the evening. Access to water was mostly sufficient, but not consistently available or within reach for all patients. Fluid balance charts were consistently incomplete, with totals not being calculated at the end of shifts, when appropriate to do so.

Mealtime arrangements were variable. Some patients were supported to sit upright with tables positioned appropriately; however, hand wipes were not routinely provided, and staff confirmed this had never been common practice. The distribution of meals appeared timely, and food presentation was generally acceptable. Patients reported receiving choices and adequate assistance where needed, additionally, some said that no handwipes available before eating, and staff confirmed this had not been common practice. Ensuring wipes and hand hygiene prompts are consistently available would improve experience and IPC

Nutrition and hydration assessments varied, with some assessments incomplete, and oral care assessments were mainly addressed within pre-operative checks completed by anaesthetists.

The health board must ensure that:

- **Hand wipes are provided to all patients at the bedside, specifically those who are unable to mobilise to wash their hands ahead of eating**
- **Fluid balance charts are completed appropriately and in a timely manner**
- **Nutritional assessments are completed when appropriate to do so.**

Effective

Effective care

During the inspection, we found that the ward has systems in place to support the early identification and management of sepsis. Staff use NEWS2, with escalation triggered at a score of 3 or above, and demonstrate awareness of sepsis indicators, escalation procedures, and the importance of the “golden hour.” A sepsis pathway, including the Sepsis Six care bundle, is available and in use. One recent case of sepsis was managed effectively in line with best-practice guidance. Staff can access clinical policies, procedures, and NMC record-keeping standards, and report confidence in escalating concerns.

Ward staff reported that although they strive to provide safe care, high patient acuity and bed pressures affect the ward manager’s ability to maintain supervisory time. Staffing levels were below the agreed establishment on the day reviewed, with shortages in both HCSW and reception roles and unsuccessful attempts to secure bank staff cover. Despite this, staff reported that patients were satisfied with the care received.

Routine safety processes are partly embedded. Intentional rounding is supported through checklists completed on admission. IPC and hand hygiene audits are undertaken, with 100% hand-washing compliance reported for December 2025. Staff confirmed awareness of clinical guidelines relevant to their practice. Systems for monitoring patient status, such as electronic boards, are in use, although accuracy and completeness were not confirmed. Participation in national quality improvement programmes, where applicable, was either not relevant or not evidenced. No concerns were raised by patients, although some expressed a desire for more timely access to surgery.

Some patients commented:

> ***“Waited about 2 years for surgery and eventually came to A&E as an emergency. This has impacted on my work as a carpenter needs to be able to lift so hernia got much worse.”***
>
> ***“Was cancelled twice and was called to be cancelled again but had the surgery after explaining daughter had changed shifts to care for me.”***

Patient records

A review of patient records showed that documentation practices vary depending on the patient’s length of stay, and the availability of standard assessment booklets. Short-stay and day-case patients generally had fewer recorded assessments, and staff explained that usual documentation templates were

temporarily unavailable, resulting in reliance on theatre care plans and photocopied sheets. Despite this, staff demonstrated awareness of patients' immediate needs, and patients consistently reported positive interactions with staff, particularly in relation to pain management and general communication.

The health board must ensure that all care-planning documents (templates) relevant to SSSU are readily available, so that patients' care needs can be fully assessed, appropriately planned, and consistently monitored.

Pain management was a consistent strength, with most patients reporting timely access to analgesia and evidence of pain score documentation in several records. In some cases, scores were not updated, although patients described their pain as well managed. Admission assessments were generally completed promptly, and relevant risk assessments were undertaken when indicated.

Record-keeping standards relating to legibility, signatures, dates, and times were consistently met. Handovers were supported by printed patient lists and verbal reports focused on allocated patients. Paper records remain the primary system on the ward, supported by computer-generated daily patient lists. Confidential waste procedures were in place, though a full bin had led to patient information being left on top of it rather than disposed of securely, and is not acceptable.

The health board must ensure that confidential waste bins are emptied regularly, and that no patient-identifiable information is left unsecured or placed on top of waste containers, in accordance with GDPR requirements.

Efficient

Efficient

The service demonstrated effective arrangements to support safe and efficient patient movement through care and treatment pathways. Staff reported that although few patients require social care input on discharge, there are established processes for coordinating with district nursing teams for ongoing support. Robust discharge and admission arrangements were evidenced, with staff using relevant documentation, such as the extended thromboprophylaxis care pathway and ensuring referrals to the multidisciplinary team where appropriate.

Communication with relatives was consistently described as positive, with families actively involved in discharge planning and medication discussions. Observations highlighted safe discharge practices, including staff remaining on duty to ensure patients leave the unit safely or are transferred appropriately when the unit closes. Overall, staff were described as hard-working, and discharge pathways were effectively utilised within the unit.

Quality of Management and Leadership

Leadership

Governance and leadership

Overall, governance arrangements on the SSSU are progressing. During inspection, staff described established patient escalation pathways, and highlighted the supportive senior nurse, and regular mechanisms for quality and safety reviews. Staff also reported clear lines of accountability, access to policies, and good support from senior nurses during daily flow meetings. However, the wider evidence gathered through the staff survey indicates concerns regarding the unit's overall culture, including reports of unprofessional communication, perceived unfairness, and inconsistent application of the unit and shift management processes. These concerns however, contrast with the positive interpersonal care experienced by patients and highlight important cultural and managerial issues that require organisational attention.

Patients generally described staff as kind, courteous and reassuring, with confidence in the nursing and clinical support provided. However, some patient experiences also reflected system-level leadership challenges, particularly delays and cancellations of surgery and reduced responsiveness or cleanliness at weekends. These issues were also strongly echoed in staff feedback, who described unsafe staffing levels, reduced weekend cover and operational pressures that affected their ability to deliver consistent care.

The unit's senior leaders were visible during the inspection and were available to provide day-to-day clinical oversight; staff confirmed they could escalate concerns and receive timely guidance from them. Information was cascaded effectively through meetings, emails, messaging groups and forums, ensuring staff were aware of policy updates and safety notices. Staff demonstrated an understanding of risk assessment processes and described regular quality and safety sessions to support ongoing improvement.

The staff survey, however, highlighted concerns regarding behaviours relating to unit and shift leadership, which also contrasted with the positive observations made during the inspection. Survey feedback described perceptions of limited leadership visibility during busy periods and management approaches that were not always experienced as open or supportive. Examples of this include staff being spoken to abruptly or inappropriately in front of patients and feedback being critical rather than constructive. Staff told us that this affected their confidence and emotional wellbeing and created hesitancy in raising concerns or engaging in formal discussions with senior staff.

