Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Ward B2, 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 goal

To be a trusted voice which influences and drives improvement in healthcare

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 priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at the University Hospital of Wales, Cardiff and Vale University Health Board on 17 and 18 February 2026. The following hospital wards were reviewed during this inspection:

- Ward B2 - 23 beds providing gynaecological and oncology services.

Our team, for the inspection comprised of two HIW healthcare inspectors, two clinical peer reviewers and one patient experience reviewers.

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 12 questionnaires were completed by patients or their carers, but NIL was completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

The ward relocated to B2 in August 2025. Dignity and respect were generally observed to a high standard, with staff demonstrating compassion, privacy and sensitivity, including sensitive support for emotionally distressing conditions. Patient feedback was mixed, with some reporting dismissive interactions, delays in receiving analgesia outside of general ward rounds and concerns about feeling unsafe.

Patient-facing information to support health promotion, wellbeing, and signposting was limited. Patient information boards such as “Know How We Are Doing” were outdated or incomplete. Patient-facing sepsis awareness and smoking cessation information were not available. Appropriate escalation of deteriorating patients and prioritisation of urgent needs seemed appropriate, though some patients reported delayed investigations. Communication was generally courteous and supportive, including use of translation tools, but inconsistencies were reported. There was limited visible information for patients with sensory impairments.

Equality and diversity awareness was evident, with reasonable adjustments made and no reports of discrimination. Bathroom areas required some maintenance, and estates need to ensure all toilet and shower facilities are operational.

This is what we recommend the service can improve:

- Improve availability and maintenance of patient-facing information and health promotion materials
- Ensure timely administration of ‘as needed’ (PRN) analgesia and access to pain relief
- Improve signage and resources to support patients with sensory or cognitive impairments.

This is what the service did well:

- Effective use of translation tools to support non-English-speaking patients
- Appropriate escalation and prioritisation of urgent and deteriorating patients
- Consideration of cultural, religious, and equality needs, with reasonable adjustments in place.

Delivery of Safe and Effective Care

Overall summary:

The ward environment was clean, accessible and well maintained, with controlled access and appropriate signage. There was some clutter in stock rooms and improvements required in equipment storage.

IPC standards were reported as strong, with high training compliance and no current infections. There was regular audit activity, however visibility of audit outcomes was limited.

Medicines management processes were largely safe, structured and well organised, with appropriate use of electronic Prescribing and Medicines Administration (ePMA), secure storage and effective pharmacy support. Confidence and consistency in blood transfusion procedures needed to be strengthened. Completion of patient records, including do not attempt cardiopulmonary resuscitation (DNACPR) documentation could be strengthened.

Patient feedback was mostly positive, though some patients raised concerns regarding delays in care. Documentation and reassessment practices, particularly for pressure damage, falls and short-stay admissions, were inconsistent. There was generally positive communication with families.

This is what we recommend the service can improve:

- Improve consistency in IPC practices and display of audit results
- Improve reassessment and documentation for pressure damage, falls and nutrition

This is what the service did well:

- Clean, spacious and accessible ward environment with controlled access
- Stable staffing, low sickness levels and positive health care support worker (HCSW) retention
- Clear incident reporting and governance processes with shared learning.

Quality of Management and Leadership

Overall summary:

The service demonstrated structured governance and leadership arrangements, with regular handovers, risk meetings and professional forums where actions and changes were recorded. Leadership presence across the wards was evident and staff reported feeling informed, supported and confident in escalation processes for staffing pressures and incidents. Risk management systems, including Datix reporting, concerns trackers and regular reviews, were in use.

The workforce was described as stable, with low turnover, appropriate staffing levels and an adequate skill mix to meet patient needs. Governance arrangements for incidents, risks and audits were in place, supported by regular meetings and use of systems such as DATIX, Audit Management and Tracking (AMaT) and Tendable. There was clear incident reporting with shared learning. However, the absence of a dedicated ward coordinator created additional pressure for the nurse in charge during busy periods.

Staff supervision and appraisals were in place, with full appraisal compliance and mandatory training compliance was monitored, although overall completion was reduced due to sickness absence. Portable oxygen cylinder training had not been completed and had been escalated.

A positive ward culture was reported, with staff feeling able to raise concerns within a no-blame environment. Duty of Candour processes were understood and applied appropriately, though visibility of ‘Putting Things Right’ information was inconsistent. Information governance systems supported monitoring and reporting, and a range of quality improvement, audit and research activities were ongoing. Partnership working was limited but effective where established.

This is what we recommend the service can improve:

- Improve mandatory training compliance, including portable oxygen training
- Ensure ‘Putting Things Right’ information is clearly displayed on the ward.

This is what the service did well:

- Clear governance structures with regular meetings and documented actions
- Visible leadership and effective escalation processes
- Routine use of audits, feedback and incident learning to drive improvement.

3. What we found

Quality of Patient Experience

Patient Feedback

We received questionnaire feedback from 12 patients. Responses were mixed, 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:

> ***"Excellent care and able to raise concerns when needed"***
>
> ***"I am happy with the ward and feel well cared for. Food is tasty. Buzzers answered right away however, analgesia requests are delayed. This needs to be improved"***
>
> ***"Pleased with care provided at the ward in hospital"***
>
> ***"Very unhappy with the care and don't feel safe. Having self referred to my cardiologist and is now being taken seriously. This ward treats me and dismiss my concerns.***
>
> ***"The ward itself is fine and satisfied with staff. Nurses are kind and attentive. Limited understanding of treatment awaiting MRI. No one seems to know what is going happening."***
>
> ***"Not been offered translation but ward itself is clean and food is good.***
>
> ***"Nurses bedside manner could be better."***

Person-centred

Health promotion

The ward relocated to its current location in August 2025. There was very limited patient-focused information available in either hard copy or digital format to support health or wellbeing, provide signposting, or promote access to relevant support groups. Despite this, oncology patients spoke positively about the responsiveness and support provided by oncology staff during admission and following discharge. Hand hygiene information was displayed in some patient toilet areas.

There were no clearly identifiable or comprehensive patient information boards on the ward. The ‘Know How We Are Doing’ boards were available but had not been updated, with the ‘Who’s looking after you today’ section last completed on 7 January 2026. There was also no information available regarding staff uniform identification, access to hearing loops, or ward orientation. Given that the ward relocated in August 2025, there had been sufficient time to establish and maintain up-to-date, visible and meaningful patient information displays.

