Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Ward D, Morriston Hospital, Swansea Bay University Health Board

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Morriston Hospital, Swansea Bay University Health Board on 17 and 18 March 2026. The following hospital wards were reviewed during this inspection:

- Ward D - 25 beds providing Care of the Elderly services.

Our team, for the inspection comprised of two HIW healthcare inspectors, two clinical peer reviewers and a 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 five questionnaires were completed by patients or their carers but NIL 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:
Compassionate care and staff commitment were evident. However, improvements were required to address environmental constraints, strengthen person-centred care and improve communication, privacy and inclusion to ensure a consistently positive patient experience.

Feedback from patients and carers was generally positive, with all respondents rating the service as good or very good. Patients consistently described staff as kind, respectful and compassionate, and we observed patient-centred interactions throughout the ward, including with people living with dementia.

Staff were seen to prioritise patients with urgent or time-critical needs and medicines were generally administered in a timely manner. Patients also reported good standards of cleanliness within bed spaces and were reassured by practices such as daily bedding changes.

Despite these positive findings, environmental pressures significantly impacted aspects of patient experience. The ward was operating above its intended capacity, with additional beds reducing space between patients. This constrained environment adversely affected privacy, dignity and safe access around bed spaces. Patients and carers reported difficulty having conversations with staff without being overheard and we observed confidential discussions often took place at the bedside or in areas that did not support privacy. Some patients did not consistently have access to call bells, particularly those cared for in additional or unallocated bed spaces, which reduced assurance that support could be summoned promptly when required.

There were also gaps in the provision of person-centred care and supportive information. Tools intended to promote individualised care, such as ‘This is Me’, were not used consistently and care planning relied heavily on generic templates. Limited resources were available to support health promotion, communication needs and inclusion, including a lack of patient-friendly information, minimal bilingual signage and no hearing loop on the ward. In addition, patients and relatives were generally unaware of the formal complaints process.

Staff demonstrated awareness of equality and diversity principles and made reasonable adjustments where possible. However, environmental and resource

limitations reduced assurance that all patients consistently received a fully personalised and inclusive experience.

This is what we recommend the service can improve:

- Reviewing additional bed arrangements to reduce overcrowding, improve space between beds, ensure patients are dressed appropriately and safeguard confidentiality during conversations
- Ensure tools such as 'This is Me', personalised care planning and catheter documentation are consistently completed, supported by appropriate signage and space for physiotherapy and occupational therapy
- Improve access to call bells and alarms, provide health promotion and bilingual patient information, ensure access to a hearing loop, support Welsh language visibility through 'iaith gwaith' badges and display information on Llais clearly.

This is what the service did well:

- Staff consistently treated patients with kindness, dignity and respect, including during challenging interactions with people living with dementia
- Patients with urgent or time-critical needs were prioritised, with timely medicines administration and responsive care for infection control and end-of-life needs
- Reasonable adjustments were evident, staff demonstrated awareness of protected characteristics and equality, diversity and dementia training supported inclusive practice.

Delivery of Safe and Effective Care

Overall summary:
The ward environment presented significant risks to patient safety, primarily due to damaged flooring, overcrowding and cluttered spaces. Corridors and areas around the nurses' station were worn, torn and unable to be cleaned effectively, creating slips, trips, falls and infection prevention and control (IPC) risks. Although bed spaces were clean and patients reported good hygiene, the wider environment appeared tired and unkempt, limiting effective cleaning and safe movement.

The ward routinely operated above its designated capacity, increasing from 25 to 29 beds. As a result, additional beds placed in already crowded bays restricted movement, reduced privacy and dignity and increased the risk of falls. While some risk assessments had been undertaken, concerns remained about the safety implications of surge bed use, including shared access to oxygen and suction

equipment, insufficient space around beds, and inconsistent access to call bells. These issues were managed through the immediate assurance process.

Limited storage resulted in a lack of bedside lockers, inadequate seating for visitors and reliance on corridor storage for equipment such as hoists, further compromising safe access, particularly for patients living with dementia.

IPC arrangements were negatively impacted by overcrowding, damaged flooring, poor equipment labelling and insufficient personal protective equipment (PPE) disposal facilities. While hand hygiene compliance and PPE use were strong, the proximity of beds increased the risk of cross-contamination. The lack of PPE doffing receptacles, unresolved estates issues and shortages of linen and continence products also reduced assurance. Additional concerns included inconsistent cleaning of medication trolleys and incomplete adherence to infection control procedures for patients with infectious conditions.

Safeguarding systems were in place and patients reported feeling safe. However, significant delays and expired documentation relating to deprivation of liberty safeguards (DoLS) were identified, reducing assurance that legal requirements were met in a timely manner.

Immediate assurances:

- The ward was operating above its designated capacity, with additional beds placed in bays. This reduced space for safe access, compromised privacy and dignity, increased the risk of falls and involved shared access to oxygen and suction equipment
- Flooring throughout the ward was damaged, lifted and unable to be cleaned effectively, creating IPC risks and increasing the likelihood of slips, trips and falls
- There was a lack of suitable receptacles for the safe removal and disposal of PPE. Given the presence of infectious patients, this increased the risk of cross-contamination
- Several environmental and IPC concerns had previously been reported to the estates department but had not been resolved
- Several patients, including those with cognitive impairment, were not wearing identification bands, increasing the risk of harm associated with medicines administration, treatment delivery and allergy identification
- Pressure ulcer risk assessments were not consistently completed on admission, with delays of up to three days identified
- Falls risk assessments were not completed in a timely manner for several patients, with delays of up to eighteen days noted. This significantly

reduced assurance that patients at risk of falling were being adequately protected
- Patient records were observed left unattended in unlocked trolleys and communal areas, presenting confidentiality and data protection risks.