Several staff also perceived favouritism within rota management, including repeated shift deployment to other wards for certain individuals, while others were rarely moved. There were also reports of inequitable theatre list/ patient allocation, and the inconsistent assignment of healthcare support staff. Staff also described feeling pressured to swap shifts at short notice, including on days off, and highlighted a lack of flexibility and understanding in relation to shift requests. These concerns indicate leadership practices that may contribute to low morale and reduced team cohesion.

Some staff raised allegations of racism and discriminatory behaviours, including the alleged use of derogatory terms, and the perceived disproportionate assignment of undesirable winter pressure shifts to certain healthcare support workers. Staff also described poorer treatment of colleagues from minority ethnic backgrounds and inconsistent application of expectations depending on personal relationships. While the patient survey did not identify any reports of discrimination, the staff allegations are serious and require further review under appropriate health board processes.

Following the inspection, we wrote to the health board after our review of the staff survey results, to seek assurance that the issues highlighted would be reviewed and addressed as appropriate. We have since received a response from the health board and are satisfied that the allegations are being reviewed, and where appropriate, investigated appropriately.

Staff described uncertainty about the service's broader quality vision, stating they were not routinely involved in strategic decision-making about patient allocation to the ward, with many decisions made externally through 'Bronze' meetings. Although communication channels were in place, staff reported that senior nurse/ management visibility above ward level was limited.

The Health Board must ensure that:

- **A review of local leadership is undertaken, to address concerns raised by staff about unprofessional communication, leadership visibility, and impact of management interactions that left staff distressed or reluctant to escalate concerns**

- **A structured programme is introduced to improve leadership behaviours, including expectations around communication, feedback, dignity and respect, and safe 'speaking-up' environments**

- **Mechanisms are established to ensure staff are involved in operational decision-making, including bed allocation, patient flow assumptions and rota decisions, rather than these being made solely at external 'Bronze' meetings**

- **Leadership visibility and oversight of the surgical clinical board is strengthened, ensuring that senior nurses/managers routinely visit the ward, engage with staff directly and provide oversight during high-pressure periods.**

Workforce

Skilled and enabled workforce
The unit has faced sustained workforce pressures, including vacancies, staff sickness, and reliance on bank and agency staff, particularly during weekends. Staff told us that these pressures resulted in variable staffing levels, difficulties securing healthcare support worker cover, and increased reliance on shift deployment from the SSSU to other ward areas. They reported that these issues directly affect staff wellbeing and the consistency of care delivered.

Staff survey feedback highlighted further concerns relating to alleged unsafe weekend and Saturday working arrangements, where reduced staffing, absence of medical or pharmacy teams, and lack of housekeeping services contributed to increased clinical risk. Staff described days when only one member of staff was present on the ward for periods of time, missed staff breaks, and an expectation to complete complex discharge processes within half-day shifts. These concerns aligned with patient feedback highlighting limited weekend specialist availability, and lower standards of cleanliness, including reports of blood and bodily fluids on the floor during weekends.

Despite these challenges, staff described strong peer support, positive teamwork, and access to wellbeing resources. Mandatory training compliance remained high, with staff demonstrating commitment to maintaining competencies and understanding of organisational policies. Staff valued the support available from senior nurses and expressed pride in their work, even amid significant pressure.

The Health Board must ensure that:

- **A review of weekend and Saturday staffing arrangements is undertaken, including clinical cover, housekeeping services, pharmacy availability and operational support, in response to staff descriptions of unsafe weekend shifts and patient reports of reduced cleanliness, delays and unavailability of required teams**

- **Rota allocation, redeployment and theatre list assignments are applied consistently and fairly, supported by transparent criteria and regular auditing to address perceptions of favouritism, inequitable movement and inconsistent workload distribution**

- **A plan is developed to restore staffing establishment, particularly healthcare support worker vacancies, to reduce reliance on bank staff and mitigate the impact of short-notice redeployments on patient safety and staff wellbeing**

- **Workload pressures are regularly reviewed, with actions taken to ensure patient acuity and dependency are adequately matched to safe staffing levels, and escalations are supported rather than normalised.**

Culture

While the onsite inspection observed examples of an open culture with staff committed to patient-centred care, the staff survey identified concerns about the local team culture, including bullying, harassment and low morale. Staff reported witnessing colleagues in tears, reluctance to speak up due to fear of negative repercussions, and persistent tensions between nursing and healthcare support worker roles, arising from workload inequities and inconsistent leadership. These issues may suggest a fractured local culture that contrasts with the positive team ethos described by senior leadership, and that observed during the inspection.

Patient feedback about staff behaviour remained positive overall, with patients describing respectful communication, kindness and professionalism. However, one patient comment highlighted a visitor being refused permission to sit with them despite travelling long distances, and others raised concerns about delays, cancellations and weekend availability, indicating that leadership challenges at operational and cultural levels may be impacting patient experience.

Formal signposting to advocacy services and concerns processes such as the NHS Wales Putting Things Right (PTR) process was limited, and there was no local record of concerns, to support trend analysis and timely action. Staff reported familiarity with Duty of Candour principles, although few had recent direct experience of implementing them.

The Health Board must ensure that:

- **All allegations of racism, discriminatory behaviour and inappropriate language are investigated promptly and robustly, in line with dignity-at-work and equality policies, with appropriate support provided to staff who may have been affected**

- **A ward-level culture improvement programme is developed, addressing bullying, harassment, fear of repercussions, and concerns raised about distressing interactions with management**

- **Mechanisms for safe, supported speaking-up are strengthened, including clear signposting to 'Freedom to Speak Up', Llais, union representation and internal HR support**
- **Visitor policy is reviewed to ensure compassionate, consistent application, following patient feedback that visitors were turned away even after travelling long distances.**

Information

Information governance and digital technology
Systems to support the secure handling, accessibility and governance of patient and staff information were in place, though improvements were required to ensure consistent compliance. Staff described using individual logins and accessing policies through the health board intranet, and key safety information was cascaded through established channels. However, the inspection identified inconsistent use of electronic systems, with some staff relying heavily on IT support to navigate digital tools, which limited the timely utilisation of available data for monitoring and improvement purpose.

The inspection also found evidence of poor information governance practice, including unsecured patient records left in open areas, confidential documents placed on top of full confidential waste bins, and the patient 'status at a glance' (PSAG) board displaying identifiable information, visible to visitors and other patients. Although immediate steps were taken during the inspection to mitigate these risks, this indicates a need for strengthened oversight and routine monitoring of record-handling practices. Staff survey feedback reinforced this theme. Several staff described cluttered workspaces, overfull confidential waste bins, and disorganisation in areas, such as medication rooms and notes storage, which increased the likelihood of lapses in information security. The information governance issues were addressed under our immediate assurance process highlighted in Appendix B.