The ward would benefit from the development of a centralised and dedicated patient information area to improve accessibility, visibility and overall patient experience.

The health board must ensure that:

- **Health promotion information is displayed on the ward to include, smoking cessation, keeping healthy and other key health promotion information**

- **The information boards on the ward are kept up to date.**

Dignified and respectful care
Dignity and respect were observed to be of a high standard, with only a small number of improvements required, particularly around environmental issues. Staff demonstrated sensitivity when supporting patients undergoing early pregnancy loss, gynaecology procedures or other emotionally distressing conditions, with privacy, compassion and time being prioritised.

Staff were observed interacting with patients in a kind, respectful and compassionate manner. Patients from a range of cultural and linguistic backgrounds were present on the ward and staff were seen making appropriate efforts to support those whose first language was not English. This included the use of translation applications to help ensure patients understood their care.

However, patient feedback was mixed. Whilst many patients stated they felt involved in decisions about their care and were complimentary about the support they received, a small number of patients reported negative experiences. These comments described staff as dismissive or unhelpful, and some felt their symptoms were not always taken seriously. One patient reported feeling unsafe and that aspects of their care were not dignified or respectful. Another reported delays in receiving analgesia and perceived that ‘as needed’ (PRN) medication requests were not responded to promptly. This was echoed by another patient in the same bay.

The health board must ensure that:

- **Staff are helpful and responsive to patient needs**

- **PRN medication, where prescribed, is given when required in a timely manner.**

The ward environment was calm, and staff maintained the privacy and dignity of patients when discussing sensitive issues or providing personal care. Curtains around bed spaces were used appropriately and private areas were available when more discreet conversations were required. Staff were discreet in their communication, using low voices and ensuring curtains were fully drawn during examinations or personal care. Patients confirmed they felt their privacy was respected.

Toilet and shower facilities in one bay were out of order during the inspection, and it was not clear when the faults were first identified or reported for repair. Despite this, the overall ratio of toilets and showers to patients was good.

The health board must ensure that all toilets and showers are in working order.

Continence needs were assessed appropriately and nursing records demonstrated that individual needs were identified and met. Some assessments were not completed for younger day-case patients where this was deemed unnecessary. Where continence issues were identified, appropriate referrals were made and equipment provided.

Curtains were drawn around patients, and they remained drawn throughout the day, rather than being used exclusively during patient care. This did not provide line of sight care in the bay environment, and opening of curtains should be encouraged.

The health board must encourage patients to open curtains whenever possible, which assists staff to conduct line of sight care.

Individualised care
Widely used initiatives, such as a 'This is Me' document, or the 'Butterfly Scheme', to support people with cognitive impairment, were not commonly used on the ward. This was due to the rapid care delivered on the ward and the environment was not generally intended for patients requiring enhanced cognitive support. However, the health board must be mindful that despite not being a designated

area for supporting cognitive needs, some patients may attend for treatment, who have significant cognitive impairments.

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

Patients were generally provided with appropriate and timely support. Staff were observed giving patients sufficient time to ask questions and receive explanations about their care. Medical staff were seen communicating clearly with patients and their relatives, providing updates and addressing concerns sensitively.

Staff reported that when staffing levels were appropriate, they were able to deliver high-quality physical and emotional care. However, they acknowledged that some patients were experiencing distressing circumstances and would have benefited from additional time and psychological support.

Patients with urgent or time-critical needs had their care prioritised appropriately. Observations within the emergency gynaecology unit demonstrated that patients were assessed and treated in order of clinical urgency. A patient whose condition deteriorated overnight was managed promptly, with the patient transferred for emergency care without delay. During the inspection, we observed patients requiring continuous monitoring due to their deteriorating clinical status, which staff escalated appropriately and their need for surgery was prioritised.

Medicines were generally administered in a timely manner, and medication rounds were observed to be well managed. However, feedback from patients was mixed. Whilst several patients stated analgesia had been provided without delay, others reported longer waiting times, which appeared to vary depending on ward activity and staffing levels. One patient described a prolonged wait for intravenous (IV) medication overnight, which impacted their ability to sleep.

We observed staff displaying compassion when responding to patients experiencing pain or emotional distress. Staff addressed discomfort swiftly and offered reassurance. A patient who voiced concerns about their care was appropriately supported, with the nurse committing to seek medical review and return with an update. Another patient reported an initial delay in receiving analgesia during their emergency admission, though noted that pain relief was provided regularly and without issue following surgery.

Some patient survey comments received:

> ***"Staff have not spoke to me kindly. I don't have analgesia when needed. Busy ward but need to look after patients on ward."***
>
> ***"I had to wait sometime last night for pain relief and then given medicine that I'm not able to take so had to be revisited and removed. Nurses bedside manner could be better"***
>
> ***"I experienced pains post hysterectomy and wanted meds which were delayed"***

The health board must ensure patients receive timely pain relief.

Some patients and families expressed frustration regarding delays in investigations, particularly where these were required to progress to multidisciplinary team (MDT) discussions to inform treatment plans. Concerns were also raised about timeliness of referrals to secondary care and delays within the GP pathway, although the latter falls outside the scope of this inspection. A patient reported self-referring to a medical consultant to expedite treatment for a non-gynaecology condition due to perceived delays.

Equitable

Communication and language

Staff were observed communicating with patients in a timely, courteous and respectful manner. We noted examples of staff taking appropriate steps to address language barriers. This included the use of translation applications and the

language-line iPad to support patients whose first language was not English. Staff demonstrated patience and compassion when supporting individuals with communication needs, and the multicultural composition of the ward team further supported effective communication.

Mixed feedback was received from patients regarding communication. Several patients reported that staff were attentive, informative and took time to explain care and treatment plans clearly. For example, a nurse was observed spending considerable time ensuring that a non-English-speaking patient and her family understood information relating to treatment, discharge planning and falls risk. Medical staff were also observed introducing themselves and explaining treatment options in an accessible manner. However, some patients felt that staff did not always have sufficient time to explain things fully, while others described communication as inconsistent.

A patient survey comment included:

> ***"I'm Spanish and the nurse used google translate to speak to me in my first language. I am happy with the ward and feel well cared for."***

While staff took steps to access translation services when required, there was no multilingual welcome board or visible information outlining the availability of translation or communication support services. Similarly, there was no evidence of patient-facing tools to support individuals with sensory impairment, such as hearing loop systems, pictorial signage, braille materials or large-format clocks.