This is what we recommend the service can improve:

- Some bed spaces did not have sufficient room for bedside lockers, resulting in patients' belongings being stored under chairs. Visitors and relatives often lacked appropriate seating and frequently sat on patients' beds
- The ward did not have access to a dining room, day room, activity resources, televisions or designated rehabilitation areas, limiting opportunities to promote mobility and reduce the risk of patient deconditioning
- Ongoing shortages of linen, towels and incontinence pads were reported, which affected staff ability to consistently meet patient care needs
- Medication trolleys were not always cleaned when moving between infected and non-infected areas. Some equipment in storage was not clearly labelled as clean, creating uncertainty about readiness for use
- Information on infection rates was not displayed on the ward for staff, patients or carers, limiting transparency and opportunities to reinforce infection prevention awareness.

This is what the service did well:

- Despite environmental constraints, patients and relatives consistently reported good standards of cleanliness in bed spaces, including daily bedding changes
- Risks and incidents were consistently reported through DATIX, reviewed by senior staff and escalated to appropriate governance meetings when required, with learning shared across the ward
- Staff demonstrated strong hand hygiene technique and appropriate use of PPE, supported by good knowledge of IPC principles, adequate supplies and high audit compliance
- A structured audit programme was in place, including monthly IPC audits and additional reviews during periods of increased infection risk, with feedback shared during handovers
- Staff demonstrated a clear understanding of safeguarding responsibilities and reported using less restrictive approaches, such as conversation and diversion, where appropriate. Patients spoken with reported feeling safe on the ward.

Quality of Management and Leadership

Overall summary:
The service demonstrated structured governance and leadership arrangements supported by regular morning and evening handovers, band six discussion groups and clinical risk meetings. Information was routinely shared with staff through ward managers, safety briefings, emails, online communication platforms and ward meetings. Leadership presence was visible, and staff reported feeling engaged, informed and supported. Ward management also felt supported by senior leaders, including access to on-call senior managers, and staff demonstrated a clear understanding of their roles, responsibilities and escalation processes for staffing shortages and serious incidents. Inspectors observed a strong team culture, with staff supporting one another while working under sustained pressure.

Despite this, the service experienced ongoing workforce challenges. Staffing levels were consistently below establishment, with registered nurses and healthcare support workers frequently redeployed to support other areas. The ward was unable to use agency staff and relied on redeployment and bank cover, which affected continuity of care. Although skill mix was generally appropriate and patient acuity was considered when allocating care, staff reported they did not always have sufficient time to meet all care needs.

Staff supervision and appraisal systems were in place although appraisal completion rates were below expected levels at the time of inspection, improving shortly thereafter. Mandatory training compliance was high, but staff often completed training in their own time due to a lack of protected time. A wide range of development opportunities was available, including leadership progression, vocational qualifications and Welsh language training. However, staff were unable to demonstrate awareness of oxygen cylinder safety requirements, with no evidence of completed British Oxygen Company (BOC) training.

The ward culture was described as friendly, open and no-blame, with staff confident raising concerns through Datix and Duty of Candour arrangements understood and applied appropriately. While systems supported information governance, audit and quality improvement, low visibility of patient feedback and limited evidence of recent patient or family feedback being gathered, displayed and acted upon reduced assurance of sustained improvement.

This is what we recommend the service can improve:

- Staffing levels were consistently below establishment, with registered nurses and healthcare support workers frequently redeployed to other wards, affecting continuity and consistency of care

- Staff were unable to demonstrate awareness of governance and training requirements relating to oxygen cylinder safety and there was no evidence of completed BOC training
- Information on providing feedback was not clearly visible on the ward and there was no evidence of recent patient or family feedback being gathered, displayed or acted upon.

This is what the service did well:

- Structured governance processes were in place, including regular handovers, clinical risk meetings and clear escalation pathways, with visible and supportive leadership at ward and senior levels
- Staff were described as proud to work on the ward, with a strong team connection observed and a supportive, no-blame culture encouraging openness and collaboration
- Staff had access to a wide range of training and development, including leadership progression routes, vocational qualifications for HCSWs and support for students
- Electronic systems supported data collection, reporting and audit activity, with regular quality and safety meetings, review of performance measures and learning shared across the service.

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 five patients or their carers, responses were generally positive. They all rated the service as ‘good’ or ‘very good’, infection and prevention control measures were being followed and staff treated them with dignity and respect. However, patients or carers stated they could not speak to staff without being overhead by other patients and they did not always have access to a buzzer (call bell).

Patient comments included:

> *“Bedding changed daily.”*
>
> *“No buzzer as my bed was an unallocated bed meaning I couldn't call for help if needed.”*
>
> *“An issue with my belongings going missing transferring wards.”*
>
> *“Clean but too tight between beds. I find it hard to move safely.”*

In addition to the comments received from the completed surveys, the inspection team met with service users and their families in the unit at the time of inspection. Patients we spoke with were very positive about the care they have received.

Person-centred

Health promotion
Limited information was seen to support patients’ health and wellbeing. Only minimal dementia and oral-health materials were visible. No patient-friendly information was seen to help individuals understand their care and no materials were available for patients or carers to take away.

Sepsis information and smoking-cessation resources were not observed, in addition there was no information on bowel screening, breast screening, carer support and obesity. This information would be relevant to the patients in the ward. It was difficult to confirm whether patients were provided with relevant information due

to several of the patients on the ward being unable to engage fully. However, there was general information on corridor walls to wards C and D. This included information on safeguarding, preventing deconditioning and carers support.

The health board must ensure relevant information is displayed in the ward, including relating to how patients can maintain their physical and mental health along with other healthy living information.

