Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Ward D2 East, Royal Gwent Hospital, Aneurin Bevan University Health Board

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

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

Our priorities

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

Contents

1. What we did 5

2. Summary of inspection 6

3. What we found 11

- Quality of Patient Experience 11
- Delivery of Safe and Effective Care 17
- Quality of Management and Leadership 26

4. Next steps 32

Appendix A – Summary of concerns resolved during the inspection 33

Appendix B – Immediate improvement plan 35

Appendix C – Improvement plan 41

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 Royal Gwent Hospital, Aneurin Bevan University Health Board on 25 and 26 February 2026. The following hospital ward was reviewed during this inspection:

- Ward D2 East - 21 beds providing urological 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 13 questionnaires were completed by patients or their carers, but none 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:
Responses to the patient survey were generally positive with all but one patient rating the ward as ‘very good’. The ward demonstrated a strong commitment to health promotion, with a wide range of accessible information displayed to support patient wellbeing. Patients were provided with leaflets at discharge, including guidance on preparing for surgery, falls prevention and infection prevention. Smoking cessation support was also available.

Care was consistently delivered with dignity and respect. Staff interacted with patients kindly, professionally and with discretion. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) discussions were handled sensitively and appropriately recorded. The ward environment supported privacy, offering single-gender facilities, discreet personal care and appropriate equipment such as hoists and pressure-relieving mattresses. Patients reported feeling respected, listened to and well cared for and a dignity and respect charter reinforced organisational values.

Patients were encouraged to maintain independence, supported by prompts such as the “Get up, get dressed and get moving” posters. Equipment and assistance were provided to promote mobility, communication and self-care. Minor issues with signage relating to patient needs were promptly rectified during the inspection. Relatives were encouraged to remain involved in care, including outside standard visiting hours.

Care was timely, with staff responding promptly to call bells and providing emotional and practical support. End-of-life care was well coordinated, with multidisciplinary involvement and clear planning. Staff made appropriate clinical decisions when patient conditions changed.

In terms of equity, communication support was generally good, although the ward lacked a functioning hearing loop and prominent large clocks. Staff ensured language needs were considered. Equality, diversity and inclusion were well embedded, with staff trained, aware of spiritual and cultural needs and supportive of individual preferences.

This is what we recommend the service can improve:

- Reinstate a functioning hearing loop system and install large clocks to better support patients with hearing or visual impairments
- Maintain consistent bedside signage, such as mobility status and fall-risk indicators, ensuring they remain accurate and continuously in place.

This is what the service did well:

- High-quality, compassionate and dignified care, consistently recognised by patients and supported by clear policies and staff behaviours
- Strong health promotion and patient information provision, including accessible leaflets and visible educational materials across the ward
- Effective individualised and timely care, supported by prompt staff responses and strong multidisciplinary collaboration.

Delivery of Safe and Effective Care

Overall summary:
The ward demonstrated a largely safe and well-maintained environment, with clean, well-maintained surroundings and organised storage areas that supported effective infection prevention and control (IPC). Staff had good visibility across patient bays and facilities were accessible for individuals with mobility needs. Equipment such as hoists and bathroom areas were well maintained, although issues were identified with unsecured oxygen cylinders and an unlocked cleaners' cupboard containing hazardous materials, requiring action to ensure safe storage.

Incident reporting processes were well established, with high audit compliance through the Audit Management and Tracking (AMaT) system. However, several clinical risks were noted, including faults with wall suction and oxygen flow meters and the lack of pre-fitted oxygen tubing at bed spaces.

IPC practices were generally robust, with high hand hygiene compliance, regular auditing and appropriate personal protective equipment (PPE) use. Patients consistently reported high cleanliness standards. However, concerns were identified regarding the removal of clinical waste bins from patient bays, inconsistent labelling of cleaned equipment and the absence of a routine cleaning schedule for cloth privacy curtains.

Safeguarding processes were well understood, supported by strong training compliance and access to specialist advice and advocacy. Blood management processes were safe and well controlled, with staff demonstrating competence in transfusion practice.

Equipment management showed gaps, particularly with overdue calibration of key medical devices and limited accessibility of air mattresses. Medicines management was strong, with secure storage, consistent documentation and good pharmacy support, though medication trolleys required improved security.

Risk assessments, nutrition support and falls prevention measures were well embedded. However, gaps in patient record completeness, inconsistent care planning and missed NEWS2 escalation actions highlighted areas requiring immediate improvement.

Patient flow was supported by efficient admission and discharge processes, multi-disciplinary team (MDT) involvement and the use of the HOUDINI catheter protocol.

Immediate assurances:

- Correct observations and escalation actions had not been carried out in line with required guidance when NEWS2 scores for three patient records where the score was five or six. Additionally, a sepsis screen did not occur.

This is what we recommend the service can improve:

- Ensure safe and secure storage of hazardous items and equipment, including oxygen cylinders, cleaning materials and medication trolleys
- Strengthen IPC practices by reinstating clinical waste bins, labelling cleaned equipment and implementing routine curtain-cleaning schedules
- Improve clinical documentation and escalation processes, ensuring complete patient records, consistent care plans and adherence to guidance.

This is what the service did well:

- High cleanliness standards, strong IPC compliance and consistently positive patient feedback on ward hygiene
- Effective incident reporting, high audit performance and good use of AMaT for monitoring quality and safety
- Safe medication and blood management processes, supported by competent staff, secure storage and regular checks.

Quality of Management and Leadership

Overall summary:
Governance and leadership on the ward were supported by structured systems, regular communication and visible, approachable managers who demonstrated

commitment to the ward's values. Routine audits were undertaken, though attendance at ward meetings was low. While formal mechanisms existed for disseminating safety notices from MHRA and Welsh Government, key requirements, such as portable oxygen cylinder training and safety-netting discharge leaflets, had not been implemented. Several key policies submitted for inspection were overdue for review.

Staff demonstrated clear understanding of escalation processes for staffing shortages, serious incidents and major incidents. Despite staffing pressure, the skill mix was appropriate and staff felt able to provide safe care. Twice-daily hospital operational meetings helped monitor acuity and staffing. Staff appraisal compliance exceeded 92% and opportunities for Continuing Professional Development (CPD), supervision and revalidation were available. Mandatory training compliance was over 85%, although Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training compliance was below 12%. Staff had not yet received portable oxygen training, which was due to become mandatory.

The ward culture was described as open, supportive and non-blaming. Staff wellbeing initiatives were visible. Information on complaints processes and providing feedback was available. However, patient feedback outcomes were not displayed. Staff awareness of Llais was limited and duty of candour training compliance was reported at 53%.

Information governance processes were generally robust, though paper records were not consistently stored securely. Quality-improvement initiatives were evident, including successful interventions to reduce Clostridium difficile (C. diff) infections and outreach work relating to ketamine-associated risks. The ward had received several certificates recognising improvement activity.