The health board must ensure that equipment and information such as hearing loop systems, pictorial signage, braille materials and large-format clocks are made available to assist patients with sensory impairments on the ward.

Staff were aware of the diverse needs of the patient population and demonstrated sensitivity when communicating with individuals from varied cultural and religious backgrounds. Several examples were observed where staff responded appropriately to patients requiring additional support, including those with limited English proficiency and those expressing religious preferences. Staff were also observed escalating concerns appropriately and providing reassurance to families when discussing care and management plans.

Rights and Equality
Staff demonstrated an awareness of equality and diversity as well as individual patient needs. Mandatory training included equality, diversity and anti-discrimination. Staff spoke positively about the non-judgemental culture within the ward. Multi-faith calendars had recently been introduced to support staff

understanding of different religious observances and governance days routinely included equality and diversity topics as part of ongoing learning.

Some reasonable adjustments were in place to ensure equitable access to care. These included accommodating patients' religious preferences regarding the gender of staff providing care, using translation services via iPads and approved online tools and making use of a multi-faith room at the hospital for prayer and reflection. Adjustments were also made for staff, including flexible working arrangements to allow access to the prayer room when required.

Appropriate facilities such as disabled toilets and mobility equipment were available. Patients reported no concerns regarding discriminatory behaviour, and the diversity of the patient population was reflected within the staff team.

The ward reported having cared for several transgender patients over time and demonstrated appropriate planning to support their needs. Staff explained that they often received advance notice of transgender patients attending. Staff emphasised the importance of ensuring patients felt supported and respected throughout their visit.

Families and carers, particularly those supporting patients whose first language was not English, reported feeling involved in care and decision-making, although some expressed concerns about delays in communication and feedback. No patients or relatives reported experiencing discrimination. The quiet room provided a suitable space for private or sensitive discussions, and the ward was taking steps to make this area more welcoming.

It was evident that patients' cultural, linguistic and religious needs were considered during admission and throughout their stay, with nursing documentation reflecting this. Visiting arrangements were in place and observed to be followed, with relatives supported to stay with patients in the emergency gynaecology unit where appropriate. When patients were critically unwell, staff moved them to a side room and offered relatives open access.

Delivery of Safe and Effective Care

Safe

Risk management
The environment was accessible via lifts and door widths appeared suitable for wheelchair users. The ward was recently opened and was clean, bright and well maintained. Reception staff checked visitor identification and internal ward areas had controlled access.

Call bells were visible and accessible and appropriate signage was used when cleaning was in progress. Spillages were observed to be managed promptly. The ward was spacious and free from clutter, however, the stock rooms contained some clutter and lacked clearly defined areas for storing medical devices. The cleaning cupboards containing various chemicals was secured with coded entry.

Incidents and risks were reported through DATIX, which was described as the primary mechanism for documenting events. These were reviewed weekly by senior staff, with escalation to fortnightly clinical risk meetings where required. For complex incidents, situation-background-assessment-recommendation (SBAR) documentation was completed. Incident learning and updates were communicated through a range of channels, including ward meetings, safety briefings, a safety messenger application, online application style groups, handover and email. Patient safety staff and a specialist clinical midwife contributed to oversight and review. Repeated DATIX submissions linked to delays in emergency gynaecology had led to service changes such as reducing overnight emergency activity and introducing HOT clinics for rapid access for urgent suspected cancers or acute gynaecological assessment.

Incidents were managed locally in the first instance, with follow-up actions agreed through governance processes. Service reviews and guideline changes were taken through professional meetings, which met quarterly. Learning was shared with staff through formal and informal mechanisms, including daily safety briefings, emails, messaging groups and regular meetings. Senior staff undertake audits and any non-compliance escalated to teams for action. A recent significant incident was described with actions and learning implemented.

Risk monitoring included patient-specific assessments, with an example provided of managers completing a detailed risk assessment for a patient presenting with mental health concerns. This was documented in the patient notes and retained within the ward files. Actions taken were appropriate and followed policies and processes.

Infection, prevention and control (IPC) and decontamination
IPC standards were appropriate, with training compliance, hand hygiene audits and cleaning for credit (C4C) scores reported as above 95%. There were no current infections on the ward. Staff described appropriate management of infectious patients, including barrier nursing, isolation procedures and visitor restrictions where necessary.

IPC audits were undertaken monthly using Tendable, a digital quality inspection platform designed to enhance healthcare quality assurance and streamline audits, or through the Audit Management and Tracking (AmaT) system. Environmental assessments showed wards to be accessible, spacious, clean and suitably maintained, though some clutter and inappropriate toiletry items were identified in certain shower areas, along with specific repair needs in one bay. No green clean stickers were noted to be used on equipment, and heavy duty cleaning cloths (red wipes) were not used for commodes.

The health board must ensure that reusable items are appropriately decontaminated between use and that clean equipment is clearly and consistently labelled.

Policies relating to infection control were available on shared systems, including those covering decontamination and water management. Cleaning records and schedules were present. Staff stated they were not aware of the evaluations for care, hand hygiene audits and accreditation. They stated they would only be told if they were not up to standard and would welcome the audit scores and results displayed on the ward.

The health board must ensure that audits results and actions required are displayed prominently throughout the ward.

Patient feedback indicated a clean, calm and pleasant ward environment; however, concerns were raised by one patient who reported feeling unsafe due to aspects of nursing and medical care, although we are unable to seek further clarity due to the anonymity of respondents.

Safeguarding of children and adults
The ward reported no current Deprivation of Liberty Safeguards (DoLS) in place, although one patient had been subject to DoLS within the previous two months. Staff demonstrated a general understanding of DoLS processes, with decisions described as being made by doctors, the multidisciplinary team and best interest assessors. Staff stated that the least restrictive options are always considered prior to a DoLS application.

There were no current Protection of Vulnerable Adults (POVA) referrals, although safeguarding concerns had been made historically and addressed appropriately. Elsewhere, the ward reported one recent safeguarding referral, with staff able to access a safeguarding lead for advice. We witnessed safeguarding meetings being held, and the main doors to the ward were temporarily locked to prevent an individual leaving and potentially harming themselves. Other patients and visitors were able to leave the ward via the reception area which was always staffed. Care was provided to the unwell patient in a sensitive manner, with reduced staff and students during ward rounds not to overwhelm them. All steps followed to safeguard the individual were deemed appropriate. Staff explained that outcomes of referrals are typically managed by other teams within the health board rather than the ward itself.