Dignified and respectful care
Staff consistently treated patients with kindness, compassion and respect, and were observed communicating in a courteous and patient manner. Patients and relatives also reported that staff were kind and respectful.

However, the ward environment limited privacy and made discreet communication challenging. The lack of an appropriate room for confidential discussions meant that sensitive conversations often took place at the bedside, where the proximity of beds, the use of thin curtains and the fact that many patients were hard of hearing increased the likelihood of conversations being overheard. Staff handovers were undertaken at the central ward reception, which did not provide adequate privacy.

Overcrowding and restricted space around beds also affected dignity and safety, reducing ease of access and making it harder to maintain discretion. Staff sought to protect privacy where possible, for example by drawing curtains appropriately during personal care and closing doors to single rooms.

Patients appeared well cared for and were generally dressed in their own clothing, although this was mainly bedwear. We did notice some patients who were not wearing trousers or pyjama bottoms.

Concerns were also identified regarding confidentiality and property management. On one occasion, a relative was given information about the wrong patient during a discussion with a doctor, and on another, a patient's belongings were lost during transfer.

The health board must ensure:

- **The additional bed arrangements on the ward are reviewed to ensure patients' privacy and dignity are protected**

- **Staff check the identity of the relative to ensure the correct information is supplied about patients, providing the patient has given authorisation for that discussion**

- **Patients are dressed appropriately to maintain their dignity**

- **Greater care is taken when transferring personal items between areas of the hospital.**

Individualised care
Initiatives intended to support personalised care such as 'This is Me' were available on the ward but not actively used. 'Butterflies', to identify patients with dementia, were included on the daily handover sheet where required.

Patients we spoke with about their experiences on the ward were satisfied with care and appreciated staff efforts.

However, we did not see signage on toilet doors or within the ward environment to support patients with sensory or cognitive difficulties.

Walking aids were readily available and supported patient mobility, but there were no dedicated spaces for physiotherapy or occupational therapy. This limited opportunities for structured rehabilitation and may contribute to deconditioning.

Care planning relied heavily on generic templates and was not consistently personalised. Core instructions relating to urinary catheter care were not routinely completed, with documentation often limited to basic details such as catheter type and date of insertion. This reduced clarity about individual care needs and ongoing catheter management.

The health board must:

- **Complete documentation such as 'This is Me' and core instructions on urinary catheter care for relevant patients in full**

- **Ensure relevant signage is displayed to assist patients with sensory or cognitive difficulties**

- **Make space available for physiotherapy and occupational therapy to ensure patients are not deconditioned.**

Timely

Timely care
Patients generally received appropriate and timely support. However, staff explained competing care pressures and limited staffing sometimes made it

challenging to avoid rushing care. Several staff members reported staffing levels were frequently difficult, which affected their ability to provide timely emotional and practical support to patients.

Patients with the most urgent needs were prioritised, with staff responding quickly to call bells and focusing on infection control and end-of-life priorities when required. Patients with time-critical conditions were identified, prioritised and blood glucose monitoring and insulin administration were delivered promptly.

Medicines were generally administered in a timely and appropriate manner, including intravenous (IV) medications. Staff demonstrated compassionate care towards patients living with dementia, including during periods of distress. No patients appeared to be in pain at the time of observation.

One patient reported waiting a prolonged period for a monitoring machine to be turned off after it had been alarming, with staff unaware until the patient raised it. This occurred in an area where intentional rounding, a structured process of regular checks with patients, should have been undertaken. Some patients acknowledged the demands placed on staff and recognised immediate attention was not always possible.

The health board must ensure call bells and alarm bells are answered promptly by staff.

Equitable

Communication and language

The ward had limited resources to support people with hearing, visual or language needs. No hearing loop was available on the ward, although a large clock was present to aid orientation. The ward was well signposted from the main entrance.

Inspectors observed courteous, patient communication, including during challenging interactions with individuals living with dementia. However, a relative raised concerns about communication, reporting staff tended to provide information rather than listen. There was no evidence that staff routinely asked patients about their preferred language and a Welsh-speaking patient said they were not asked this during admission. Welsh language communication was observed only with a therapist, not with ward staff. No ‘iaith gwaith’ badges or other visual indicators of Welsh-speaking staff were seen during the inspection and bilingual information on the ward was minimal.

A list of staff available to support language barriers was held at the hospital switchboard and translation services could be used if needed. While a hearing loop

was available elsewhere in the hospital, the ward itself had no dedicated communication aids for people with sensory impairment.

Staff reported caring for people with dementia could present communication challenges. Dementia training formed part of the mandatory training programme and helped equip staff to support these patients, although environmental and resource limitations continued to impact communication.

The health board must ensure

- **The ward has access to a hearing loop for patients with hearing difficulties**

- **Relevant staff wear a 'iaith gwaith' badge to identify them as Welsh speakers**

- **More bilingual information is made available on the ward to ensure Welsh signage has an equal status with English signage on the ward in line with the Active Offer.**

Rights and Equality
There was a clear commitment to promoting equality and diversity. Staff and patients were protected from discrimination, with bullying and harassment policies in place and policies to support an inclusive environment and staff described working cohesively as a team. Equality and diversity training was available through the health board's electronic staff record (ESR), alongside Paul Ridd learning disability awareness training. The training gave staff awareness of the barriers faced by people with a learning disability when accessing healthcare, with additional support from the learning disability team. Quick response (QR) codes were available for feedback and dementia resources were accessible through the health board internet. The ward also worked collaboratively with the patient advice and liaison service (PALS).

Reasonable adjustments were evident for individuals with protected characteristics. The ward benefitted from ground-floor disabled access and wheelchair access. Whilst no recent staff adjustments had occurred, examples were provided where working hours and duties had been previously adapted to meet individual needs. Staff were aware of the importance of placing transgender patients appropriately and using their preferred pronouns.