Partnership working was well established, particularly in discharge planning, which began on admission and involved close collaboration with external agencies. Safety-netting arrangements and communication pathways were effective in supporting safe and timely discharge.

This is what we recommend the service can improve:

- Improve compliance with key mandatory training, particularly MCA, DoLS and portable oxygen training
- Ensure timely review and updating of key policies, including medicines management, consent, safeguarding and incident reporting
- Strengthen information governance, ensuring all paper records are securely stored at all times.

This is what the service did well:

- Strong, visible leadership and a positive workplace culture, with staff feeling supported and confident in escalation procedures
- Effective workforce management, including safe staffing levels, robust daily operational meetings, high appraisal rates and access to CPD
- Active quality-improvement work, demonstrated by reductions in C. diff infections, outreach programmes and recognition through awards and certificates.

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

3. What we found

Quality of Patient Experience

Patient Feedback

We received questionnaire feedback from 13 patients. Responses were generally positive with all but one patient rating the ward as 'very good', the other responded with 'good'. Patient comments included:

> ***"Staff are very patient, despite clearly being extremely busy. One thing that would have improved my stay on the ward: A genuine reason to get up and about beyond just going for a walk or using the toilet. I've noticed since going home I've gotten much more activity just wondering back and forth to little jobs, which has made getting more active in general a lot easier."***
>
> ***"Excellent on this ward."***
>
> ***"No complaints at all."***
>
> ***"Ultimate care and service. All needs met."***
>
> ***"On assessment unit as no beds available, would prefer to be on the ward."***

Person-centred

Health promotion

There was a wide range of health promotion material displayed throughout the ward, offering clear and accessible information to support patients in maintaining and improving their health and wellbeing. This included practical guidance to help patients understand how they could contribute to their own care.

Information relating to standards of care and patient safety was also prominently displayed across the ward.

We were told patients were provided with a range of information leaflets on discharge, including those about sepsis. Additional leaflets available to patients included guidance on preparing for surgery, falls prevention, Clostridium difficile

(C. diff) and caring for a stent. We noted a deteriorating patient poster displayed on the ward instructing staff to call the critical care outreach team if the patient was causing concern including where the patient had a NEWS2 score of 3 or over and requiring over 40% oxygen.

As part of smoking cessation support, doctors were able to prescribe nicotine patches and alternative products, including low-nicotine plastic inhalator tubes that were safe for use on the ward.

Dignified and respectful care
Staff treated patients with dignity, respect and kindness throughout the inspection. They introduced themselves appropriately and addressed patients courteously. Interactions were observed to be calm, compassionate and professional, with staff demonstrating sensitivity and discretion when speaking with patients or discussing patient information with colleagues.

Arrangements were in place to ensure discussions and decision-making relating to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) were undertaken appropriately and sensitively. Evidence of these discussions was clearly recorded within patient notes.

The ward was equipped with the necessary devices to support safe and effective care, including hoists, monitoring equipment, commodes, mobility aids and pressure-relieving mattresses. No environmental issues were identified that would compromise patient dignity. Toilet facilities were single-gender with functioning door locks. Staff were discreet when delivering personal care, with curtains used appropriately between bed spaces. Patients were observed receiving assistance with toileting needs in a respectful and supportive manner. Accessible toilets and a wheelchair-accessible shower with hoist facilities were also available.

All respondents in the patient survey felt staff treated them with dignity and respect and said measures were taken to protect their privacy, such as curtains drawn. Most patients said staff helped them with their toilet needs in a sensitive way. All patients who expressed an opinion in the survey said the ward was accessible.

Patients spoke highly of the staff and consistently reported being treated with dignity and respect. They told us they had no concerns and staff responded promptly to their needs.

A dignity and respect charter was displayed, outlining the importance of feeling respected, listened to and treated with compassion. This charter reflected the health board’s commitment to providing high-quality, person-centred care for

patients, families and staff. A staff handbook on Dignity and Respect in Person-Centred Care was also available to guide and support staff in maintaining these standards.

Individualised care
Evidence indicated that initiatives supporting individualised care, including the 'Butterfly Scheme' for patients with dementia, were implemented on the ward. Butterflies were displayed above the beds of relevant patients, and this information was also reflected on the patient status at a glance (PSAG) boards.

Patients appeared well cared for and were clean, comfortable and appropriately presented. Where clinically appropriate, patients were encouraged to wear day clothing. “Get up, get dressed and get moving” posters were prominently displayed to promote independence and mobility. Patients told us they were supported to look after themselves and were encouraged to remain as independent as possible. Staff provided appropriate equipment to help patients mobilise, eat, move and communicate. All patients in the survey all agreed that staff provided care to them when needed.

At the start of the inspection, signage above some beds, such as fall risk indicators, mobility status and nil-by-mouth information, was not in place. Additionally, whilst supportive signage was available on toilet doors for patients with sensory or cognitive needs, one toilet did not display the required sign. **These issues were addressed and resolved during the inspection and are listed in Appendix A**.

Relatives were able to stay with loved ones outside standard visiting hours and staff encouraged relatives to participate in care where appropriate. Where relatives were involved, this was recorded within patient notes. Patients told us relatives who supported their care at home were permitted to continue this involvement on the ward. During the inspection, we observed relatives assisting patients with eating during mealtimes.

There was no designated private area for patients to meet with family members. However, staff assured us a quiet and suitable space would always be found to facilitate private conversations when required.

Timely

Timely care
Patients were observed receiving timely and appropriate support, including emotional reassurance related to their care, treatment and condition. Staff responded promptly to call bells and requests for assistance. Patients told us they

did not have to wait long for help and consistently reported care was delivered in a timely and efficient manner. They described feeling safe and well cared for and told us staff were readily available, spent time listening to them and provided reassurance when needed. Nursing staff were visible on the ward throughout the inspection.

For patients approaching the end of life, we noted clear and comprehensive plans were in place, with evidence of good involvement of family members in decision-making and care arrangements. The patient was seen regularly by palliative care, the speech and language therapy (SALT) team, dietitian and doctors who reviewed their care for the patient daily.

We were also told of an instance where a patient who was due for discharge reported feeling unwell, staff took the appropriate clinical decision to postpone the discharge and keep the patient on the ward overnight.

All patients had access to call bells, positioned within easy reach. Call bells were responded to promptly and nursing staff were consistently visible throughout the inspection. In the patient survey, all but one patient responded that staff were kind and sensitive when they carried out their care and treatment. All patients said they had access to a call bell and agreed that when they used the call bell staff came to them.

Equitable

Communication and language
There was no hearing loop system available on the ward and there were no prominent large clocks to support individuals with hearing or visual impairments. We were informed the hearing loop had been recently removed following the installation of a new alarm system. One patient told us when their hearing aid battery failed, staff promptly sourced and provided a replacement battery.