Patients did not raise direct concerns about information governance in the survey. However, patient comments described cluttered waiting and storage areas, including unsecured personal belongings, highlight how physical environment issues may indirectly increase risks associated with maintaining confidentiality.

Overall, while governance structures are present, the operational practice requires strengthening to ensure full compliance with GDPR, secure documentation management, and the effective use of digital systems for ongoing monitoring.

The Health Board must ensure that:

- **Patient records are always stored securely, including preventing records from being left on trolleys, counters or atop full waste bins, and ensuring the PSAG board does not expose identifiable information**

- **Confidential waste is removed frequently enough to prevent overflow, with clear accountability for timely disposal and escalation when bins are full**

- **Digital systems are used consistently and confidently, with training provided to staff who reported difficulty navigating electronic tools or requiring IT intervention for routine tasks**

- **Ward spaces are decluttered and organised, ensuring records, files and personal belongings are not placed in areas where confidentiality or security may be compromised, reflecting findings from both staff and patient feedback.**

Learning, improvement and research

Quality improvement activities
The service demonstrated a commitment to learning and improving, with staff able to describe regular quality and safety meetings, audit processes, and access to clinical guidelines. Quality improvement initiatives, such as the nurse-led discharge process, were positively received and reflected collaborative working across disciplines. Staff also reported pride in their work and engagement in mandatory training, despite organisational pressures.

The staff survey however, revealed significant barriers to learning and improvement, including repeated cancellation of study days due to staffing pressures, inconsistent access to required competencies, and an absence of clear expectations for new starters regarding training requirements. Staff described limited opportunities for development, especially given the increased acuity and dependency of patients routinely admitted to the unit.

Some staff noted that seeking training or escalation routes for clinical skills, for example, PEG/JEG care, relied heavily on self-directed learning, due to the lack of structured, protected time for development. Others described a lack of confidence among senior staff in certain clinical situations due to insufficient recent practice, exacerbated by workforce shortages and constant pressure to prioritise immediate operational demands.

From a patient perspective, feedback highlighted delays in care, repeated cancellations of surgical procedures, and limited weekend clinical cover, all of

which indicate systemic constraints that also hinder continuous learning and service development. Patients noted that teams required to undertake essential procedures were sometimes unavailable on weekends, resulting in deterioration or prolonged length of stay.

While the unit does not currently participate directly in research activity, staff received updates related to investigations and reviews within the wider directorate. The inspection found enthusiasm for contributing to improvement efforts, but insufficient protected time, and variable leadership practices limited the ability to embed learning systematically. The lack of a local concerns records also restricted opportunities to track themes and drive improvement based on combined feedback.

Overall, although there are pockets of strong improvement practice, sustainable learning requires improved staffing resilience, equitable access to training, and stronger local leadership support.

The Health Board must ensure that:

- **Protected time is allocated for staff training and development, addressing repeated cancellations of study days and insufficient access to essential skills training**

- **Clear, standardised induction and competency frameworks are provided for all new staff, ensuring role expectations and required training are understood from the outset, addressing concerns about inconsistent onboarding**

- **A local concerns log is established, enabling the ward to track, analyse and learn from patterns in complaints, concerns and compliments, rather than relying solely on centralised systems**

- **Regular structured opportunities for shared learning are embedded, including follow-up on incidents, near misses, patient feedback and weekend-specific themes, ensuring lessons are consistently disseminated**

- **Training provision reflects the increasing acuity of patients, including updating staff competency in skills where they reported reduced confidence due to lack of recent exposure.**

Whole-systems approach

Partnership working and development

The service demonstrated established relationships across surgical pathways, with staff describing effective coordination with district nursing teams, primary care, and theatre services for safe patient flow. Pathways such as ESTEP supported appropriate referrals, and discharge planning arrangements were generally well understood and implemented.

Both patient and staff survey however, suggested that wider system pressures and how they are managed, are significantly affecting the unit. Daily over-allocation of surgical patients to the 31-bed and two chairs unit, reliance on assumptions about rapid turnover, and recurring delays in discharge led to frequent cancellations of procedures and increased operational strain. Staff reported that cancellations negatively affected patient wellbeing, while patients described repeated postponements and long waits contributing to deterioration in their health.

Staff survey responses further highlighted that decision-making related to patient ward allocation took place externally through 'Bronze' meetings, with little involvement of ward staff. This limited their influence over processes significantly affecting workload, acuity and flow, and contributed to feelings of disempowerment.

Cross-system issues relating to weekend service provision, including limited availability of specialist teams, absence of pharmacy cover, and reduced domestic services, had an impact on patient outcomes and staff ability to maintain safe standards. Patients reported delays or unavailability of key procedures at weekends, while staff described unsafe Saturday working conditions and insufficient clinical or cleaning support.

While there was evidence of constructive engagement with some system partners, the triangulated findings indicate gaps in coordinated planning, capacity management, and cross-service escalation processes that directly affect both staff experience and patient care. A more proactive whole-systems approach, linking operational pressures, workforce planning, governance and quality improvement is required to achieve sustainable improvement.

The health board must ensure that:

- **The daily over-allocation of patients to the unit is urgently addressed, ensuring capacity planning reflects the actual 31-bed and two chairs limit and avoids routine cancellations, delays and deterioration described by patients and staff**

- **Weekend medical, pharmacy and domestic services are strengthened, ensuring safe and consistent provision throughout the week. This**

includes addressing gaps that may lead to worsening conditions, delayed treatment and poor cleanliness at weekends

- SSSU staff are actively involved in cross-service decisions affecting workload and flow, reducing the disconnect between ward reality and decisions made externally, such as patient allocations through 'Bronze' meetings

- Clear escalation pathways are defined for situations where essential teams are unavailable, especially during weekends, in response to patient reports of deterioration due to lack of timely

- Waiting areas and patient-facing spaces are improved, ensuring safe storage for belongings, appropriate seating, removal of office equipment (photocopiers), and provision of basic amenities such as water dispensers.

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
We looked at the medication storage arrangements and found that the treatment and medication rooms were open and unlocked. Whilst the treatment room had a keypad entry lock in place, this was not being used. The medication room had swipe card entry which we were told was broken and awaiting repair. As a result, these rooms were easily accessible to any visitor, patient, or unauthorised member of staff.	This posed a potential risk to the safety and wellbeing of patients and other individuals who may access, tamper with and/or ingest substances considered hazardous to their health.	HIW discussed with the senior nurse manager to remove all expired medication immediately and source a means to lock the medication room door. We asked that they: • Remove all expired medications promptly	The senior nurse manager contacted the UHW pharmacy for immediate removal of expired medication. Most expired medication was removed, however, despite the pharmacist attending the ward, some out of date medication

		• Safely and appropriately discard the unidentifiable liquids, and ensure staff, in future, do not store such items • Restore use of the keycard entry to the medication room as soon as possible, or ensure the room is locked if there is an issue with swipe entry in future	remained, as did non-identifiable liquids in the fridge. A single key was provided to the unit to lock the medication room door until the keypad entry / swipe access could be repaired/restored.