Individual needs were considered during care. Spiritual and cultural support was available, which could be contacted through the hospital switchboard. Relatives were permitted to stay overnight when a patient was critically ill, although

facilities to support this were limited unless a patient could be moved to a cubicle during end-of-life care. Families and carers were encouraged to participate in care where appropriate, including assisting with feeding.

The ward lacked a dedicated relatives' room, the ward manager's office was used for confidential discussions when required.

The health board must make a dedicated room available for confidential discussions when these are required for both patients and their relatives or carers.

Patients and relatives were generally unaware of the formal complaints process. Information on Putting Things Right was visible, although no information relating to Llais was seen.

The health board must ensure information on Llais, the patient voice in health and social care, is prominently displayed and available to patients and their carers.

Delivery of Safe and Effective Care

Safe

Risk management
The ward environment presented potential safety concerns, primarily due to damaged flooring, overcrowding and cluttered spaces. General floor areas, particularly corridors and areas around the nurses' station were worn, torn and unable to be cleaned effectively, creating tripping hazards and infection control risks. Although the bed spaces themselves were clean and patients confirmed good hygiene standards, the wider environment was described as tired and unkempt, with cleaning impacted by the condition of the flooring.

The ward routinely operated above its designated 25-bed capacity, increasing to 29 beds (116%) with additional beds placed in already crowded bays. This resulted in restricted movement, insufficient space for safe access and reduced dignity for patients. While a basic risk assessment had been conducted, which highlighted that patients in these bays were subject to Do not attempt cardiopulmonary resuscitation (DNACPR) orders and beds six and seven were sharing access to oxygen and suction equipment, significant safety concerns remained. The use of surge beds undermined the ward's ability to maintain patient privacy, dignity and safety. This included an ongoing risk of patient falls due to the reduced space between beds. **These concerns were addressed through our immediate assurance process, as detailed in Appendix B.**

Some bed spaces lacked room for lockers, requiring relatives to store belongings under chairs. Visitors and relatives did not have adequate seating and frequently sat on patients' beds due to the limited number of chairs and a lack of space between beds.

The absence of a ward dining room or day room, activity resources, televisions, or rehabilitation areas contributed to an environment that could promote deconditioning. Essential facilities such as call bells were missing from some of the additional beds. Equipment, including hoists, was stored in corridors, further reducing safe access, particularly for elderly patients with dementia who might wander.

The health board must ensure:

- **There is sufficient space for safe access for patients and room for lockers to secure their personal possessions near their bed space**

- **Patients have quick access to call bells at their bedside**

- **Corridors are cleared of equipment to allow unrestricted movement for patients**

- **Patients have access to facilities and space to allow for physiotherapy and occupational therapy.**

Despite additional beds in various bays, patients and relatives consistently highlighted good cleanliness, including daily bedding changes. Nevertheless, the cumulative issues, environmental wear, clutter, lack of space, insufficient facilities and ongoing operational pressures, significantly impacted the ward's ability to maintain a safe, dignified and therapeutic environment.

Housekeeping areas were not always secure, chemicals on housekeeping trolleys were left unattended. The tea trolley with boiling water was also left unattended. These all posed safety risks. **This issue was addressed and resolved during the inspection and listed in Appendix A**.

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 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, online application groups, handover and email.

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. Learning was shared with staff through formal and informal mechanisms, including emails, messaging groups and regular staff meetings.

Infection, prevention and control (IPC)and decontamination
The ward was cluttered, overcrowded and difficult to clean, with damaged flooring and inadequate personal protective equipment (PPE) disposal. Additional beds, poor equipment labelling and limited isolation capacity increased infection risks despite generally robust cleaning processes. Staff demonstrated strong hand hygiene and PPE compliance, with adequate supplies and high audit scores. Healthcare support workers (HCSWs) and registered nurses (RNs) consistently demonstrated correct hand hygiene technique and were able to explain the six stages of handwashing. Staff displayed good understanding of infection control principles and used PPE appropriately, changing items between each patient

contact. PPE supplies, including gloves, aprons, masks and cleansing wipes, were readily available throughout the ward. The staff adhered to the bare below the elbow policy whilst on the ward. Staff wore facemasks when entering the post-Covid step-down area and a dedicated post-Covid bay remained in operation. Hand hygiene audits showed 100% compliance in February, with IPC training compliance reported at 91%.

The senior management team described a structured audit programme including IPC audits completed monthly, with daily reviews during periods of increased infection.

Although perimeter cleaning within bed spaces was satisfactory, the proximity of patients in two of the bays meant an ongoing risk of cross contamination due to the reduced space between beds, which were positioned at less than an arm's length apart.

Flooring throughout the ward was outdated, torn, lifted in places, damaged beyond basic repair and could not be cleaned effectively. The nurses' station surface was also made from the same deteriorated flooring material. This presented IPC risks, as well as slips, trips and falls hazards. Given a significant proportion of patients had cognitive impairments and mobility issues, this posed a significant risk to patient safety. **These concerns were addressed through our immediate assurance process, as detailed in Appendix B**.

Whilst personal protective equipment (PPE) was available and used correctly, there were no receptacles to 'doff' PPE other than in ward toilets. During our inspection there were several infectious patients and the lack of receptacles to 'doff' PPE increased the risk of cross-contamination. **These concerns were addressed through our immediate assurance process, as detailed in Appendix B.**

Although evidence was provided that several concerns had been reported to the estates department, relating to IPC issues and patient safety issues, remedial actions had not been completed and the issues remained outstanding. **These concerns were addressed through our immediate assurance process, as detailed in Appendix B**.