The health board must ensure the needs of patients who are hard of hearing or who have visual difficulties are fully considered and a functioning hearing loop system and prominent large clocks are installed on the ward.

Clear signage and directions were displayed throughout the unit and some bilingual signs, posters and reading materials were available.

Information to support patients and carers in understanding their care was readily accessible. A large information board at the ward entrance displayed ‘who’s who’ details of staff working on the ward. Staff informed us easy read materials could be provided when required.

In the patient survey, all but one said they were able to speak with staff without being overheard by other patients. All respondents felt staff listened to them and answered their questions and felt they were involved as much as they wanted to be in decisions about their healthcare. All patients we spoke with told us staff listened to them and communicated effectively.

On admission, patients were asked for their preferred language. Although there were no Welsh-speaking staff working on the ward at the time of the inspection, staff had access to Welsh language awareness training and demonstrated an understanding of the importance of communicating with patients in their preferred language. Where needed, staff would seek assistance from Welsh-speaking colleagues elsewhere in the hospital.

Language line was available and staff also had access to a translation application on electronic tablets used within the ward.

Rights and Equality
Staff demonstrated an awareness of patients' spiritual, cultural and individual needs, with access to relevant support services and colleagues when required. There was evidence that equality, diversity and inclusion (EDI) were actively promoted within the organisation.

We noted facilities were available to support patients of different faiths, including multi-faith prayer rooms. Cultural dietary requirements, such as Halal or vegetarian meals, could be provided on request. Bereavement leaflets were available for staff, patients and relatives to support understanding of cultural and spiritual needs at the end of life.

EDI training was mandatory for staff, with a compliance rate of 85%. We were told EDI champions were in place within the health board to support good practice.

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

A 'This is Me' document was completed for patients living with dementia or for those who lacked capacity, helping staff understand the individual's preferences, routines and personal history.

Patients were observed to be treated equally and respectfully. Staff addressed individuals by their preferred names and used appropriate pronouns where applicable. A diverse staff team was working on the ward.

An equality and diversity policy was in place, setting out the health board's commitment to promoting inclusive practice and maintaining a compassionate and supportive culture across its services. The policy aimed to ensure equitable, person-centred care for all patients and carers across the health board area.

Delivery of Safe and Effective Care

Safe

Risk management
The ward environment was visibly clean, well maintained and free from clutter. This included the stock room which was well organised. Surfaces, floors, walls and ceilings were in a good state of repair, supporting effective cleaning practices. Despite being busy, the ward environment remained calm and not excessively noisy. Three single rooms with ensuite facilities were available for barrier nursing. One patient was appropriately isolated, with clear signage displayed.

Staff work areas were positioned to ensure good visibility across patient bays. The ward layout supported safe observation, with wide corridors, accessible doorways and appropriate facilities for people with mobility difficulties.

Ward equipment was in good working order, furniture and fittings were maintained to a suitable standard. Hoists were stored safely near the main entrance and fire exits were unobstructed. Bathrooms were clean and well presented.

Several free-standing oxygen canisters were observed stored in an alcove. Whilst this did not pose an immediate hazard, the issue was escalated to the head of nursing for action.

The health board must ensure all oxygen cylinders are appropriately secured and stored.

The cleaners' cupboard was found unlocked at the start of the inspection, with some cleaning materials, including bleach, stored on the floor. Disinfectant tablets were also not secured. These materials were moved during the inspection. However, no functioning locks were in place on the sluice cupboards. Staff told us this issue had been escalated to estates in 2023 and had now been re-escalated.

The health board must ensure all cleaning materials, including bleach and disinfectant tablets, are securely stored in a locked area.

Ward and senior management outlined clear processes for reporting incidents, including significant incidents. They reported no patient-related incidents had occurred in the past two years. Learning from incidents was shared with staff through digital channels and face-to-face meetings. Quality, safety and risk were monitored through the Audit Management and Tracking (AMaT) system, with January audits showing compliance rates above 94% and most exceeding 99%.

Issues were identified with wall suction and oxygen units at nine bed spaces, due to faulty flow meters. The estates department attended during the inspection and most issues were partially resolved. Oxygen tubing and face masks were not pre-fitted at bed spaces but were available within the bays.

The health board must ensure:

- **Oxygen tubing and face masks are easily accessible at all bed areas**

- **All wall suction and oxygen units are fully operational.**

Infection, prevention and control (IPC) and decontamination
Ward staff were able to describe IPC controls in place, demonstrate how to access IPC policies and explain expected hand hygiene practices and actions required following a sharps or needlestick injury. Safer sharps devices were available and sharps were disposed of appropriately.

Patients told us maintaining cleanliness was a clear priority for staff. They reported all areas, including beds and tables, were cleaned regularly and thoroughly and overall cleanliness standards were very high.

We observed disposable clinical waste bins were not available within patient bays. As a result, staff were required to carry clinical waste from the bedside through the ward to the sluice, at times, while still wearing used PPE. Staff informed us the bins had been removed on instruction from the health board's IPC team.

The health board must ensure IPC instructions are appropriate and the risks associated with transporting clinical waste through the ward are fully considered.

Current IPC policies were in date and accessible to staff via the intranet, which also included a dedicated IPC page. IPC mandatory training compliance was reported as over 84%.

Audit scores were displayed for visitors and patients at the entrance to the ward. Ward management meetings were held to discuss audit outcomes. Hand hygiene compliance had been consistently recorded at 100% for the preceding four months.

IPC Leads operated across the health board to conduct regular ward audits and to highlight required learning or actions.

Personal protective equipment (PPE) was available and used appropriately. PPE supplies were stored outside cubicles and bays.

Green 'Keep Me Clean' stickers were not in use to indicate when equipment had been cleaned and was ready for use. Staff were observed cleaning equipment between patient use and a daily equipment cleaning schedule was in place. Staff demonstrated a good understanding of which items required cleaning between patients.

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

Cloth privacy curtains were in use throughout the ward, with no routine cleaning schedules in place. One visibly soiled curtain was identified to ward management. Staff stated curtains were cleaned when visibly dirty and hydrogen peroxide vapour cleaning was used when required. We were informed the facilities business support manager was exploring the introduction of a manual curtain cleaning register.

The health board must ensure effective cleaning schedules are implemented for cloth curtains.

Credits for Cleaning (C4C), a national monthly estates and facilities standard for cleanliness and infection prevention, was reported at 96%.

Hand gel was available at each patient bed space. However, hand hygiene gel was not initially available between the adjoining wards D2E (East) and D2W (West), which was used as a staff thoroughfare between the two wards. **This issue was addressed and resolved during the inspection and listed in Appendix A**.

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

Safeguarding of children and adults

Staff described a clear escalation process for safeguarding concerns, which included seeking advice from senior ward management in the first instance. We were told a flow chart was available to guide staff through the escalation process. Staff were also aware of the safeguarding team based at the hospital. Safeguarding training compliance for staff was reported at 90%.