Appendix B - Immediate improvement plan

Service: SSSU, University Hospital of Wales

Date of inspection: 13 and 14 January 2026

Findings

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

We looked at the medication storage arrangements and found that the treatment and medication rooms were open and unlocked. Whilst the treatment room had a keypad entry lock in place, this was not being used. The medication room had swipe card entry which we were told was broken and awaiting repair. As a result, these rooms were easily accessible to any visitor, patient, or unauthorised member of staff.

This posed a potential risk to the safety and wellbeing of patients and other individuals who may access, tamper with and/ or ingest substances considered hazardous to their health.

Within the medication room we also found:

- Expired medication, this included oral MST and Oxycodone in the CD cupboard, which appeared to be in use, and were not segregated from in-date medication, in addition expired patients' own medication.
- Unlabeled medication
- Two pots of unidentified liquid stored in an unlocked fridge

In addition, we found that the medication room was dusty and extremely cluttered, with boxes stacked in the center of the room. The space was disorganised, as ward stock was mixed with patient To Take Home (TTO) medications and patients' own

medications, which were stored in baskets in one corner. Storing all these items together increases the risk of medications being mixed up or dispensing errors to patients.

HIW inspectors immediately raised these issues with senior staff on day one and staff implemented the following actions:

1. The treatment room door was closed with pin code entry enforced.
2. A single key was provided to lock the medication room door.
3. Pharmacy staff attended to remove excess or expired stock from the medication room
4. Cleaning and decluttering of medication room took place

On day two, we found significant improvements had been made to de-clutter and clean the medication and treatment rooms, however some expired medication and unidentifiable liquid remained in place.

Improvement needed	Service action	Responsible officer	Timescale
The health board must: • Remove all expired medications promptly	All expired medications were immediately removed by the Clinical Board Pharmacist following the inspection. A dedicated pharmacist has since been allocated to SSSU and will be contacted when expired medications are identified for return to Pharmacy.	Dean Whittle, Clinical Board Pharmacist	Completed
• Implement a robust process to ensure staff are checking the dates on stock oral medication.	All controlled drugs will be checked every night shift and a register of these checks maintained. Staff have been reminded to escalate any expired medications at the morning safety briefing. The Ward Manager/nominated Deputy will undertake weekly checks to ensure any expired medication has been removed.	Deborah Barry, SSSU Ward Manager	Completed and ongoing

• Safely and appropriately discard the unidentifiable liquids, and ensure staff, in future, do not store such items	A process for removal of expired medications has been agreed with SSSU and Pharmacy. Contact will be made with the newly allocated pharmacist, who will attend and remove expired controlled drugs. Compliance with this will be audited by the Ward Manager/nominated Deputy during the weekly expired medication checks.	Elisabeth Mosca, Senior Nurse for General Surgery	Completed
	Unidentified liquids were removed from the fridge immediately. Staff ahave been reminded that all items stored in the fridge must be labelled. A notice reminding staff of the requirement to label all liquids has been placed on fridge door.	Deborah Barry, SSSU Ward Manager	Completed
	Weekly checks will be undertaken by the Ward Manager/nominted deputy to ensure all fridge items are labelled. Tendable Audits will also include this check.	Deborah Barry, SSSU Ward Manager	Completed and ongoing
• Restore use of the keycard entry to the medication room as soon as possible, or ensure the room is locked if there is an issue with swipe entry in future	Keycard access has been restored. The Ward Manager/nominated deputy will undertake daily checks to ensure the functionality of the lock. Secure locking of the medication rooms is included in the following Tendable audits: Core Standards Audit, Lead and Senior Nurse Audit and Medicines Audit, are undertaken monthly. The results of these audits will be monitored by the Senior Nurse.	Deborah Barry, SSSU Ward Manager	Completed and ongoing
	A UHB-wide medication storage audit will be undertaken in Q4 to support a standardised response to deviation from the required standard with an action plan developed within 10 working days of	Jason Roberts, Executive Nurse Director/	Completed for 31 March 2026

	the audit outcome.	Alexandra Scott, Assistant Director of Quality and Patient Safety.	

Findings:
HIW was not assured that patient records were always stored securely. The inspection team saw paper patient records, including documents due for archive, stored and unattended in various locations throughout the unit, including in an unlocked patient records trolley, at the bedside, on counter tops, and on top of a full confidential waste bin.

Improvement needed	Service action	Responsible officer	Timescale
The health board must ensure that patient records are stored securely at all times.	Lockable notes trolleys have been ordered	Deborah Barry, SSSU Ward Manager	Anticipated delivered 18th February 2026
	In the interim, all notes trolleys have been relocated to within sight of the nurses station. Only records required for the direct delivery of care will remain in the clinical area. All other notes will be stored in a locked room.	Deborah Barry, SSSU Ward Manager	Completed
	All staff have been reminded about the importance of secure storage of patient records. Posters reinforcing this standard has been displayed within SSSU, including on all trolleys.	Deborah Barry, SSSU Ward Manager	Completed
	As an interim measure, a temporary lockable room has been	Deborah Barry,	Completed

	repurposed for notes storage	SSSU Ward Manager and Gareth Simpson, Estates Manager	
	The Lead and Senior Nurses will undertake weekly unannounced spot checks to ensure compliance. Any non-compliance will be raised with the staff on duty and escalated to the Ward Manager. Secure storage of records has been added to the Tendable Core Standards. audit for SSSU which is undertaken monthly by the ward management team.	Elisabeth Mosca, Senior Nurse General Surgery Emma Thomas, Lead Nurse, Elisabeth Mosca Senior Nurse, General Surgery Deborah Barry, SSSU Ward Manager	Completed Completed Completed and ongoing

Findings:
HIW was not assured that patient safety was maintained at all times. We found immediate environmental and health and safety risks including:

- The arm 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 did not see evidence of this during inspection

- There was clutter and dust throughout the ward, including the medication and treatment rooms. Additionally, not all toilets were cleaned to an acceptable standard. Three of five toilets were out of use for maintenance (including faucet leak repairs). Staff told us that the issue had been reported to the estates department on several occasions but remained outstanding.
- Not all clean equipment had been labelled with green 'keep me clean' stickers, to show that the equipment had been cleaned and was ready for use. We checked the commode, which we were told was clean, but unlabeled, however, the ward audit, which includes the need for green stickers, incorrectly showed 100% compliance. Furthermore, the bladder scanner and hoist, had green stickers attached, but they were dated August 2025, and the equipment was visibly unclean. The single use hoist sling appeared unused but was out of its protective packaging.
- There were single glazed windows at the rear of the unit (in a two bedded bed bay and staff kitchen), which were very dirty therefore, impacting patient experience, and they could not be easily cleaned. A top opening window could not be closed by staff, impacting patients due to the cold and sleep deprivation from loud clattering due to swaying movement of blinds. The vertical blinds
on these windows were very dirty, were damaged or missing slats.