Housekeeping staff demonstrated strong awareness of cleaning responsibilities, were familiar with schedules and outbreak procedures and had access to appropriate equipment. Toilets required attention, with one staff toilet found littered with used paper towels and an overfilled orange clinical waste bag. Additionally, there were frequently issues with shortages of linen including towels and a lack of incontinence pads.

Items were disinfected using appropriate disinfectant wipes, then stored in a secure room and labelled with green tape to confirm cleaning. Infusion pumps, mattresses and commodes were cleaned between use. However, the drug trolley was observed moving between areas without being cleaned after entering or leaving an infected bay. Some equipment in the storage area was not labelled as clean, creating uncertainty regarding readiness for use.

Staff explained the correct process for washing infected linen. We noted two patients with Clostridium difficile were nursed in single rooms. However, the doors to these rooms remained open for extended periods and one patient's relative was present without PPE. Limited cubicle availability (only three on the ward) complicated isolation arrangements for infected patients.

Sharps devices were compliant with safety standards and sharps bins were correctly labelled, dated and stored. Staff were knowledgeable about the actions required following a needlestick injury. No infection-rate data was displayed on the ward for staff or patients.

IPC audits demonstrated improvement, with environmental audit scores increasing from 60% to 80% in recent months. Feedback was shared via an online application and morning handovers. Staff accessed IPC policies via the electronic Community of Interest Network (COIN) system, including details of the employee assistance programme. Staff immunisation records were maintained by Occupational Health.

The health board must ensure:

- **Staff toilets are cleaned regularly to ensure they do not pose an IPC risk**
- **Medication trolleys are cleaned appropriately**
- **The correct procedures are followed when nursing patients with infectious diseases**
- **Regular items used on the ward are available at all times**
- **Infection rate data is displayed in the ward for staff, patients and their carers to view.**

Safeguarding of children and adults
Patients spoken with reported they felt safe on the ward and those able to respond confirmed they could speak with staff if they were worried. Patients were identified as lacking capacity were subject to deprivation of liberty safeguards (DoLS). Some patients were admitted with existing DoLS authorisations.

Further review identified significant delays in DoLS assessments. One patient had their cognitive ability documented but no risk assessment completed on admission or thereafter and their DoLS form was three weeks out of date. Another patient's documentation was completed 48 hours after admission and another patient did not have an assessment until 15 days after admission. A further case showed a DoLS form three days out of date.

A total of eight patients were reported to have a DoLS in place but several had expired. Staff reported the DoLS team had advised that extensions were unnecessary for standard-risk patients due to capacity issues and feedback had not been received. The ward highlighted shortages of DoLS assessors, with interim monitoring arranged via email over weekends. Only one mental capacity assessment best interest decision was found in patients notes.

The health board must ensure DoLS documentation is completed when required in a timely manner. Any issues with lack of Supervisory Body response times must be added to the health board risk register.

Staff demonstrated a clear understanding of safeguarding procedures and were aware of organisational policies relating to children and vulnerable adults. Advocacy arrangements, including access to an Independent Mental Capacity Advocates (IMCAs), were available for patients lacking capacity. Staff described using less restrictive alternatives, such as conversation and diversionary activities, to avoid the need for DoLS where appropriate.

The ward environment was secure with locked doors and controlled visitor access.

Blood management
Systems to identify risks and ensure the safe, sufficient supply of blood and blood products were managed outside the ward, with the ward focusing on appropriate use. Alternatives to transfusion were promoted through iron infusions, supported by a specific checklist and all patients received anaphylaxis medication prior to transfusion. Staff confirmed blood products were ordered specifically for each patient.

All staff involved in transfusions were fully trained and competent, with checks embedded through the 'Right blood, right patient, right time', the Royal College of Nursing (RCN) guidance for improving transfusion practice. Incident forms were completed for internal and external reporting, including serious hazards of transfusion (SHOT). Ward meetings and handovers ensured investigation of events, implementation of actions and shared learning.

Management of medical devices and equipment
Staff described clear maintenance arrangements for the ward equipment. A medical electronics team was available on site during the day to service devices, maintain centralised logs and recall equipment when servicing was due. Beds and mattresses were serviced externally by their respective suppliers, with four items checked and in-date.

Staff reported essential equipment was generally available, although frequent faults with air-flow mattresses caused repeated disruptions to patient comfort and required multiple replacements per shift. The air flow mattresses were reported as being changed on the same patient several times a shift as they kept alarming and were clearly faulty.

A sample review confirmed equipment labelling generally showed the most recent service dates, although one item, a hoist, was overdue a service since January 2026, the ward manager was aware of this. Fault-reporting processes were effective, staff reported faults were raised through the ward receptionist, who logged and escalated issues. While faults were reported promptly, staff noted timely responses to repairs remained a challenge.

The health board must:

- **Investigate the issues with air flow mattresses to ensure they do not cause repeated disruptions to patient comfort and avoid multiple replacements per shift**

- **Ensure all equipment servicing is completed in a timely manner and that broken air flow mattress are appropriately bagged and tagged as broken or faulty.**

Medicines management
Medicines documentation was generally completed correctly. The All-Wales Drug Charts were accurately maintained, with each electronic chart containing the patient's full name, date of birth and registration number. Administration records were clear, including self-administered medication. Instances of refusal were also clearly recorded and no missed-dose concerns were noted during the observed round. When required, medicines could be accessed out of hours via the on-call pharmacist or neighbouring wards.

Prescribing and monitoring of oxygen was documented on the All-Wales Drug Chart, with clear target ranges recorded. However, no oxygen was being administered at the time of review, flow rate and delivery method were not

prescribed, though available within the protocol. Oxygen cylinders were available within the ward and adjacent corridor.