A dedicated safeguarding page was available on the intranet, which included links to All-Wales policies, relevant legislation and guidance on making a referral.

For patients who lacked mental capacity, a dementia senior nurse was available on site to provide advice and support. Advocacy services for non-English-speaking individuals were also available. Both health board-based advocacy representatives and independent advocacy services could be accessed as required.

Blood management
Robust systems were in place to support the safe management of blood and blood products. Staff demonstrated clear knowledge of the transfusion process, including the actions required in the event of an adverse reaction.

We observed good practice whereby two nurses undertook the required checks with the patient prior to commencing the transfusion. Staff were also able to explain the clinical indicators that would necessitate stopping a transfusion should a reaction occur.

Arrangements were in place to ensure all staff involved in the transfusion process were appropriately trained and competent. This included relevant induction training and mandatory updates to assess and maintain staff competency.

Management of medical devices and equipment
Ward equipment was in good working order, furniture and fittings were maintained to a suitable standard. Hoists were stored safely near the main entrance and fire exits were unobstructed. However, we identified issues with the accessibility of air mattresses. In addition, five items of equipment—including an electrocardiogram (ECG) machine, infusion pumps and blood pressure monitors, were overdue for calibration, with one calibration date exceeded in 2024.

The health board must ensure all medical devices are available, serviced and calibrated in a timely manner.

Medicines management
A review of five patient records showed All-Wales Drug Charts were completed appropriately, including the prescription of administered oxygen. Intravenous (IV) fluids were prescribed, monitored and recorded on the All-Wales fluid balance charts. Medicines administration was documented consistently and contemporaneously. We also found evidence of appropriate checking and administration practices.

The ward had access to a dedicated pharmacy team. We were informed “to take out” (TTO) medicines issued out of hours were supplied using FP10 prescription forms. Each FP10 issued was recorded in a register, which demonstrated sound

practice and staff awareness of the requirements for safe medicines management. FP10 forms were stored securely in a locked cupboard.

A check of the medication room confirmed medicines were in date. Controlled drugs were accurately accounted for and stored securely in a locked cupboard. Weekly controlled drug checks had been completed and documented in the controlled drug register.

Medication fridge temperatures were checked and recorded daily, with records stored in the drugs room. Daily checks of the emergency (resuscitation) drugs trolley had also been completed. These checks formed part of the required "safe to start" processes, alongside other clinical safety checks.

We observed staff providing support to patients who required assistance to take their medication. Parents, carers and guardians were also supported to understand prescribed medicines to enable safe administration following discharge.

At the start of the inspection, one medication trolley was found unsecured. **This issue was addressed and resolved during the inspection and listed in Appendix A**. In addition, medication trolleys were not chained to the wall and no anchor points were available. Senior staff informed us the estates department was reviewing this issue.

The health board must ensure medication trolleys are securely chained to the wall.

Preventing pressure and tissue damage

Patients were assessed for their risk of pressure and tissue damage on admission, with evidence of timely and appropriate skin assessments. For all five patient records reviewed, the assessment outcomes were clearly documented and corresponding care plans were developed in line with the identified level of risk.

Pressure-relieving care bundles were completed according to individual patient needs and recorded electronically. Where patients were assessed as being at risk of malnutrition, nutritional screening and weekly weight monitoring were undertaken and documented appropriately.

A 'Take the Pressure Off' display was visible within the ward area. This provided clear information on protecting skin integrity, preventing pressure ulcers and selecting appropriate equipment to reduce the risk of tissue damage.

Falls prevention

Falls risk assessments were completed and documented for all five patient records reviewed. Staff informed us the ward had access to a specialist falls service. There had been one patient fall within the previous month, which was undergoing review by the falls panel.

A ward-based display provided information on falls prevention, including visual examples demonstrating how to identify hazards around the bedside environment. This emphasised the importance of patient positioning, pain management, placement of essential items and personal need in reducing falls risk. Patients were also provided with written information on preventing falls.

Additional posters were displayed, including falls-prevention footwear advice from the podiatry and orthotics service and materials from the 'Call, Don't Fall' campaign, which promoted safe mobilisation and encouraged patients to request assistance when needed.

The ward had also been awarded a gold certificate of achievement in recognition of its falls awareness health promotion activities and strong patient engagement.

Effective

Effective care

Audit activity was recorded on the AMaT system and recent audit outcomes and associated actions were displayed on the ward's entrance noticeboard. Relevant risk assessments were also in place.

Staff told us National Early Warning Score (NEWS2) observations were recorded using an iPad. The system prompted staff when observations were due, with timings adjusted according to the patient's NEWS2 score.

We were informed sepsis training was available to all staff and had been incorporated into the NEWS2 training. Qualified staff completed sepsis training as part of the Journey of Excellence, a professional development programme aligned to learning and development for new staff and during clinical induction. Staff also received a clinical skills update every three years. However, this was not recorded on the electronic staff record (ESR). Sepsis training was not a mandatory requirement. Ward-level training compliance was reported as 89.74%.

The health board disseminated updated clinical guidelines through emails, ward meetings and online messaging platforms. Staff were required to sign to confirm they had read and understood any changes. Staff demonstrated knowledge of how to access relevant clinical policies and procedures online and qualified staff were

familiar with accessing the Nursing and Midwifery Council's Record Keeping Guidance.

Staff used handover sheets that reflected the information presented on the PSAG. These sheets contained appropriate and useful patient details. A PSAG board in the nurses' office, whilst it was covered to prevent unauthorised view, was not up to date with information about current patients. **This issue was addressed and resolved during the inspection and listed in Appendix A**.

There was no fluid warmer available on the ward to heat intravenous or irrigation fluids when required, to reduce the risk of hypothermia. Staff explained that whilst the health board did not routinely provide fluid warmers on general wards, they were available in surgical high dependency areas and theatres.

Nutrition and hydration

Meals were observed to be provided to patients promptly following the arrival of the food trolley. Patients who required assistance with eating and drinking received appropriate support. Menu choices were completed each morning for that day and staff used these selections at mealtimes to ensure patients received their preferred options.

Staff were aware of patients requiring assistance through handover information. During the visit, all patients identified as needing support were observed receiving help in a respectful and dignified manner. Relatives were also encouraged to assist where appropriate.

Patients identified as malnourished were promptly referred to the dietetics team for assessment, including the provision of high-protein supplements where required. Referrals to the SALT team were also made when indicated, as reflected in patient documentation. Patients were weighed weekly and staff demonstrated awareness of nutritional risk assessments.

All patients said in the questionnaire, they had time to eat their food at their own pace and staff helped them to eat and drink, if they needed assistance. They all said always had access to water on the ward. Water jugs were changed at least twice daily and were accessible to patients. Staff encouraged patients to maintain adequate hydration.