Staff confirmed they have up-to-date safeguarding training, including DoLS and wider safeguarding competencies. Staff were aware of organisational safeguarding policies and understood escalation processes, typically seeking initial advice from management or the safeguarding lead.

Advocacy arrangements were reported as accessible, including dementia specialist support, language advocacy services and access to both internal and independent advocacy.

Most patients reported feeling safe, although two patients raised significant concerns regarding the safety and effectiveness of their care. These concerns related to delays or omissions in clinical management, including issues with anticoagulation, blood transfusion reactions and perceived dismissiveness of symptoms as anxiety. Another patient reported concerns about previous GP care but felt reassured by the ward team.

The health board must ensure that all instances of clinical concern are reported via DATIX immediately for discussion and solutions by the most appropriate teams.

Blood management

Staff were generally able to describe the key stages of the blood transfusion process. However, most required prompting and were not consistently confident in articulating each step. Whilst some elements were described accurately, others were incomplete or unclear. Staff reported that they would refer to the step-by-step guidance contained within the All-Wales Blood Administration Chart when undertaking a transfusion. They also stated they were up to date with the required blood transfusion training.

Most staff were able to explain when observations should be completed and what clinical signs they should be monitoring during a transfusion. They also demonstrated awareness of the blood transfusion protocol and the actions required in the event of suspected complications, such as a transfusion reaction.

We were told that decisions regarding the need for a blood transfusion were made by medical staff, based on factors such as the patient's haemoglobin (Hb) level, clinical presentation and reason for admission. They described that alternative management options, such as iron infusion or conservative treatment, would also be considered by the medical team.

Most staff were able to correctly identify the documentation required for a blood transfusion, including the appropriate labels and safety checks.

Management of medical devices and equipment
Maintenance of equipment was reported to be the responsibility of all staff members. Staff explained that any faults identified would be reported to the nurse in charge so that appropriate action could be taken, including escalating issues to the estates or maintenance department.

Equipment seen on the ward displayed labels indicating when items were last checked or serviced. Notices were displayed in areas where repairs were required. Staff were advised to ensure that the date and time of reporting were clearly recorded on these notices to support timely follow-up.

The ward had sufficient medical devices and equipment for its patient group, including commodes, wheelchairs, language-line iPads and electrocardiogram (ECG) machines.

Medicines Management
All prescription charts were held on the electronic Prescribing and Medicines Administration (ePMA) system. Entries were appropriately signed and dated by staff, and all medicines were prescribed by a doctor with clear instructions regarding dose and timing. The ePMA system clearly indicated which medicines were active, on hold, administered, or outstanding. Refusals of analgesia were consistently and clearly recorded on the ePMA. The majority of ePMA charts reviewed were complete.

Staff reported that three pharmacists and one pharmacy technician covered the ward across different days, providing what they described as adequate pharmacy support.

Inspectors were shown a cupboard containing medications used for out-of-hours discharges. These medications were checked by two nurses before issue and a copy of the medication list was left for the ward pharmacist to review the following day. An on-call pharmacist was available out of hours.

Oxygen was also prescribed appropriately on the ePMA. Administration and monitoring of oxygen were recorded on the NEWS2 charts, with oxygen saturation levels documented and monitored. Staff raised no concerns regarding oxygen supply. Staff confirmed they had received training and were aware of the risks, including the requirement to limit the number of cylinders stored on the ward. Piped oxygen was also available.

Intravenous (IV) fluids were prescribed correctly on the ePMA, including clear documentation when fluids had been discontinued. Fluid balance charts reflected IV fluids prescribed and administered.

Medicine rounds were observed to be calm and well-organised. Staff were able to complete rounds with minimal interruption. Trolleys were taken around with the ePMA device and staff checked due medications and enquired about analgesia needs where appropriate. Medication trolleys remained under staff supervision.

Staff were able to explain how to access relevant medicines management policies on the health board intranet.

Staff reported that the self-administration assessment form was now included in the admission booklet. No patients on the ward at the time of inspection were self-administering their medicines. Patient bedside medicines lockers were locked.

All medicines, including controlled drugs, were stored securely. The medication room door was locked and all cupboards required keys for access. Medicines trolleys were unlocked but stored inside the locked medicines room. The medicines in the trolley were in date, boxed correctly and organised appropriately.

A random check of the Controlled Drugs Accounting (CDA) register showed that regular checks were completed, with two signatures, dates and times recorded as required.

The medicines fridge was locked, and temperature records were up to date and completed on the appropriate chart. Inspectors noted an unused fridge in the medication room; consideration may be needed regarding whether it should be removed.

A sample of patients on the ward were checked, and all were wearing identification bands. During the observed medicines round, staff were seen confirming patient identity verbally. Names and unit numbers were consistently recorded, including on the ePMA.

There were no young patients on the ward during the inspection. Staff stated that although doctors did not always document weight and height, nursing staff recorded these on admission and BMI was completed.

Staff reported that, prior to discharge, medicines were reviewed with the patient and family or carers. Sharps boxes were provided for those who required them at home.

Preventing pressure and tissue damage

Across the cases reviewed, most patients had an initial pressure ulcer risk assessment completed on admission. However, there was limited evidence of appropriate skin assessments being undertaken consistently and in several cases no evidence of reassessment following theatre or changes in condition. There was little evidence of ongoing monitoring or repositioning for applicable patients. Care plans aligned to risk scores were present for some patients but not all, and there was limited or no evidence of repositioning charts or skin bundle documentation for those requiring it. Monitoring of pressure areas was inconsistently recorded, with some cases showing no ongoing checks. Referrals to tissue viability services were not applicable in most cases.

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

Initial falls risk assessments were completed for most patients who met the threshold of remaining in hospital longer than six hours, although this was not consistent across all cases. There were no specialist falls service available, staff reported that patients who fell were managed by the nursing and medical teams in line with the falls protocol. Suitable footwear was encouraged and enhanced support to further reduce fall incidents. Where patients were not identified as being at risk, care plans and reassessments were not applicable.

Effective

Effective care

Evidence indicated that regular audit activity was undertaken across the ward areas, with monthly audits completed through electronic systems such as AMAT

and Tendable. These include core standards audits, IPC checks, care-specific audits and monitoring of areas such as hand hygiene, falls and pressure damage. We were told that audit outcomes were recorded and actions were generated as required, although in some areas audit results were not consistently displayed for staff or relatives. Risk assessments were undertaken at both ward and patient level, with staff reporting that risks were monitored through ongoing audit activity and individual patient assessments.