No IV fluids were prescribed at the time of inspection, although previous administration records were visible. Medicines administration was recorded contemporaneously and the medicines management policy was available online. All medicines, including controlled drugs, were stored securely in locked cupboards and trolleys. Controlled drugs were correctly recorded, stored in a locked room and checked daily, a random check during the inspection showed compliant entries. Stock checks were also completed, with records demonstrating appropriate dual signatures. Fridge temperatures were monitored and fridges remained locked.

During the observed medicines round, staff verified patient identity by requesting date of birth. Several patients, including two with cognitive impairment, were noted not to have patient identification bands in place. Given a significant proportion of the patient group had cognitive impairments, this presented a risk to patient safety, particularly in relation to the administration of medication, delivery of treatment and identification of allergy status. **These concerns were addressed through our immediate assurance process, as detailed in Appendix B.**

Staff were observed administering medicines safely, ensuring each patient had taken their medication before moving on. The electronic system did not flag late administration, which could lead to delays in time-critical medicines. One medication dose was not administered on an empty stomach as required, as breakfast had already been provided.

Medication patients brought with them was not always returned on discharge, including controlled drugs, which were held in a separate register for residents' own items. Drug trolleys were not left unattended. Pain management was inconsistently monitored. As required (PRN) prescriptions lacked meaningful instructions and pain assessment tools were rarely used due to accessibility challenges within a separate electronic system. Although analgesia was given, documentation did not consistently record the rationale, location of pain, or effectiveness.

The health board must ensure:

- **Time bound medication is given when prescribed**
- **Patients' own medication is returned to them on discharge**

- **Pain management is monitored including PRN medication pain assessment tools.**

Preventing pressure and tissue damage
The ward did not undertake pressure area audits, despite these being essential for assuring compliance with recognised standards and supporting early identification of risks.

The health board must ensure pressure area audits are completed regularly on the ward.

A review of five patient records showed pressure ulcer risk assessments were not consistently completed on admission, with only three patients assessed at the point of entry. One patient did not receive the required checks until three days after admission. **This concern was addressed through our immediate assurance process, as detailed in Appendix B.**

While initial assessments were inconsistent, all records demonstrated appropriate skin assessments and care plans were documented where indicated by risk levels. For patients requiring intervention, there was clear evidence of frequent repositioning both day and night and ongoing monitoring of pressure areas was completed for all five patients.

Falls prevention
The ward did not undertake falls audits, limiting its ability to monitor compliance with expected standards or identify areas for improvement. A review of five patient records showed significant inconsistency in the completion of falls risk assessments. Only two of the five patients had an assessment documented within an appropriate timeframe following admission. The remaining assessments were completed substantially later, including examples at six days and eighteen days post-admission, indicating a lack of timely evaluation for patients at risk. **This concern was addressed through our immediate assurance process, as detailed in Appendix B.**

Staff confirmed there was no specialist falls service available to support the ward. Where patients were identified as being at risk, documentation showed care plans were predominantly generic and did not always reflect individualised interventions. A patient who was at risk did not have an up-to-date, personalised plan in place to guide staff in implementing appropriate preventative measures.

Overall, the documentation demonstrated delayed assessments, limited access to specialist support and inconsistent care planning, reducing assurance that falls risks were being effectively identified and managed.

Effective

Effective care

Evidence indicated regular audit activity was undertaken across the ward areas, with monthly audits completed through electronic systems such as Audit Management and Tracking (AMAT) and Tendable, a quality assurance solution. These include core standards audits, IPC checks, care-specific audits and monitoring of areas such as hand hygiene. We were told audit outcomes were recorded and actions were generated as required, although in some areas audit results were not consistently displayed for staff or relatives.

The National Early Warning Score (NEWS2) and Sepsis Six were actively used and staff were aware of infection control responsibilities. Despite training and governance structures, staffing pressures and incomplete documentation limited assurance of consistently safe and effective care. However, patients and relatives, reported overall satisfaction with the care provided.

The ward used NEWS2 to support timely identification of potential sepsis. NEWS2 charts were completed from admission onwards, stored with paper records and standard observations were undertaken twice daily. Where a patient scored higher, the frequency of observations was increased. One example showed a patient scoring four, with observations repeated two hours later, showing improvement.

A sepsis pathway and the Sepsis Six care bundle were in place. However, the sepsis pathway booklet was not always completed thoroughly, with some actions lacking clarity. Staff reported there had not recently been a septic patient requiring full pathway completion. One individual case of confirmed sepsis had been managed appropriately, with the patient commenced on intravenous antibiotics in line with clinical guidance.

The health board must ensure the sepsis pathway booklet is completed thoroughly.

RNs completed immediate life support (ILS) level two training and annual sepsis training with compliance above 95% for active staff. Staff demonstrated understanding of sepsis indicators and were able to describe how they would manage a deteriorating patient in line with the NEWS2 trigger system and the Sepsis Six bundle.

Staff described ongoing staffing challenges, with frequent deficits affecting safe delivery of care. On some shifts only three RNs were available instead of four and one to one enhanced care was sometimes covered by a single HCSW responsible for an entire bay. Under the Nurse Staffing Levels (Wales) Act, planned staffing for the early shift was four RNs and five HCSWs. On the inspection the ward was two HCSWs below this level. Senior staff confirmed compliance was not achieved on the day. RNs reported caring for up to ten patients each. Concerns were raised about the number of student nurses, including seven on placement at once, with third-year students supporting first-years. Staff questioned the quality of the learning environment given the pressures. Some staff expressed sustained staffing shortages were contributing to stress and risk of sickness absence and two RNs reported deficits were common. Staff redeployment between the older persons assessment and liaison service, the acute medical unit and emergency department occurred daily, adding to inconsistency. **These concerns were addressed through our immediate assurance process, as detailed in Appendix B.**

Staff were familiar with accessing relevant clinical policies via the COIN system and understood how to access Nursing and Midwifery Council Record Keeping Guidance online.