Patients in the waiting area and assessment units at the end of the ward were offered a drink if waiting for more than two hours and food if waiting for over four hours.

Patient records

Overall, from our review of five patient records, we noted clear accountability and documented evidence demonstrating how decisions relating to patient care were made. However, not all entries were up to date and several gaps were identified. Records were also stored across four separate systems, two electronic platforms and two sets of written medical and nursing notes, which increased the risk of fragmentation and inconsistency.

The health board should consider fully implementing a comprehensive electronic patient record system to support the effective access, coordination and management of clinical information.

Patients' needs were assessed promptly on admission and relevant risk assessments were completed. Records reflected identified risks, required actions and the patient's preferred language. There was evidence of care being planned to promote independence and care delivered was documented in patient care plans and clinical notes, including decisions such as DNACPR. Medical notes also demonstrated clear discussions with patients and their families.

Initial nutritional risk assessments were completed appropriately. However, some food and fluid charts were not fully completed each day. All patients had a mental capacity assessment on admission and there was evidence that pain was being measured, addressed and re-evaluated. Current pain scores were consistently recorded within NEWS2 charts.

For three records, formal care plans were not available. We were advised that care was being driven by risk assessments. However, multidisciplinary team (MDT) staff had clearly documented the plan of care in the patient notes. Transfer of care and discharge planning were evident, although for half of the records reviewed there was no documentation of appropriate discharge packages when patients were nearing discharge.

While effectiveness of care was evaluated regularly, not all records were contemporaneous. In two of the five records, entries were not completed immediately after care was delivered. Where entries were made, they were signed, dated and timed and handwriting was legible. Risk assessments were completed promptly on admission, but some records were missing patient identification stickers.

The health board must ensure that all relevant sections of the patient record are completed fully and consistently.

During the inspection, we reviewed five NEWS2 scores within three patient records where the score was five or six. We found that correct observations and escalation

actions had not been carried out in line with required guidance. These scores should also have triggered a sepsis screen, yet there was no evidence this had occurred. **These concerns were addressed through our immediate assurance process, as detailed in Appendix B.**

Efficient

Efficient
Services were organised to support the timely and effective movement of patients through care and treatment pathways. Review of clinical records demonstrated patients were referred appropriately to relevant multi-disciplinary teams. This included the use of the urology assessment unit, located at one end of the ward, for emergency and urgent urological cases. The short-stay nature of this unit supported early assessment, diagnosis and management of urological emergencies.

Processes for admission and discharge were arranged to promote efficiency. Staff routinely referred patients to district nursing services when required and a designated discharge planning coordinator was in place to facilitate timely and safe discharge from the ward.

A display outlining the HOUDINI protocol, a recognised tool describing the indications for continued use of an indwelling urinary catheter, was visible within the ward, supporting staff awareness of appropriate catheter management.

Quality of Management and Leadership

Leadership

Governance and leadership
Governance and leadership on the ward were supported through structured systems and regular communication processes. Routine audits were undertaken, with findings disseminated to staff. Leaders on the ward were visible and approachable. Staff confirmed management were regularly present and demonstrated clear commitment to the ward's values and vision. Whilst attempts had been made to hold ward meetings, attendance was reported to be low.

Managers outlined the established processes for disseminating safety notices issued by the Medicines and Healthcare products Regulatory Agency (MHRA) and the Welsh Government (WG). Despite these mechanisms, staff had not completed the required portable oxygen cylinder training and were unaware of the safety-netting discharge leaflets for adults and children. Both requirements were outlined in separate Welsh Health Circulars (WHC) issued in August 2024 and December 2025.

Clear leadership was evident on the ward and ward management was viewed positively despite existing staffing pressures. Staff demonstrated awareness of appropriate escalation procedures for staff shortages, serious incidents and major incidents. Staff at all levels articulated a clear understanding of their individual roles.

Several policies submitted as part of the inspection key document request were overdue for review by the health board. These included policies relating to medicines management, safeguarding, consent to examination or treatment, incident reporting and treatment and escalation.

The health board must ensure:

- **All policies are reviewed and updated in line with their designated review dates**

- **Safety notices including WHCs are disseminated and the requirements of the circulars complied with.**

Several issues were identified during the inspection which were addressed and resolved at the time and detailed in Appendix A. Ongoing monitoring is required to ensure that these issues do not occur again.

The health board must ensure robust checks are implemented and maintained to prevent any recurrence of the issues outlined in Appendix A.

Workforce

Skilled and enabled workforce

Staff told us the number and skill mix of the ward team were appropriate for the needs and acuity of patients. Staff also reported they had sufficient time to deliver safe and effective care. Whilst the established staffing levels aligned with the actual staffing complement, we were informed some staff were currently on secondment. We were told agency staff were not used on the ward and staff sickness rate was reported as under 7%.

The hospital held twice-daily operational meetings. The morning "safe to start" meeting reviewed staffing, emergency care practitioners (ECPs), capacity and quality and safety metrics. The afternoon meeting examined staffing levels in relation to patient acuity. Staff told us if acuity changed during the day, ward management would escalate concerns to senior nurse managers and a Datix report would be submitted when staffing levels were insufficient or not aligned with acuity.

Review of staff rotas showed the ward was compliant with safe-staffing requirements. Senior managers also confirmed staffing and acuity were monitored throughout the day. Where additional staff were required, they could be redeployed from other wards and where this was not possible, bank staff were utilised.

All staff we spoke with told us they had received an annual appraisal and had opportunities to discuss further training needs with management. ESR data indicated over 92% of staff had completed their annual appraisal. Staff also had access to supervision, continuing professional development (CPD) and revalidation support.

Staff wellbeing information was visible within staff areas, including wellbeing posters. All staff had access to occupational health services provided by the health board.

Staff reported access to a range of training opportunities. This included four healthcare support workers (HCSWs) undertaking flexi-nurse training while continuing in their HCSW roles. We were also told a ward clerk had received training to take on the role of discharge coordinator.

We observed students working on the ward and we were informed they were supported by both the university and the health board. A large display of specialty-specific information for students was present on the ward.

Mandatory training compliance exceeded 85%, including compliance for new starters. Individual compliance ranged from 66.7% for a new starter to 100% for some staff. However, compliance for Mental Capacity Act (MCA) and DoLS training was below 12%. Staff told us arranging face-to-face training sessions, such as those required for MCA and DoLS, had been challenging.

In addition to mandatory modules, staff had completed training in consent, blood transfusion and the Paul Ridd Learning Disability Awareness Training. Training compliance was monitored through monthly ESR reports.

We were informed staff had not yet received portable oxygen training, which was planned to become mandatory.