Overall, we were not assured that the health, safety and wellbeing of patients, staff and visitors was being maintained. Whilst we were shown paperwork that the estates department had been notified of these issues, these had not been actioned and remained outstanding.

Improvement needed	Service action	Responsible officer	Timescale

The health board must ensure that:			
Housekeeping staff are enabled to clean the ward sufficiently to maintain appropriate infection prevention and control (IPC).	A deep clean was undertaken following the inspection, and joint walkarounds are undertaken with the Ward Manager and Housekeeper. Ongoing IPC environmental audits are undertaken and recorded on Tendable. Tendable IPC Core Standards Audit undertaken on 3rd February 2026 reported 100% compliance for environment	Deborah Barry, SSSU Ward Manager	Completed and ongoing
	The SSSU environment will be subject to ongoing audit, which will be recorded on Tendable. The Ward Sister/ Nurse in Charge will inspect the environment on each shift and will escalate to the housekeeping rapid response team as required.	Deborah Barry, SSSU Ward Manager.	Complet ed and Ongoing
	There is a health board gap analysis underway against the new CNO cleaning standards (issued in August 2025) to identify areas of required development.	Georgina Mather, Interim Operational Service Manager- Estates and Facilities.	31 March 2026

Multi-patient use items, such as BP cuffs, are appropriately decontaminated between use, and that clean equipment is correctly labelled.	Staff have been reminded that multi-patient use items must be decontaminated between use and labelled appropriately. Signs have been placed on each portable blood pressure/monitoring machine, to prompt. This standard will be subject to ongoing audit by the Senior Nurse for General Surgery. On 3rd February 2026 the Tendable IP&C audit demonstrated 100% compliance for equipment, noting that all equipment (such as drip stands, dynamaps and trolleys) were visibly clean and appropriately labelled with a green sticker/tape. Daily audits undertaken by the Practice Development Nurses will continue to monitor ongoing compliance with decontamination of BP cuffs.	Deborah Barry, SSSU Ward Manager Elisabeth Mosca, Senior Nurse General Surgery	Completed and ongoing. Completed and ongoing
Estate requests are actioned and completed in a timely manner and should include:	The window blinds have been cleaned and secured or removed since the inspection.	Georgina Mather, Interim Operational Service Manager-	Completed
• Remove or replace damaged and dirty vertical window blinds • Repair/ Close top opening windows • Repair leaking faucets	New curtains have been ordered to replace existing blinds and facilitate more effective IP&C management. These will be replaced on a six-monthly basis. Estates undertook initial work to allow the window to close. Since then, Contractors have attended and work to fix the window commenced. Immediately following the inspection, the Estates Team attended SSSU and have confirmed that all toilet facilities are in full working	Deborah Barry, SSSU Ward Manager Gareth Simpson, Estates Manager	Estimated by 31st March 2026 6th February 2026 Completed

	order.		

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): Clare Wade

Job role: **Director of Nursing Surgery Clinical Board**

Date: **19th January 2026**

Updated **5th February 2026**

Appendix C - Improvement plan

Service: Short Stay Surgical Unit

Date of inspection: 13 and 14 January 2026

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.	Some health promotion material was available but considered insufficient.	The health board must ensure more health promotion information is available to patients, such as healthy eating materials and information from charities such as Age Cymru Dyfed to support elderly vulnerable people	Health promotion	Health-promotion resources (healthy eating, Age Cymru Dyfed, falls prevention) to be supplied by the patient experience team and installed on a leaflet rack near the front desk. Leaflet volunteers will be responsible for replenishing stock regularly.	Senior Nurse for General Surgery	30 April 2026
2.	Materials and signage are insufficient	The health board must ensure that: • Person-centred tools such as “This is Me” and the “Butterfly Scheme” are used to support	Individualised Care	All patients will receive a formal assessment to identify cognitive impairment in pre-assessment clinic and wherever possible patients with cognitive impairment	Senior Nurse for General Surgery	31 March 2026

		patients with cognitive impairments if required		will not be cared for in SSSU. The use of 'This is Me' tool will be used for every patient who is identified as having mild cognitive impairment, who can be cared for in SSSU.		
		• The signage is improved to ensure a more dementia friendly environment.		A walk-around has been scheduled with the Capital Assets Manager and Senior Nurse for General Surgery to review all existing signage. As part of this process, they will assess opportunities to improve visibility, consistency of design, and accessibility, ensuring signage supports patients with additional communication or cognitive needs.	Senior Nurse General Surgery/Capital Assets Manager	31 May 2026
				Signage available from Alzheimer's Society printed and to be displayed showing exits and toilets.		Complete

3.	The surgery lists are over allocated daily	The health board must review and address the issues of over allocating patients to the unit, which leads to several patients being cancelled each day.	Timely Care	A revised booking criteria aligned to SSSU capacity, with weekly monitoring of list numbers and cancelled cases will be implemented. Monthly reports will be presented at clinical board meetings.	Deputy Director of Operations	30 June 2026
4.	There was no 'Meet the team' board. The patient's waiting room was clean, however was cluttered with storage units next to various size and shape chairs as a seating area. There was a make-shift partition between patient chairs and an area that patient personal belongings were kept unsecured and a photocopier used regularly by	The health board must ensure that: • The implementation of a 'Meet the Team' board is considered to support patient understanding of staff and their roles • The patient waiting room is reviewed to make it appropriate for those awaiting surgery, and should include a solution for the secure storage of patients' personal belongings • The unit has the relevant equipment and tools to support	Communication and Language	Capital expenditure funding for 2026/27 has been requested to enable the installation of a 'Meet the Team' board. If this is bid is unsuccessful the directorate will work with medical illustration to create an alternative resource. Removal of clutter and non-clinical equipment from waiting room has been undertaken and patient's belongings have been moved to a secure lockable room to the rear of the unit. The Unit will be assessed by the Patient Experience	Senior Nurse General Surgery Senior Nurse General Surgery Head of Patient Experience	30 April 2026 Complete 19 March 2026