Staff had access to sepsis training through the electronic staff record (ESR), national early warning scores (NEWS2) training, and internal educational programmes, with the ward reporting training compliance above 95%. Awareness of guidelines was maintained through intranet resources, departmental communication, meetings, screen savers and digital updates.

Policies and tools such as the Sepsis Six pathway and associated screening tools (including NEWS2 scoring) were in place. Staff described using vital signs monitoring and established scoring systems to identify deterioration, with escalation to medical teams undertaken promptly. Sepsis trolleys and screening tools were available within the ward environment. Some staff required prompting to recall sepsis management processes but were able to outline relevant procedures.

Across acute medical and surgical wards, safe nurse staffing levels were reviewed twice daily, with senior nurses adjusting staffing according to patient acuity and professional judgement. Staff were expected to escalate concerns regarding staffing deficits and Datix incident reports were completed when levels fell below expectation.

Ward staff provided mixed responses regarding their ability to provide safe and effective care, with several noting time pressures and limited capacity to meet all patient needs. Some staff reported variability in familiarity with clinical guidelines and policies, including Nursing and Midwifery Council (NMC) record-keeping guidance.

Patient status boards were in place and generally updated. Patient feedback also varied, with a majority reporting satisfaction with overall care once admitted, though some concerns were raised about delays in analgesia and isolated experiences of staff being perceived as dismissive. Some patients provided positive praise for individual staff members demonstrating empathy, responsiveness and efficient care.

Senior managers confirmed that quality indicators and audits for areas such as falls, infection control and pressure areas were completed and uploaded, although

visibility of results to staff varied. Internal record-keeping audits were completed via online systems. Staffing challenges were reported in some areas, particularly for newly appointed managers balancing ward responsibilities and staff deployment.

Nutrition and hydration
Patients told us they had a good choice of food options, including access to halal meals. Special diets were available, and some patients expressed a preference for family-provided food in addition to what was offered.

A system was in place to identify patients requiring assistance with eating and this was clearly displayed on the Patient Status at a Glance (PSAG) board and communicated during staff handovers. This information was also shared with kitchen staff, who notified ward staff when meals were ready to serve.

We were told that patients rarely required support with eating or drinking. Water jugs were accessible and replenished regularly throughout the day. Most patients were self-caring and able to reach their meals and drinks independently. We observed tea and toast being provided to a patient returning from theatre, which was a positive practice. However, assistance with buttering the toast was only offered after prompting, despite the patient displaying clear discomfort.

Meals were served three times daily by kitchen staff delivering trays to the bedside. When assistance with positioning was needed, nursing staff were called and responded promptly. Assistance was not required or observed during the inspection. Between mealtimes, nursing staff prepared and offered snacks and drinks.

Patients' nutritional needs and ability to eat and drink were assessed, recorded and addressed. Religious and cultural dietary needs were met, with flexibility for meals to be prepared within the ward kitchen if required. Fresh meals were cooked on site and staff obtained meal preferences directly from patients.

Providing consistent access to hand wipes and clear hand hygiene reminders would enhance both patient experience and IPC measures.

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.

Patient records
A review of patient records and ward practice demonstrated variable compliance with assessment, documentation and care planning requirements. Records were

easy to navigate, with clear medical entries and appropriate surgical documentation. However, some nursing documentation was incomplete, delayed, or lacking sufficient detail.

Across multiple cases, mental capacity assessments were present on admission where required, but documentation relating to decisions and DoLS authorisations was inconsistent. Nutritional risk assessments were not always completed within expected timeframes and food/fluid monitoring was absent where it should have been in place. Oral care plans were frequently missing.

In planning and delivering care, not all care provided was recorded and some risk assessments were outdated. Transfer-of-care planning was inconsistent, with clear discharge processes evident only for some patients. Documentation of Do not attempt cardiopulmonary resuscitation (DNACPR) decisions were notably absent where applicable. MDT involvement was recorded where applicable and written handovers were present and generally clear.

Observations on the ward confirmed confidentiality of records was maintained. Notes were stored securely in trolleys that were closed but not locked, reflecting the need for rapid clinical access. Nursing notes were completed electronically, while medical notes remained paper-based.

Overall, record-keeping quality varied. Medical entries were generally clear and contemporaneous, but nursing documentation showed gaps, particularly for emergency or short-stay admissions. In several cases, assessments were incomplete, overdue, or not reassessed after changes in patient condition. Staff acknowledged outstanding assessments and indicated an intention to update records. Despite these issues, care delivered at the bedside was often described positively by patients, with needs largely being met, though delays in analgesia and incomplete evaluations of pain were recurrent concerns.

The health board must ensure patient records are completed in full by all members of the multidisciplinary team.

Efficient

Efficient

Referrals to other services were reported to be infrequent for this ward area. Most patients were discharged following surgery and were generally mobile and independent. Where additional support was required, staff advised that referrals were made to the discharge liaison team.

Staff told us they rarely encountered complex discharge needs and patients typically did not require onward referral to external services. Whilst staff were not familiar with the safety netting discharge information leaflet, they reported that patients received verbal information regarding their procedure, potential complications and relevant follow-up arrangements. The safety netting discharge leaflets for adults and children were required by Welsh Health Circular (WHC) 2025/051. This WHC gave instructions to health boards about adopting and integrating the new safety netting leaflets for adults and children with suspected or confirmed infection into the discharge process.

The health board must ensure that all staff are aware of Welsh Health Circulars (WHC) and ensure that the requirement of the WHC are complied with.

Communication with families was described as positive, with staff maintaining close contact to ensure relatives were informed of care and discharge plans. Where necessary, staff liaised with specialist nurses and members of wider multidisciplinary teams to support coordinated care.

Quality of Management and Leadership

Leadership

Governance and leadership
The service demonstrated structured governance arrangements, with regular handovers and engagement meetings such as band six discussion groups, clinical risk meetings, Datix reporting and the gynaecology professional forum, where discussion, actions or changes were recorded.

Leadership presence across the wards was observed and reported as effective, with staff feeling engaged, informed and supported. Additional oversight was provided through on-call senior managers and completion of situation reporting information for executive review.