The health board must ensure all staff complete:

- **All mandatory training, including Mental Capacity Act and Deprivation of Liberty Safeguards**

- **Portable oxygen training, in line with the relevant Welsh Health Circular.**

Culture

People engagement, feedback and learning
Staff at all levels told us they felt able to raise ideas or concerns and described the culture as open and non-blaming. Many staff spoke positively about working on the ward, with some stating D2E or D2W would be their preferred wards within the health board.

The ward culture promoted the wellbeing of both staff and people using the service. Staff described a supportive, inclusive environment, with consistent support from managers at qualified staff level and above. A range of wellbeing initiatives were evident, including visible wellbeing prompts displayed in staff areas.

The “Putting Things Right” leaflet, the formal NHS Wales mechanism for raising concerns or complaints, was not displayed. However, posters informing patients and relatives how to make a complaint were available and staff stated they would provide the leaflet on request.

Information on how patients and families could provide feedback was clearly displayed. However, there was no information available on the ward demonstrating how feedback had been used to drive improvement. We were told due to low response rates, feedback data was only available at divisional level.

The health board must ensure patient feedback results are displayed on the ward, for example through a 'You Said, We Did' notice.

Staff we spoke with were not familiar with Llais, the independent statutory body representing the views of people in Wales regarding health and social care services. However, a poster explaining how to contact Llais was displayed.

Information relating to the duty of candour was available on the intranet, including guidance on the harm-level framework and trigger process. Staff were able to describe the duty and we were told there had been no incidents requiring its application. Compliance with mandatory duty of candour training was reported as 53%.

Information

Information governance and digital technology

The service had systems in place to support the effective collection, sharing and reporting of information within an appropriate information governance framework. Staff accessed electronic systems using individual logins and demonstrated a clear understanding of procedures for the appropriate disposal of records. We were informed the service had arrangements to ensure required data and notifications were submitted to external bodies in a timely manner. Regular audits were undertaken to monitor the quality of care and identify areas for improvement.

During the inspection, we observed paper patient records were stored in lockable cabinets. However, these cabinets were not consistently locked and cabinets were left open within ward corridors, which were busy and accessible areas.

The health board must ensure patient records are stored securely at all times.

Discharge documentation for patients returning home or transferring to a care home was completed through the clinical workstation system.

Learning, improvement and research

Quality improvement activities

A range of quality improvement initiatives were in place on the ward. Senior staff told us there had been an increase in healthcare-acquired Clostridioides difficile (C. diff) infections during quarter two of 2024. In response, the management team

implemented an MDT approach to support early identification of patients at risk. This included reinforcing expectations around isolation procedures and timely specimen collection. Staff reported these measures resulted in a prompt reduction in ward-based infections and the learning had been shared across the wider surgical division.

Posters promoting the 'Get it straight, reduce the wait' campaign were visible, providing guidance on the correct specimen containers to use. A "grab bag" had also been introduced for managing patients presenting with diarrhoea, containing relevant equipment and a flow chart outlining required actions, appropriate specimen pots and infection-prevention precautions.

We were told a senior nurse, alongside an advanced nurse practitioner, had undertaken outreach work with local colleges to raise awareness of the risks associated with ketamine use, including ketamine-related uropathy. A working group had been established with third-sector organisations and public bodies to support wider awareness-raising and staff from the Welsh Ambulance Service Trust (WAST) had also been engaged to support education activities. Staff had also linked with the university in Newport, as a health promotion and preventative measure, to advise students via lectures of the side effects of ketamine.

Senior staff described the Professional Standards Group, which reviewed themes such as pressure ulcers, falls and medication-related issues, as a mechanism for sharing learning and promoting improvement.

Recognition of improvement activities was also evident. The ward had received a certificate of achievement for being nominated for the Patient Choice Awards in 2024. The Nursing and Midwifery Pledge was displayed, outlining values, behaviours and commitments to patients and colleagues. Additional certificates included acknowledgement of six months' compliance with cleaning standards (dated December 2025) and an undated "journey of improvement" certificate for achieving bronze level in continuous quality improvement.

Whole-systems approach

Partnership working and development

The ward-based discharge planning coordinator demonstrated effective communication with patients and their relatives regarding the ongoing discharge process. They also engaged with external agencies and the third sector. Discharge planning was initiated at the point of admission, enabling the coordinator to gather information about individual needs early in the patient pathway.

Patients were required to be medically fit before referral to the social services department. Appropriate discharge safety-netting arrangements were in place, including teaching catheter and stent care and providing necessary supplies. This role contributed positively to the overall discharge pathway on the ward.

The ward worked collaboratively with a range of system partners, including social workers, community physiotherapists, district nurses, occupational therapists and equipment services. General practitioners were routinely informed of the patient's discharge through a formal discharge summary.

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
Hand hygiene gel was not initially available between the adjoining wards D2E (East) and D2W (West), which was used as a staff thoroughfare between the two wards.	The potential cross infection between the two wards.	Deputy ward manager informed.	Hand hygiene gel was placed on a table near the adjoining doors.
A medication trolley was found unsecured as the lock was thought to be broken.	The trolley could be accessed and medication used inappropriately.	Deputy ward manager informed.	Estates visited the ward and repaired the lock.

The PSAG board in the nurses' office, was not up to date with information about current patients.	Any member of staff using the board could be misinformed about any patient on the ward.	Deputy ward manager informed.	PSAG updated to reflect the status of the patients on the ward.
At the start of the inspection, signage above some beds, such as fall risk indicators, mobility status and nil-by-mouth information, was not in place. Additionally, whilst supportive signage was available on toilet doors for patients with sensory or cognitive needs, one toilet did not display the required sign.	Staff would not be aware at a glance of the needs of certain vulnerable patients. Patients may not be able to identify appropriate toilet doors.	Deputy ward manager informed.	Appropriate signage was placed above patient beds. All toilet doors had appropriate signage.

Appendix B – Immediate improvement plan

Service: Ward D2 East, Royal Gwent Hospital
Date of inspection: 25 and 26 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.	HIW was not assured that key risk assessments were completed when appropriate, therefore patient safety was not always being maintained. During our inspection we checked a sample of five instances in three patient records where the National Early Warning Score (NEWS2) were scored	The health board must ensure that all staff have received training, complete patient risk assessments appropriately, take the relevant action in line with local or national guidance and document this in patient records. This includes:	Delivery of safe and effective care – Managing Risk and Health and Safety	Immediate senior nurse oversight of all ward-level NEWS scores to confirm compliance with observation and escalation processes and address any gaps identified.	Senior Nurse	Complete - 26/02/2026
				Ward meeting to discuss immediate action and verbal feedback.	Senior Nurse/Ward Manager	Meeting set for 09/03/26
				Reviewed and actively use D2E Careflow compliance data to inform		09/03/26