The patient status at a glance board was broken, two screens at reception were normally used instead. The daily multidisciplinary huddle was held in a public area, raising concerns about confidentiality, as patient information could be overheard.

The health board must ensure the patient status at a glance board is repaired and the daily multidisciplinary huddle is held in a confidential area.

Although several issues were identified, in general both patients and relatives were satisfied with the overall level of care and appreciated the efforts of staff.

Nutrition and hydration

Patients were provided with a choice of food and drink. All patients and carers confirmed meal options were offered. Water jugs were covered, refreshed at least twice daily and positioned within easy reach, ensuring patients had access to fluids whenever required.

During the lunchtime food serving observed, food was delivered promptly to the ward. However, tables were not cleaned or cleared prior to serving and not all patients were appropriately positioned upright for eating, despite meals being

placed within reach. Hand wipes or handwashing prior to meals were not witnessed, which may affect mealtime hygiene standards. Additionally, we were told there was frequently a shortage of plates or cutlery to feed patients.

Meals were served by nursing staff, who dispensed food as quickly as possible on arrival of the food trolley. We were told despite these efforts, meals were not always served in a timely manner, as staff were often managing competing care pressures, including personal care needs and patient toileting requests. The requirement to assist patients with feeding further added to these delays.

Patient feedback on meal quality was mixed. Some patients reported meals were satisfactory, while others commented certain items, such as chips, were consistently cold. Observations indicated some dishes appeared unappetising, although alternatives such as jacket potato and beans were more acceptable. We were also told there were instances where insufficient sandwiches were provided for the patients in the evening.

The health board must ensure:

- **Patients' tables are cleaned and cleared prior to food serving**
- **Hand wipes are made available and handwashing is encouraged**
- **Food is served in a timely manner to ensure the food is hot, ideally by housekeeping staff or HCSW**
- **Sufficient cutlery and plates are available for patients at mealtimes**
- **Food is provided as required and requested for patients on the ward.**

The ward did not use the red tray system, which identified patients requiring assistance with eating. Instead, staff relied on verbal communication during handover, with RNs overseeing patients' nutritional support needs. No patients requiring assistance were identified during the inspection, the lack of a structured system may limit consistency in recognising support needs. The All-Wales Nutrition Pathway was in place and implemented as part of the Welsh Nursing Care Records (WNCR) programme.

Patient records

A review of five patient records showed inconsistent completion of mental capacity assessments, with only one of five patients assessed on admission. Records did include information on decisions around mental capacity and DoLS authorisations.

Nutritional assessments were inconsistently completed, with three of five patients assessed within 24 hours of admission. Monitoring of food and fluid intake was in place for one of three relevant patients. One patient requiring intervention did not have a care plan or referral to dietetics or the speech and language team. Oral care planning was also insufficient, with no oral care plan in place for one of four applicable patients. The review indicated concerns such as significant weight loss without ward-based weight recording or appropriate referral, delayed assessment of nutritional risk and one assessment completed ten days after admission. **These concerns were addressed through our immediate assurance process, as detailed in Appendix B.**

Where appropriate, sepsis screening had been undertaken and a sepsis pathway and Sepsis Six bundle were in place. Staff ensured consistent and effective clinical management and NEWS2 charts were used reliably as part of routine observations.

Three of five patients had their needs promptly assessed on admission and all patients had relevant risk assessments completed. Records reflected identified risks and the required actions. Language preference was both asked and documented for all patients.

Care provided was recorded in patient plans, with DNACPR decisions documented where relevant. DNACPR forms were completed appropriately, with correct signatures and the ward doctor showed a clear understanding of their responsibilities in holding sensitive best-interest discussions. Care planning was individualised, supported independence and showed evidence of discharge planning. One patient nearing discharge had appropriate support packages in place and was documented as medically fit.

Care effectiveness was regularly evaluated and four of five records were updated immediately after care. Handwriting was legible for two of four records reviewed and entries were consistently signed, dated and timed. Evidence of written handover and MDT contribution was present.

Records relating to continence needs were inconsistently completed on the two-hourly care documentation, making it difficult to assess whether appropriate support had been provided. A two-hourly safety-rounding tool was used to support routine care, although records were not always fully completed, with omissions noted in areas such as oral care and continence. Record keeping checked demonstrated clear accountability, accurate documentation and involvement of families where appropriate. However, nursing electronic records were often updated late in the day. Paper and electronic systems caused confusion, with care plans completed retrospectively.

The health board must ensure patient records are completed in full in a timely manner.

The inspection team also noted paper patient records were stored and left unattended in various locations throughout the unit, including in an unlocked patient records trolley, at the bedside and on counter tops. **This concern was addressed through our immediate assurance process, as detailed in Appendix B.**

Efficient

Efficient
There was clear multidisciplinary working within the ward. Daily multidisciplinary huddles took place. These huddles along with a thorough assessment of the patient and regular discharge planning meetings ensured information sharing and multidisciplinary involvement.

Admissions were managed centrally through the hospital's bed management system, meaning the ward had limited control over the criteria or timing of admissions. Staff from the older people's assessment unit contacted the ward up to three times a day to obtain bed status updates, demonstrating ongoing pressure on patient flow, as they sought available beds.

Significant challenges were reported regarding patient discharge processes. The allocation of social workers often took considerable time, with staff reporting delays of up to a month, depending on area. Additional delays occurred where patients required interventions before discharge, despite the patient being medically fit. At the time of review, 18 of 29 patients were medically fit for discharge but were awaiting either placement, care packages, or other external actions. A dedicated patient flow coordinator oversaw discharge activity across four wards and liaised closely with the ward team to progress discharge actions.