Staffing levels were generally stable across the service. Agency use was said to be rare, with bank staff mainly used to cover health care support workers (HCSW) roles. Three registered nurse vacancies had recently been advertised, with an expectation they would be filled, potentially by returning students. Sickness levels were low and regular sickness monitoring occurred through monthly clinical board meetings. HCSWs had recently been upgraded from band 2 to band 3 and retention was reported to be positive.

Information was shared with staff through ward managers, email updates, safety briefings, online groups, safeguarding meetings and occasional ward meetings. Safety notices were circulated to all staff, with ward managers further displaying and sharing these through online discussion.

Staff and leaders reported confidence in their roles and awareness of escalation processes for staffing shortages and serious or major incidents, with clear lines of escalation identified. Risk management processes were evident through discussions with ward leaders, including use of risk reports, concerns trackers and regular review mechanisms.

Some areas, such as leadership development strategy and organisational vision, were not explored during the inspection. They were described by the senior team as part of ongoing planning discussions around emergency service changes and service improvement aims.

Workforce

Skilled and enabled workforce

Ward staff reported that overall staffing numbers were appropriate to meet patient needs. However, the absence of a ward coordinator was highlighted as a consistent challenge, particularly during periods of high acuity. Staff explained that although patient care needs were met, coordination responsibilities placed additional pressure on the nurse leading the shift. Skill mix was generally considered adequate, with a balance of junior and senior staff, including three qualified nurses, three HCSW and designated emergency staff when available. Acuity was monitored daily and additional staffing for one-to-one care could be sourced through nurse bank arrangements when required. Staff felt they generally had enough time to deliver patient care, though pressures on the nurse in charge were noted.

Staff turnover was reported as low. Staff supervision and annual appraisals were in place, with completion monitored via ESR; appraisal compliance was 100% for those staff in work. Staff described regular communication through daily online safety briefings, monthly or bi-monthly meetings and email updates. Ward culture was described as positive, with good feedback from bank staff and very few formal grievances reported over recent years. Staff felt able to raise concerns, supported by an open-door management approach and improved office confidentiality.

Access to training, particularly online modules, was confirmed and mandatory training compliance was monitored through ESR at approximately 75%. The percentage was reduced due to sickness absence rather than availability of training. The training including health and safety, safeguarding, equality and diversity, infection control, manual handling and resuscitation. Whilst Sepsis training was not mandatory, it was covered through NEWS2 training. Student nurses were supported by a designated student lead nurse, who coordinated supervision and shift planning. A new student introduction pack had recently been implemented.

It was however a concern to note that portable oxygen cylinder training had not been completed and had been escalated to the health board, particularly since previous national patient safety alerts have been circulated to NHS University healthcare providers, regarding the safe use of portable BOC Oxygen Cylinders.

Staff had access to optional training via ESR in relation to the Welsh language and other health board resources. Some staff wore Welsh-language ‘Iaith Gwaith’ lanyards or badges, and awareness of the ‘Active Offer’ varied, with limited proactive promotion observed. Staff reported understanding the importance of communicating with patients in their preferred language and used translation services when required. Language requirements formed part of recruitment processes, with English essential and other languages considered beneficial.

Employment information, pre-employment checks and job descriptions were managed by NHS Wales Shared Services Partnership on behalf of NHS Wales organisations. Ward managers confirmed that they supported staff with continuing professional development (CPD) and revalidation as needed. We reviewed the staff rotas and ward staff reported that staffing levels and skill mix were sufficient to run the service safely.

The health board must ensure training compliance is improved, including the completion of the required portable oxygen training in line with previous national patient safety alerts regarding the safe use of portable BOC Oxygen Cylinders.

Culture

People engagement, feedback and learning

A Duty of Candour (DoC) policy was in place and incidents were recorded through Datix. Staff on the ward were able to describe the DoC and their roles in meeting the duty, with the ward manager demonstrating good knowledge. Evidence reviewed showed that DoC had been applied appropriately through written communication, apologies and explanations of what went wrong, with disclosures meeting expected standards.

Support for patients and families was considered, and processes were in place to notify senior managers when the DoC was triggered. Some elements, such as staff clarity on policy roles and responsibilities and visibility of the NHS Wales 'Putting Things Right' (PTR) process were not consistently completed or displayed.

The health board must ensure that 'Putting Things Right' information is displayed prominently on the ward to support patients to raise concerns about their care or treatment.

Complaints were generally received through the complaints team, with no significant recurring themes identified. Verbal concerns were captured in patient notes or recorded formally when significant. Monthly complaint reports outlined themes which were discussed at clinical risk meetings, where actions and learning were shared. Learning from complaints was disseminated through ward meetings, clinical risk meetings, handovers and wider departmental discussions.

Staff reported feeling supported to raise concerns, work within a no-blame culture and contributed to service improvement. Staff feedback indicated pride in working for the service and a perception that wellbeing and patient needs were prioritised. A complaints tracker was in place and concerns teams met weekly with patient

experience processes aimed at resolving concerns promptly, supported by monthly reporting of themes and outstanding issues.

Some information was available regarding Llais, the independent statutory body representing the views of people in Wales regarding health and social care services, raising concerns about care and accessing free magazines. Quick response (QR) codes were displayed for participating in patient surveys and for providing compliments.

Staff confirmed access to occupational health services, with wellbeing initiatives also available. Staff organised informal social activities outside of work.

Information

Information governance and digital technology

The service had systems in place to support the effective collection, sharing and reporting of information, supported by an established internal governance framework. Electronic systems were used to support the accuracy, reliability and completeness of information used for monitoring service quality, including dashboards, key performance indicators, concerns data and routine review processes such as Datix.

Senior nursing staff completed digital Tendable audits, and the service identified areas for improvement through this process. Quality of care was also monitored routinely Tendable audits. The collection of concerns and compliments and the use of QR codes generated weekly 'Civica' reports. Staff also confirmed that reportable data and notifications were submitted to external bodies as needed.

Learning, improvement and research

Quality improvement activities

The service undertook a range of quality improvement activities, including good-practice initiatives and implemented actions triggered by recurrent themes. Staff worked closely with the patient experience team, and feedback from concerns was used to inform changes. Clinical and internal audits were routinely completed, with findings used to identify areas requiring improvement. Service performance measures were reported to the clinical board and director of nursing, with escalation processes in place where needed.