	five or six, and noted that: • On each occasion the score was escalated to qualified staff, but staff did not then follow the relevant guidance and protocol. The NEWS2 score of five or six meant the patient was high risk and likely to deteriorate rapidly. However, the patient observations were not repeated every 30 minutes as per protocol. In two instances, with a NEWS2 score of six, observations were not repeated for six hours. For the other three instances, the relevant observations	• Taking appropriate action when NEWS2 scores are three or above • Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS2 score of five or above.		ward level discussions and deliver a targeted training plan.	Senior Nurse/Ward manager	
				Retraining of all staff in NEWS2	Senior Nurse	Training commenced 27/02/26. To be completed by end March 2026 95% completed 06/03/2026
				Deliver targeted retraining for all Registered Nurses on roles and responsibilities in the recognition and management of the deteriorating patient, including sepsis, led by Practice Educators in partnership with the Quality and Patient Safety Assurance Lead.		
				Deliver unannounced ward-based outreach visits to provide practical simulation and scenario-based training, reinforcing learning and improving compliance with NEWS and sepsis recognition and management. This will consolidate existing training delivered by Practice Educators and the Quality and Patient Safety Assurance Lead	Senior Nurse	To be provided in March/April 2026

	were not completed for three hours • As the NEWS2 score was five or six, this should also have prompted a Sepsis screen. However, there was no evidence this had taken place. We noted a deteriorating patient poster displayed on the ward instructing staff to call the Critical Care Outreach Team, but there was no evidence of this escalation or to the medical team in four out of five instances.					
				Reinforce daily senior staff ward-based reviews of five patients to provide assurance that clinical risks are identified, escalated, and managed appropriately.	Head of Nursing/Senior Nurse	Complete and Ongoing - Commenced 03/03/26
				Undertake routine assurance checks using AMAT audit tools, including *One Patient, One Day*, to validate compliance with NEWS and sepsis processes.		
				Strengthen senior oversight of escalation to medical teams, ensuring timely escalation, robust treatment planning, and improved documentation for patients with elevated NEWS scores.		
				Embed a positive and psychologically safe escalation	Senior Nurse	To be discussed at ward

				culture, ensuring HCSWs are empowered and supported to escalate concerns further where they feel initial escalation to an RN has not resulted in timely action. High NEWS scores will be escalated to the Nurse in Charge (NIC) and all patients with elevated NEWS will be reviewed and discussed at multidisciplinary safety huddles held three times daily, with agreed plans clearly documented and communicated.		meeting 09/03/26
				Provide targeted information and training on delegation and escalation, supported by a dedicated bulletin board in the staffroom and reinforced through regular discussion with ward staff on the ward.	Senior Nurse/Ward Manager	By 31/03/26
				Ensure all patients with elevated NEWS and/or positive sepsis screening are clearly visible on	Ward Manager	To commence 03/03/2026

				PSAAG boards and are routinely discussed at safety huddles to support timely escalation and management.		
				Enable ward managers and senior nurses to access Care Flow Vital Clinical via PC to improve visibility and real-time oversight of patients with high NEWS scores and support timely escalation.	Senior Nurse	09/03/26
				Test and evaluate the sepsis safety-netting leaflet within the Urology Assessment Unit as an open-access model, ahead of Health Board-wide implementation.	Senior Nurse	Commence implementation following agreement with the Quality and Patient Safety Assurance Team, with a target date of May 2026.
						Complete - Compliance

				Quality and patient safety to audit NEWs compliance and share data for improvement.	Senior Nurse/Head of Nursing	data completed and shared 05/03/2026.

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): **Amanda Hale**

Job role: **Divisional Nurse for Surgery**

Date: **06/03/26**

Appendix C - Improvement plan

Service: Ward D2 East, Royal Gwent Hospital

Date of inspection: 25 and 26 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.	There was no hearing loop system available on the ward and there were no prominent large clocks to support individuals with hearing or visual impairments.	The health board must ensure the needs of patients who are hard of hearing or who have visual difficulties are fully considered and a functioning hearing loop system and prominent large clocks are installed on the ward.	Communication and Language	1) Once delivered, arrange for the installation of the newly ordered large clocks on the ward, ensuring they are positioned prominently to support patients with visual impairments.	Ward Manager	17 May 2026
				2) Liaised with Facilities re: reinstallation of the hearing loop system.	Senior Nurse	Completed April 2026

2.	Several free-standing oxygen canisters were observed stored in an alcove.	The health board must ensure all oxygen cylinders are appropriately secured and stored.	Risk Management	3) Portable oxygen storage brackets ordered and will be installed by Works and Estates, (reference 211172).	Ward Manager	30 April 2026
				4) To be discussed at Divisional Ward Management meeting.	Ward Manager and Senior Nurse	30 May 2026
3.	The cleaners' cupboard was found unlocked at the start of the inspection, with some cleaning materials, including bleach, stored on the floor. Disinfectant tablets were also not secured. These materials were moved during the inspection. However, no functioning locks were in place on	The health board must ensure all cleaning materials, including bleach and disinfectant tablets, are securely stored in a locked area.	Risk Management	5) A request was submitted for minor works to install locks on the cleaners' cupboard and any cupboards designated for storing cleaning materials (ref 211169).	Ward Manager	Completed

	the sluice cupboards.					
4.	Issues were identified with wall suction and oxygen units at nine bed spaces, due to faulty flow meters. The estates department attended during the inspection and most issues were partially resolved. Oxygen tubing and face masks were not pre-fitted at bed spaces but were available within the bays.	The health board must ensure: • Oxygen tubing and face masks are easily accessible at all bed areas • All wall suction and oxygen units are fully operational.	Risk Management	6) Oxygen tubing and face masks are accessible at all bed areas.	Ward Manager	Completed
				7) The suction and oxygen units have been replaced. All staff members have received refresher training on the procedures for checking oxygen and suction equipment.	Ward Manager	Complete and ongoing review
				8) Correct procedure and troubleshooting guide to be discussed with all staff in ward meeting.	Ward manager to continue to review	Completed
5.	We observed disposable clinical waste bins were not available within patient bays. As a	The health board must ensure IPC instructions are appropriate and the risks	Infection prevention	9) Discuss with Head of Infection Prevention and Control regarding correct procedure	Ward manager	Completed

	result, staff were required to carry clinical waste from the bedside through the ward to the sluice, at times, while still wearing used PPE.	associated with transporting clinical waste through the ward are fully considered.		10) Ward meeting to discuss and embed best practice.	Ward Management	31 May 2026
				11) Monthly Audit via AMAT	Senior Nursing Team	Complete and ongoing
				12) Spot checks to be completed bi-monthly.	Senior Nursing Team	Complete and ongoing
				13) Information to be shared divisionally in senior nurse meeting and ward management meeting.	Senior Nursing Team	31 May 2026
6.	Green 'Keep Me Clean' stickers were not in use to indicate when equipment had been cleaned and was ready for use.	The health board must ensure reusable items are appropriately decontaminated between use and clean equipment is clearly and consistently labelled.	Infection prevention	14) Green stickers should be applied following each cleaning to confirm to staff that the equipment has been properly cleaned and is ready for use.	Ward Manager	Complete – discussed at ward meeting 30 March 2026