	staff, making it questionable as being suitable for patient wellbeing. Materials to support patients with hearing, sight and language difficulties were lacking.	patients with hearing, sight and language difficulties.		Team to identify equipment and improvements required to support patients with hearing, sight and language difficulties. A hearing loop will be installed.	Head of Patient Experience	30 April 2026
5.	There was a 'patient status at a glance' (PSAG) board on the unit centrally. The information on the board was visible to everyone; there was no mechanisms in place to cover patients' details.	The Health Board must ensure that all patient-identifiable information is appropriately concealed or removed from public view to maintain compliance with GDPR requirements.	Communication and language	The PSAG board now displays anonymised information only. Weekly confidential-info spot checks will be completed with results recorded.	Senior Nurse General Surgery	Complete with Ongoing spot-checks
6.	The ward had a good number of single rooms to help maintain IPC and safe sharps systems were mostly adhered	The health board must ensure staff dispose of sharps and syringe waste appropriately and in a timely manner.	IPC	Staff will be reminded at daily safety briefings to follow IPC waste-disposal regulations, supported by weekly compliance spot-checks and ongoing Tendable IPC audits.	Senior Nurse General Surgery	Complete with ongoing spot-checks and

	to. However, isolated lapses included used needles and syringes left unsecured awaiting disposal.			SSSU mandatory staff training compliance for Health & Safety and IPC is currently as follows: • Health & Safety: 81.25% • IPC Level 1: 90.62% • IPC Level 2: 75% Outstanding training is being targeted, and compliance is expected to be 85% for all staff in work by the end of April 2026.	 Professional Practice Development Nurse (PPDN) General Surgery	Tendable audits 30 April 2026
7.	Cleanliness issues and concerns about infection control adherence was raised around weekends and the use of use of bank staff on weekends.	The health board must ensure that compliance with infection prevention and control (IPC) procedures is maintained every day, particularly at weekends, where the unit is often managed by bank staff.	IPC	Improved housekeeping scheduling has been implemented to forward plan for weekend opening, providing equitable provision with weekday services. The IPC Nurse for Surgery Clinical Board will arrange a joint walk-around with estates and housekeeping staff to identify areas of concern.	Head of Housekeeping Services IPC Nurse for Surgery Clinical Board	Complete 30 April 2026

				Monitoring of ongoing IPC audits on Tendable by Lead Senior and Nurse for General Surgery.	Lead and Senior Nurse for General Surgery	From March 2026 and ongoing
8.	During inspection, oxygen cylinders were found freestanding rather than secured.	The Health Board must ensure oxygen cylinders are secured or returned to the theatre storage area immediately after use is ceased.	Medicines Management	The installation of cylinder wall brackets has been arranged.	Senior Nurse General Surgery	20 April 2026
9.	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	SSSU will ensure that 100% of patients who remain in the department for 24 hours or longer will receive a pressure-ulcer risk assessment. Compliance will be measured and evidenced through routine Tendable audits, with monthly monitoring to confirm that performance is maintained.	Senior Nurse General Surgery	30 April 2026
10.	Audits related to pressure areas and falls were not completed.	The health board must ensure compliance with audit requirements in a timely manner.	Falls prevention	To strengthen pressure damage and falls audit compliance within SSSU, we will benchmark our current pressure-damage and falls-risk assessment practices against	Senior Nurse for General Surgery	30 April 2026

				recognised day-surgery criteria. Benchmarking will ensure our assessment processes remain aligned with comparable services, supporting the safety of our ambulant patient cohort. The review will be completed and presented to the department. Following this, consideration will be given to the reconfiguration of Core Tendable audits for SSSU. Digital Health Care Wales are currently developing the short stay Welsh Nursing Care Record which will be fully implemented once released.		
11.	Patients were not provided with hand wipes at the bedside prior to eating. Fluid balance charts were consistently	*The health board must ensure that:* • Hand wipes are provided to all patients at the bedside, specifically those who are unable to mobilise to wash	Nutrition and hydration	All patients who are unable to access handwashing facilities independently will be offered hand wipes prior to eating.	Senior Nurse for General Surgery	Complete

	incomplete, with totals not being calculated at the end of shifts, when appropriate to do so. Nutrition and hydration assessments varied, with some assessments incomplete.	their hands ahead of eating • Fluid balance charts are completed appropriately and in a timely manner • Nutritional assessments are completed when appropriate to do so.		‘Fluid Balance’ will be presented as the topic of the month with the education team, ensuring completion of a notes audit and delivery of targeted training within the unit to improve accuracy of fluid balance and nutritional assessments. Ongoing audits of fluid balance and nutritional risk assessment compliance will be undertaken on a six-monthly basis.	PPDN General Surgery Senior Nurse General Surgery	30 April 2026 Ongoing
12.	A review of patient records showed that documentation practices vary depending on the patient’s length of stay, and the availability of standard assessment booklets. Short stay and day case patients generally	The health board must ensure that all care planning documents (templates) relevant to SSSU are readily available, so that patients’ care needs can be fully assessed, appropriately planned, and consistently monitored.	Patient records	The ward receptionist will compile a list of paperwork that is routinely ordered over the next three months. This will form a baseline for document ordering.	Senior Nurse for General Surgery	30 May 2026

	had fewer recorded assessments, and staff explained that usual documentation templates were temporarily unavailable, resulting in reliance on theatre care plans and photocopied sheets.					
13.	Confidential waste procedures were in place, though a full bin had led to patient information being left on top of it rather than disposed of securely.	The health board must ensure that confidential waste bins are emptied regularly and that no patient identifiable information is left unsecured or placed on top of waste containers, in accordance with GDPR requirements.	Patient records	An external company empties the confidential waste bins on a regular basis. Regular checks will be undertaken to ensure that these bins are not overfilled in the period between scheduled emptying. Compliance will be monitored through weekly environmental checks.	Senior Nurse General Surgery	Complete and ongoing
14.	Concerns identified from the feedback	The Health Board must ensure that:	Governance and leadership	The Organisational Development, Wellbeing and Culture team are	Assistant Director of Organisational	30 June 2026

	collected through the staff survey.	• A review of local leadership is undertaken, to address concerns raised by staff about unprofessional communication, leadership visibility, and impact of management interactions that left staff distressed or reluctant to escalate concerns • A structured programme is introduced to improve leadership behaviours, including expectations around communication, feedback, dignity and respect, and safe 'speaking up' environments		undertaking a structured leadership-behaviour improvement programme. This will include expectations on communication, dignity and respect, by delivering targeted leadership development sessions, feedback mechanisms with progress monitored through monthly qualitative staff-experience reviews and completion of the People & Culture diagnostic phase. The ward meetings will be implemented and will be held on a quarterly basis. Senior Nurse representation will be present to discuss operational issues that impact the department and the wider site and to allow staff to have input into decision making and planning. The Ward Manager and Deputies have been	Development, Wellbeing and Culture Management Team, SSSU	31 May 2026