Staff were supported to engage in improvement and research activity, with input from the obstetrics and gynaecology research team. The department participated in research projects, led by the gynaecology oncology research and development

lead, who had dedicated externally funded sessions. Quality improvement, risk assessment and governance were discussed through structures, such as the Gynaecology Professional Forum, monthly risk meetings, consultant meetings and clinical governance sessions. These have recently moved from multiple half-day sessions to four full-day sessions annually.

Concerns, complaints and incident outcomes were routinely used to support learning and continuous improvement. Learning was cascaded through feedback sessions, emails, vignettes and presentations, with actions required to close Datix. Staff reported that sharing learning was generally effective but acknowledged challenges in reaching all relevant staff. Internal and external reviews were used to support service improvements, and relevant staff and partner organisations were involved in investigations when things went wrong.

Additional commentary highlighted ongoing work to optimise 12 consultant patterns, improved continuity of care through the HOT-week model for continuity of care and increased opportunities for shared learning within available resources. The biggest driver for consultant patterns was the ability to provide the best service within the resource envelope. This optimised the resource and working pattern of all the doctors. The Gynaecology Same Day Emergency Care (SDEC) looked to have patients seen and sorted in daylight hours.

Whole-systems approach

Partnership working and development
The service demonstrated limited communication with wider system partners, however, it maintained effective relationships with those it did engage with. This included charitable organisations that recently supported the acquisition of sofa beds. Other interactions included links with Outpatients and Cervical Screening Wales, alongside referrals to primary care, other hospitals for rehabilitation and ongoing care and liaison with mental health services and specialist teams within the hospital. The ward also worked with private hospitals when transferring patients.

Most patients on the ward did not require complex referrals on discharge. Staff reported appropriate use of district nursing services where wound care or follow-up support was needed.

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
No immediate concerns			

Appendix B – Immediate improvement plan

Service: Ward B2, University Hospital of Wales

Date of inspection: 17 and 18 February 2026

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate assurances					

Appendix C - Improvement plan

Service: Ward B2, University Hospital of Wales

Date of inspection: 17 and 18 February 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.	Boards to display information were present, however the relevant health promotion, and other relevant materials were not displayed.	The health board must ensure that: • Health promotion information is displayed on the ward to include, smoking cessation, keeping healthy and other key health promotion information	Person centred – Health promotion	Health promotion materials are being prepared and printed. These materials will be displayed on the boards which are already in place within the ward. This information includes smoking cessation, mental wellbeing, eating well and staff wellbeing.	Ward Manager and deputies	By 24th April 2026

		• The information boards on the ward are kept up to date.		Information displayed on ward notice boards will be reviewed monthly to ensure it remains relevant and up to date	Ward Manager and deputies	Monthly
2.	Review of patient feedback Some reporting delays in receiving analgesia and perceived that 'as needed' (PRN) medication requests were not responded to promptly.	The health board must ensure that: • Staff are helpful and responsive to patient needs • PRN medication, where prescribed, is given when required in a timely manner.	Dignified and respectful care	The importance of timely care has been reinforced to staff as part of the safety briefing. This has also been disseminated via staff communication channels. Patient feedback is received weekly via the CIVICA system. This is reviewed by the Senior Nurse and Ward Manager to identify and act on any new or emerging themes. Where required, actions and	Deputy Ward Manager Senior Nurse Gynaecology & Ward Manager	Complete Weekly

				feedback to staff is led by the Ward Manager		
3.	Toilet and shower facilities in one of the bays were out of order at the time of inspection and signage did not indicate when the faults were first identified.	The health board must ensure that all toilets and showers are in working order.	Dignified and respectful care	Repairs to toilet and shower facilities have been completed (Estates ref: 330816 & 330830). There are currently no outstanding maintenance requests within the ward. Staff have been reminded to escalate to the Senior Nurse any delays in resolving maintenance issues. When a maintenance request is submitted, staff have been reminded to place a notice with date of request and job number on the door.	Estates Ward Manager Deputy Ward Manager	Completed Completed Completed

				This will prevent duplicate or missed requests and provide visibility of outstanding maintenance for escalation.		
4.	Curtains were drawn around patients, and they remained drawn throughout the day, rather than being used exclusively during patient care. This did not provide line of sight care in the bay environment and opening of curtains should be encouraged.	The health board must encourage patients to open curtains whenever possible, which assists staff to conduct line of sight care.	Dignified and respectful care	All staff have been made aware to promote 'line-of-sight care' via the team safety briefing and communication channels. Posters are being designed and will be placed in each bay to explain to patients and their visitors the need for line-of-sight care and act as a prompt for staff. These will be in place by 30th April 2026.	Ward Manager and deputies	Complete By 30th April 2026

5.	We observed use of some aids and signage however this required improvements.	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.	Individualised care	Ward staff are familiar with the Butterfly Scheme, having used it when the Gynaecology Ward was located on C1. A new set of resources will be made available on the ward and the scheme relaunched. The current ward environment will be reviewed against the Dementia Friendly Hospital standards to identify areas for improvement. Where achievable changes are identified, these will be progressed with Estates. These standards include advice for signage, lighting, design and other environmental factors.	Deputy Ward Manager Senior Nurse Gynaecology	30th April 2026 31st May 2026

				Ward environment audits to be conducted by Senior Nurse using Tendable to ensure signage remains in place and use of the Butterfly Scheme is maintained.	Senior Nurse Gynaecology	Monthly
6.	Review of patient survey results	The health board must ensure patients receive timely pain relief.	Timely \care	The importance of timely care has been reinforced to staff as part of the safety briefing. This has also been disseminated via staff communication channels.	Deputy Ward Manager	Complete
				Patient feedback is received weekly via the CIVICA system. This is reviewed by the Senior Nurse and	Senior Nurse Gynaecology & Ward Manager	Weekly