7.	Cloth privacy curtains were in use throughout the ward, with no routine cleaning schedules in place. One visibly soiled curtain was identified to ward management.	The health board must ensure effective cleaning schedules are implemented for cloth curtains.	Infection prevention	15) A Health Board initiative is underway to transition to disposable curtains. Upon inclusion of the curtains in procurement, all wards will be required to place orders, and manufacturers are to proceed with replacements accordingly.	Senior Nurse	Ongoing - by 31 May 2026
				16) Curtains currently replaced when soiled or in contact with suspected or confirmed infections. External company awarded contract, wards to order equipment and curtains in next 1-2 weeks once on oracle. Complete transition of cloth to disposable on entire site arranged.		30 June 2026

				17) Discuss at DMT: replacement needed in all wards and capital required. To be discussed at DMT due to ongoing need to replace across all wards and subsequent capital required.	Divisional Management Team	31 May 2026
8.	We identified issues with the accessibility of air mattresses. In addition, five items of equipment—including an electrocardiogram (ECG) machine, infusion pumps and blood pressure monitors, were overdue for calibration, with one calibration date exceeded in 2024.	The health board must ensure all medical devices are available, serviced and calibrated in a timely manner.	Management of medical devices and equipment	18) EBME team have been made aware of circulating out of date calibration devices.	Ward Manager	Completed
				19) Ward staff to complete a stock spreadsheet of equipment and dates of calibration to ensure monthly review and escalation.	Ward Management and Senior Nurse	30 April 2026
				20) Monthly updates to be completed at ward level to track calibration dates.	Ward Management and Senior Nurse	Complete and Ongoing

9.	Medication trolleys were not chained to the wall and no anchor points were available. Senior staff informed us the estates department was reviewing this issue.	The health board must ensure medication trolleys are securely chained to the wall.	Medicines Management	21) Works and estate to fit anchor points to chain medication trolleys to wall.	Ward Manager	Completed April 2026
10.	Records were also stored across four separate systems, two electronic platforms and two sets of written medical and nursing notes, which increased the risk of fragmentation and inconsistency.	The health board should consider fully implementing a comprehensive electronic patient record system to support the effective access, coordination and management of clinical information.	Patient records	22) Nursing documentation is completed within the All Wales 'Welsh Nursing Care Records' principles as evidenced in AMAT audits and ward accreditation.	Ward Management Senior Nursing team	Completed
				23) Each profession has been made aware of roles and responsibilities for accurate documentation and information sharing.	Multi-Disciplinary Team	Completed

				24) Continued collaboration between the Divisional team and Digital is underway.	Digital partners	30 June 2026
				25) To be discussed at Urology Directorate, senior nursing and ward management level meetings.	Medical colleagues	30 June 2026
				26) To be discussed at ward meeting	Ward Management Senior Nursing team	31 May 2026
11.	Not all sections of the various patients records held were completed as required.	The health board must ensure that all relevant sections of the patient record are completed fully and consistently.	Patient records	27) Ensure AMAT monthly audits are completed to identify gaps in patient records.	Ward Manager	Complete – reviews ongoing
				28) Ward meeting scheduled to emphasise the significance of appropriate record keeping.	Ward Manager	31 May 2026

12.	Several policies submitted as part of the inspection key document request were overdue for review by the health board. These included policies relating to medicines management, safeguarding, consent to examination or treatment, incident reporting and treatment and escalation.	The health board must ensure: • All policies are reviewed and updated in line with their designated review dates • Safety notices including WHCs are disseminated and the requirements of the circulars complied with.	Governance and Leadership	29) Bulletin board to be placed in staff room for all bulletins/circulars and information to be shared.	Ward Manager	Complete
				Out of date Policies to be reviewed:		
				30) Medicines Management.		Complete - Updated: 09/03/26
				31) Safeguarding.		Complete - Updated: 08/12/25
				32) Consent to examination or treatment (out of date review date Oct 2025).		Complete - Updated: October 2025
				33) Incident reporting and treatment and escalation.		Complete - Updated: 12/02/26

13.	Several issues were identified during the inspection which were addressed and resolved at the time and detailed in Appendix A. Ongoing monitoring is required to ensure that these issues do not occur again.	The health board must ensure robust checks are implemented and maintained to prevent any recurrence of the issues outlined in Appendix A.	Governance and Leadership	34) Ongoing monitoring of ward signage, PSAG/above the patients' bed board monitored for completion.	Ward Manager	Complete and Ongoing
				35) Treatment door kept shut at all times and locks fixed on medication trolleys.	Ward manager	Complete April 2026
14.	Mandatory training compliance exceeded 85%. However, compliance for Mental Capacity Act (MCA) and DoLS training was below 12%.	The health board must ensure all staff complete: • All mandatory training, including Mental Capacity Act	Skilled and enabled workforce	36) All staff will be scheduled for MCA and DoLs training as dates become available. The management team will be prioritised to ensure they can guide and support junior staff effectively.	Ward Manager Senior Nurse MCA Team	31 July 2026

	In addition to mandatory modules, we were informed staff had not yet received portable oxygen training, which was planned to become mandatory.	and Deprivation of Liberty Safeguards • Portable oxygen training, in line with the relevant Welsh Health Circular.		37) All ward managers informed about portable oxygen training and detail of where to find it on ESR provided.	Ward Manager	Complete
				38) Portable oxygen training compliance to be monitored weekly until 85% target achieved.	Ward Manager	31 May 2026
15.	There was no information available on the ward demonstrating how feedback had been used to drive improvement.	The health board must ensure patient feedback results are displayed on the ward, for example through a 'You Said, We Did' notice.	People engagement, feedback and learning	39) Ward to display feedback and evidence of how we answered feedback.	Ward Manager	Complete
16.	We observed paper patient records were stored in	The health board must ensure patient records	Information governance	40) Replacement locks for trollies to be ordered.	Ward Manager	Complete - 13 April 2026

	lockable cabinets. However, these cabinets were not consistently locked and cabinets were left open within ward corridors, which were busy and accessible areas.	are stored securely at all times.	and digital technology	41) All staff to be reminded of the importance of ensuring patient records are stored securely in the meantime.	Ward Manager	Complete

OVERSIGHT AND MONITORING
Oversight and monitoring of the improvement plan will be undertaken by the following groups: - • Divisional Patient Safety Quality Meeting • Senior Management Team, to include Divisional Management Team, Directorate Meeting, Senior Nurse Meeting, Divisional Assurance • Quality Management Group • Patient Quality Safety Learning and Improvement Forum • Quality Patient Safety Outcomes Committee

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): **Donna Challingsworth**

Job role: **Head of Nursing - Surgery**

Date: **17 April 2026**