		• Mechanisms are established to ensure staff are involved in operational decision-making, including bed allocation, patient flow assumptions and rota decisions, rather than these being made solely at external 'Bronze' meetings		offered the opportunity to shadow the Clinical Operations Managers to gain an improved understanding of wider pressure in relation to bed management for emergency and planned care patients.		
		• Leadership visibility and oversight of the surgical clinical board is strengthened, ensuring that senior nurses/managers routinely visit the ward, engage with staff directly and provide oversight during high-pressure periods.		The Lead and Senior Nurses continue to visit SSSU multiple times per day, to support in bed management and patient flow and provide support with escalations where needed, but especially in periods of high pressure.	Lead and Senior Nurse for General Surgery	Complete
				Individual feedback will be gained from all staff members as part of the work undertaken by the Organisational Development, Wellbeing and Culture team, this	Assistant Director of Organisational Development,	30 June 2026

				feedback will be used to support development of staff engagement methods.	Wellbeing and Culture	
15.	Concerns identified from the feedback collected through the staff survey.	The Health Board must ensure that: • A review of weekend and Saturday staffing arrangements is undertaken, including clinical cover, housekeeping services, pharmacy availability and operational support, in response to staff descriptions of unsafe weekend shifts and patient reports of reduced cleanliness, delays and unavailability of required teams	Skilled and enabled workforce	A full review of weekend and Saturday staffing arrangements in SSSU has been completed. Senior Nurse oversight (07:00-20:30) continues during unscheduled openings. Improved housekeeping scheduling has been implemented to forward plan for unscheduled weekend opening, providing equitable provision with weekday services. Pharmacy support has improved through allocation of a dedicated pharmacist and stock ordering has now been adjusted to ensure it adequately meets the needs of this patient group.	Senior Nurse General Surgery Head of Housekeeping Lead Pharmacist Surgery Clinical Board	Complete Complete Complete

		• Rota allocation, redeployment and theatre list assignments are applied consistently and fairly, supported by transparent criteria and regular auditing to address perceptions of favouritism, inequitable movement and inconsistent workload distribution		A full review of rota allocation, redeployment and theatre-list assignment practices will be conducted, following the Health Roster analysis that was undertaken immediately following the inspection. A six-month retrospective review of allocation patterns, weekend working, staff movement and delegation equity will be undertaken. Findings will be triangulated with staff feedback and workforce data, confirming no evidence of unfair practice. Oversight processes and transparent allocation criteria have been strengthened, and staff have been assured that rota changes remain voluntary. Further opportunities for staff to raise concerns confidentially will be provided through the	Assistant Director of Organisational Development, Wellbeing and Culture	30 June 2026

				People & Culture discovery work.		
		• A plan is developed to restore staffing establishment, particularly healthcare support worker vacancies, to reduce reliance on bank staff and mitigate the impact of short notice redeployments on patient safety and staff wellbeing		A staffing review of SSSU has been carried out and the 1.8 HCSW vacancies will be recruited to via the HCSW recruitment event on the 9 April 2026.	Director of Nursing Surgery Clinical Board	31 July 2026
				SSSU ward is a low user of temporary staff during the established core hours. The 2 Registered Nurse vacancies have since been appointed to. Vacancies will continue to be monitored and appointed to in a timely manner.	Director of Nursing Surgery Clinical Board	Complete and ongoing
		• Workload pressures are regularly reviewed, with actions taken to ensure patient acuity and dependency are adequately matched to safe staffing levels, and escalations are		The ongoing use of SafeCare supports oversight of acuity on a twice daily basis where the Senior/ Lead Nurses meet in person with the Ward Manager or Nurse in Charge. This ensures appropriate escalation and mitigating actions are taken and documented,	Senior Nurse General Surgery	Complete and ongoing

		supported rather than normalised.		and report themes to the Surgical Board monthly.		
16.	Concerns identified from the feedback collected through the staff survey.	The Health Board must ensure that: • All allegations of racism, discriminatory behaviour and inappropriate language are investigated promptly and robustly, in line with dignity at work and equality policies, with appropriate support provided to staff who may have been affected • A ward level culture improvement programme is developed, addressing bullying, harassment, fear of repercussions, and concerns raised	Culture	Monthly oversight will be provided by Organisational Development, Wellbeing and Culture from April 2026 onward will ensure that any allegations of racism, discrimination, bullying or inappropriate language reported within SSSU will be investigated promptly in accordance with Dignity at Work and Equality policies, with referral pathways reiterated to staff, A ward-level culture-improvement programme has been commenced to address bullying, fear of repercussions and concerns about management behaviour, incorporating facilitated team sessions,	Assistant Director of Organisational Development, Wellbeing and Culture Assistant Director of Organisational Development, Wellbeing and Culture/Surgery Clinical Board Director of Nursing	April 2026 onward 1 May 2026

		about distressing interactions with management		psychological-safety interventions, and follow-up reviews every eight weeks, commencing 1 May 2026		
		• Mechanisms for safe, supported speaking up are strengthened, including clear signposting to 'Freedom to Speak Up', Llais, union representation and internal HR support		Speaking-up mechanisms will be strengthened by providing clear signposting to 'Speaking Up Safely', Llais, union representatives and HR support, and delivering quarterly staff briefings and anonymous reporting routes, with monitoring of uptake and themes starting June 2026.	Director of Nursing Surgery Clinical Board	1 June 2026
		• Visitor policy is reviewed to ensure compassionate, consistent application, following patient feedback that visitors were turned away even after travelling long distances.		Staff will be reminded to take an individualised and patient centred approach to ensuring that they can have the support they need while they remain in the department.	Senior Nurse General Surgery	Complete