				Ward Manager to identify and act on any new or emerging themes. Where required, actions and feedback to staff is led by the Ward Manager.		
7.	While staff took steps to access translation services when required, there was no multilingual welcome board or visible information outlining the availability of translation or communication support services. Similarly, there was no evidence of patient-facing tools to support individuals with sensory impairment, such as hearing loop systems,	The health board must ensure that equipment and information such as hearing loop systems, pictorial signage, braille materials and large-format clocks are made available to assist patients with sensory impairments on the ward.	Equitable – Communication and language	Information to be placed by entrance to the ward regarding communication needs and how to request equipment and alternative communication methods. The ward has a translation 'Language Line' iPad which is available 24/7 to support communication with patients and families	Ward Manager and deputies	30th April 2026 In place

	pictorial signage, braille materials or large-format clocks.			in a language of their choice. Large format clocks have been ordered for the ward. A clock will be placed in each patient bay. A hearing loop system is available to borrow from UHB patient experience office and Gynaecology OPD as and when required. Staff have been made aware of how to access this equipment via the safety briefing.	Ward Manager	31st May Complete
7.	IPC audits were undertaken monthly using Tendable, a digital quality inspection platform designed to enhance healthcare quality	The health board must ensure that reusable items are appropriately decontaminated between use and that clean equipment is clearly and consistently labelled.	Infection, prevention and control (IPC) and decontamination	Shower and toilet areas have been decluttered to remove any unnecessary toiletry items	Ward Manager and deputies	Complete

	assurance and streamline audits or the Audit Management and Tracking (AmaT).Environmental assessments showed wards to be accessible, spacious, clean and suitably maintained, though some clutter and extraneous toiletry items were identified in certain shower areas, along with specific repair needs in one bay. No green clean stickers were noted to be used, and heavy-duty cleaning cloths (red wipes) were not used for commodes.			Communicated to staff via safety briefing the importance of regular de-cluttering of toilet and shower areas. Patient bays are cleaned regularly, bathrooms are checked throughout the day. A sign-off sheet is being developed to increase visibility of these checks and provide assurance that they have been completed regularly. 'I am clean' Clinell green stickers and indicator tape are available on the ward and are used every	Deputy Ward Manager All ward staff and housekeeping Ward Manager	Complete In place 30th April 2026 In place

				time equipment is cleaned. Compliance with the use of the green stickers/tape will be audited via the Tendable system by Senior Nurse. Commodes are cleaned in accordance with the Health Board IP&C cleaning guidance, which requires the use of Clinell wipes and/or Actichlor. The use of red wipes is not indicated within the IP&C guidance.	Senior Nurse Gynaecology	Monthly It has been confirmed that cleaning is performed in accordance with IP&C guidance
8.	We were told and shown some audits taking place, but results were not shared or displayed for	The health board must ensure that audits results and actions required are displayed prominently throughout the ward.	Infection, prevention and control (IPC) and decontamination	Current audit data is now displayed at the entrance to the ward, including 'bare below the elbows' compliance, hand	Ward Manager and deputies	Complete

	staff or patients to view.			hygiene monitoring and falls. Audit data displayed at the ward entrance will be updated monthly.	Ward Manager and deputies	Monthly
9.	Most patients reported feeling safe, although two patients raised significant concerns regarding the safety and effectiveness of their care. These concerns related to delays or omissions in clinical management, including issues with anticoagulation, blood transfusion reactions and perceived dismissiveness of symptoms as anxiety. Another patient reported concerns about previous GP	The health board must ensure that all instances of clinical concern are reported via DATIX immediately for discussion and solutions by the most appropriate teams.	Safeguarding of children and adults	The Senior Nurse and Ward Manager discuss all new incident reports reports weekly. Any incidents of concern are escalated to the Clinical Risk meeting. Twice monthly gynaecology clinical risk meetings are in place with input from the Health Board Patient Safety Team, with escalation routes into the Clinical Board and Nationally	Senior Nurse Gynaecology & Ward Manager	In place - weekly In place - fortnightly

	care but felt reassured by the ward team.			Reportable Incident process. Feedback is given to ward staff via safety briefing and face to face staff meetings.	Ward Manager	
	Monitoring of pressure areas was inconsistently recorded, with some cases showing no ongoing checks. Referrals to tissue viability services were not applicable in most cases.	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	The importance of documentation of pressure relief care and assessment using the Welsh Nursing Care Record has been highlighted to ward staff at safety briefing and via staff communication channels. Ongoing monitoring of compliance with pressure relief care and documentation is completed monthly by the Senior Nurse,	Ward Manager and deputies Senior Nurse Gynaecology	Completed Monthly

				using the Tendable system.		
10.	Patients' nutritional needs and ability to eat and drink were assessed, recorded and addressed. Religious and cultural dietary needs were met, with flexibility for meals to be prepared within the ward kitchen if required. However, no hand wipes were provided for patients.	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.	Nutrition and hydration	Patients who are unable to mobilise to sinks are offered handwashing facilities at the bedside using soap and water in accordance with IP&C guidance.	All ward staff	In place
	Review of patient records	The health board must ensure patient records are completed in full by all members of the multidisciplinary team.		This has been communicated to staff via the safety briefing and staff communication channels. Welsh Nursing Care Record allows senior staff to review outstanding assessments and documentation.	Ward Manager and Deputies	Completed

11.	WHC were said to not be shared when received.	The health board must ensure that all staff are aware of Welsh Health Circulars (WHC) and ensure that the requirement of the WHC are complied with.	Efficient	Welsh Health Circulars received by the Health Board are managed in accordance with the Safety Notices and Important Documents Management Procedure (UHB 377). The Corporate Governance department review each WHC and share with the relevant areas via the Clinical Board structures. When a Welsh Health Circular that is relevant to Gynaecology is issued, this would be communicated to ward staff via the safety briefing and staff notice board.	Corporate Governance Team	Existing UHB procedure in place, with next scheduled review in July 2027

12.	Training compliance needs improvement	The health board must ensure training compliance is improved, including the completion of the required portable oxygen training in line with previous national patient safety alerts regarding the safe use of portable BOC Oxygen Cylinders.	Skilled and enabled workforce	An e-learning package is now available to staff via ESR, covering the safe use, storage and set up of medical gases and cylinders. All ward nursing staff will complete this training and ongoing compliance will be monitored for new starters and those returning from extended leave.	Medical Gases Group Ward Manager and deputies	E-learning package available All current ward nursing staff to have completed training on or before 12th June 2026
13.	The ward did not display PTR or advocacy information.	The health board must ensure that 'Putting Things Right' information is displayed prominently on the ward to support patients to raise concerns about their care or treatment.	People engagement, feedback and learning	Following the introduction of the new Listening to People concerns management process from 1st April, updated information is now displayed on the ward to support patients in raising	Deputy Ward Manager	Complete

				concerns. This is located near the entrance to the ward. Suggestion boxes have been put in place within the ward as an additional route to capture patient and family feedback, supplementing existing CIVICA patient experience processes.		Complete

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): **Laura Groves**

Job role: **Interim Senior Nurse Gynaecology**

Date: **9/4/26**