17.	Identification of patient records and other confidential information in various areas unsecured on the unit. Concerns identified from the feedback collected through the staff and patient surveys.	The Health Board must ensure that: • Patient records are always stored securely, including preventing records from being left on trolleys, counters or atop full waste bins, and ensuring the PSAG board does not expose identifiable information • Confidential waste is removed frequently enough to prevent overflow, with clear accountability for timely disposal and escalation when bins are full • Digital systems are used consistently and confidently, with training provided to staff who reported	Information governance and digital technology	Lockable notes trolleys are now in use on SSSU, and a dedicated lockable notes storage room is in use to store medical records for discharged patients and future admissions. Walk-arounds will be undertaken to ensure patient records are stored securely, confidential waste is removed before capacity is reached and no identifiable information is left in public areas, with results reviewed monthly from April 2026. Deliver digital-skills refresher training for SSSU staff on electronic systems (e.g., ESR, Aqua, SafeCare), with attendance monitored and	Senior Nurse General Surgery Senior Nurse General Surgery PPDN General Surgery	Complete 1 April 2026 31 July 2026

		difficulty navigating electronic tools or requiring IT intervention for routine tasks • Ward spaces are decluttered and organised, ensuring records, files and personal belongings are not placed in areas where confidentiality or security may be compromised, reflecting findings from both staff and patient feedback.		90% completion achieved, and post-training competency checks by 31 July 2026. Complete ward-wide decluttering and relocation of records, files and personal-belonging areas to prevent confidentiality risks.	Senior Nurse General Surgery	Complete
18.	Concerns identified during the inspection in addition to staff and patient surveys.	The Health Board must ensure that: • Protected time is allocated for staff training and development, addressing repeated cancellations of study days and insufficient access	Quality Improvement Activities	Introduce protected training time within the SSSU rota, ensuring essential skills sessions and study days proceed except where patient safety requires rescheduling. Monitoring of Study leave allowance is already available via the Nurse rostering dashboard. Monthly monitoring of	PPDN General Surgery	31 May 2026

		to essential skills training		study-leave access will continue to be monitored to identify emerging trends, supported by the PPDN.		
		• Clear, standardised induction and competency frameworks are provided for all new staff, ensuring role expectations and required training are understood from the outset, addressing concerns about inconsistent onboarding		Newly qualified registered nurses will continue to attend the UHB preceptorship programme and allocated study time will be given to support this. All new staff will continue to be given a minimum of a 4-week supernumerary period to ensure they are acquainted with the running of the unit and any core training sessions will be supported with allocated study time. Completion will be monitored through VBA and Health Roster records.	PPDN General Surgery	Complete
		• A local concerns log is established, enabling the ward to track, analyse and learn from		All Concern responses and DRTs (draft responses templates) for Concerns will be shared with the team for oversight. The	Senior Nurse General Surgery	30 April 2026

		patterns in complaints, concerns and compliments, rather than relying solely on centralised systems		ward management team will be supported to access Datix records to allow them to track themes and trends.		
		• Regular structured opportunities for shared learning are embedded, including follow up on incidents, near misses, patient feedback and weekend specific themes, ensuring lessons are consistently disseminated		Embed structured monthly shared-learning sessions in SSSU, covering incidents, near misses, patient feedback (including weekend-specific themes), and escalations. Themes to be covered by newly introduced 'Topic of the month' for Surgery. All learning actions will be documented and continue to be reviewed quarterly through the Clinical Board governance process and already established Professional Practice forums which take place monthly.	Senior Nurse General Surgery	1 May 2026
		• Training provision reflects the increasing acuity of		Deliver targeted competency-refresh sessions for staff in key	PPDN General Surgery	31 August 2026

		patients, including updating staff competency in skills where they reported reduced confidence due to lack of recent exposure.		clinical skills to reflect the increasing acuity of SSSU patients, while ensuring staff returning from maternity leave or long-term sickness receive supernumerary time, KIT days (where appropriate), and phased return plans. Increase training compliance and accountability by completing overdue Value Based Appraisals (VBAs) and ensuring these are uploaded to ESR in a timely manner (many had been completed but not uploaded), ensuring each staff member has an agreed 12-month development plan, and monitoring essential-skills compliance monthly through ESR.	 Management Team, SSSU	 30 June 2026
19.	Concerns identified during the inspection in addition to staff	The Health Board must ensure that:	Partnership working and development	Work is ongoing with Deputy Director of Operations to prevent beds	Deputy Director of Operations Surgery Clinical Board	Ongoing

	and patient surveys.	• The daily overallocation of patients to the unit is urgently addressed, ensuring capacity planning reflects the actual 33 patient limit and avoids routine cancellations, delays and deterioration described by patients and staff • Weekend medical, pharmacy and domestic services are strengthened, ensuring safe and consistent provision throughout the week. This includes addressing gaps that may lead to worsening conditions, delayed treatment and poor		being used outside of allocated space. A revised daily booking protocol aligned with the 33-patient capacity will be introduced, with real-time monitoring of planned versus actual occupancy, and weekly reporting of cancellations and breaches to the Deputy Chief Operating Officer fully operational by 30 April 2026. Surgery Clinical Board has a seven-day working model for all surgical clinical teams which helps facilitate planned closure at 1pm on Saturday. Any patient that are not fit for discharged will be transferred to C6, the protected elective surgical ward. This practical approach is facilitated by the Senior nurses and the	Deputy Director of Operations Surgery Clinical Board Senior Nurse General Surgery	30 April 2026 Complete and ongoing

	cleanliness at weekends		ward managers for both areas on a Friday evening.		
			Pharmacy support has improved through allocation of a dedicated pharmacist and stock ordering has now been adjusted to ensure it adequately meets the needs of this patient group.	Lead Pharmacist Surgery Clinical Board	Complete
			Improved housekeeping scheduling has been implemented to forward plan for unscheduled weekend opening, providing equitable provision with weekday services.	Head of Housekeeping	Complete
	• SSSU staff are actively involved in cross service decisions affecting workload and flow, reducing the disconnect between ward reality and decisions made		Senior and Lead nurses will feedback to SSSU following 'Bronze' meetings affecting elective admission for the following day. The Bronze meetings will continue to be attended by Senior and Lead nurses, directorate	Senior Nurse General Surgery	Complete

	externally, such as patient allocations through ‘Bronze’ meetings		teams and Senior representatives from the Surgery Clinical Board.		
	• Clear escalation pathways are defined for situations where essential teams are unavailable, especially during weekends, in response to patient reports of deterioration due to lack of timely…		Publish and embed a clear escalation pathway for accessing medical review, P@RT support and essential weekend services, ensuring all staff are briefed and signage added to the nurse station.	Management Team, SSSU	Complete
	• Waiting areas and patient facing spaces are improved, ensuring safe storage for belongings, appropriate seating, removal of office equipment (photocopiers), and provision of basic amenities such as water dispensers.		Removal of clutter and non-clinical equipment from waiting room has been undertaken and patient’s belongings have been moved to a secure lockable room to the rear of the unit. Drinking water and drinks rounds will be made available to anyone who is not ‘nil by mouth’ pre procedure.	Senior Nurse Surgery Clinical Board	30 April 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): Clare Wade

Job role: Director of Nursing Surgery Clinical Board

Date: 23 March 2026