Several patients in one bay required enhanced observations. Documentation for eight patients showed no recorded oral care over a four-day period, indicating gaps in essential care monitoring. We observed some bays were managed under the 'Baywatch' system, where specific staff members were assigned to remain within a ward bay to closely monitor patients who had been identified as being at high risk of falling. However, these bays were not always adequately staffed, which meant staff could not consistently supervise these patients, thereby increasing the risk to their safety. **These concerns were addressed through our immediate assurance process, as detailed in Appendix B.**

Quality of Management and Leadership

Leadership

Governance and leadership

The service demonstrated structured governance arrangements, with regular handovers each morning and evening as well as engagement meetings such as band six discussion groups and clinical risk meetings. Staffing levels were considered stable across the service. However staff, particularly HCSWs, were regularly removed from the ward to cover other areas, adding to inconsistent care. Agency use was said to be rare, with bank staff mainly used to cover HCSW roles where available. Sickness levels were quite low and sickness was monitored through clinical board meetings.

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

Leadership presence across the wards was observed and reported as effective, with staff feeling engaged, informed and supported. Ward management felt supported by senior staff. Despite the issues raised in the report, the ward seemed well managed even though staff were busy. Additional oversight was provided through on-call senior managers. Staff and leaders reported confidence in their roles, being aware of their duties and responsibilities in line with their banding and awareness of escalation processes for staffing shortages and serious or major incidents, with clear lines of escalation identified.

Ward management expressed their pride of their staff working under extreme pressures. Staff were highly praised by all patients and we witnessed a strong team connection, with staff working together supporting one another

Workforce

Skilled and enabled workforce

Staff reported staffing levels were consistently below establishment, with a previous over-establishment affected by the loss of four RNs and four HCSWs to meet pressures in other wards. Sickness, maternity leave and financial restrictions further impacted the workforce and the ward was unable to use agency staff, relying instead on redeployment from other areas. We were told band seven staff and students occasionally undertook band two HCSW duties.

The skill mix was generally considered appropriate for patient need and the team, now three years established, was viewed as stable. It was noted that some nurses were less likely to escalate concerns if they felt unable to manage a patient. Acuity was considered when planning care and a fifth HCSW was allocated to provide one to one support where required. Staff reported they did not always have enough time to meet all care needs due to workload and staffing pressures.

Staff supervision and annual appraisals were in place, with completion monitored via ESR. Appraisal compliance was less than 65% at the time of the inspection, with completion rates confirmed to be 95% the week following the inspection. Challenges included sickness and limited managerial capacity to complete performance appraisal. Staff and management meetings were held monthly or bi-monthly, though attendance was affected by sickness. Meetings were minuted and shared via online applications. Learning from incidents was disseminated through meetings and the online applications and additional support or training was provided where needed. Ward management also attended daily morning meetings to discuss patient and bed capacity, acuity and staffing.

The health board must ensure performance appraisals for staff are completed annually and in a timely manner.

The ward culture was described as friendly, with positive feedback from doctors and students. Senior staff actively sought suggestions for improvement. Staff felt confident raising concerns, which were managed appropriately through Datix incident reporting.

Staff reported good access to training and development, particularly online modules. Mandatory training compliance was monitored through ESR at 90-95% although staff often completed modules in their own time or during night shifts. 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, SEPSIS, manual handling and resuscitation. We were told staff also had access to training to assist their personal development. Staff were required to complete e-learning for mandatory subjects, but no protected time was provided, meaning staff completed training at home without compensation.

The health board must ensure staff are given protected time to complete mandatory training.

Leadership development for band six to seven career progression opportunities were also available. HCSWs were offered National Vocational Qualifications (NVQs)

and a two-day development programme. Supervisors and assessors were in place to support students.

The health board provided Welsh language training, with several Welsh-speaking staff on the ward. Staff understood the importance of communicating with patients in their preferred language. Language requirements were considered during recruitment, with overseas nurses assessed through objective structured clinical examination (OSCE).

Staff were unable to demonstrate awareness of governance arrangements, reporting procedures, or training requirements relating to oxygen cylinder safety and there was no evidence clinical staff had completed the required British Oxygen Company (BOC) training.

The health board must ensure staff complete BOC oxygen cylinder training.

Culture

People engagement, feedback and learning
Information for patients and families on how to provide feedback was available. However, posters were not clearly visible, requiring individuals to look carefully to locate them. While basic feedback guidance was present, there was no evidence of recent patient or family feedback being gathered or acted upon and the ward no longer displayed a 'You said, We did' board, which previously demonstrated actions taken in response to service user views.

The health board must ensure the results of patient feedback are displayed on a 'You said, We did' board or similar.

Leaders were described as visible and approachable and staff reported understanding and supporting the organisation's vision and values. Staff at all levels felt encouraged to raise ideas or concerns, supported by what was described as a strong no-blame culture. Staff were aware of how to escalate whistleblowing concerns.

Staff reported being proud to work for the service, though they noted staffing pressures and financial constraints were affecting the quality of care. Some equipment was identified as not fit for purpose, including ripped office chairs and faulty patient lockers. The overall culture was said to focus on the wellbeing of staff and people using services.

The health board must ensure equipment used by staff is serviceable.

Staff reported feeling supported to raise concerns, work within a no-blame culture and contributed to service improvements. Staff confirmed the service had a Duty of Candour (DoC) policy, which they could describe clearly with incidents recorded through Datix. Staff described where the DoC had been enacted following an issue. Evidence reviewed showed the DoC had been applied appropriately through written communication, apologies and explanations of what went wrong, with disclosures meeting expected standards. Staff reported being encouraged to share concerns openly when harm had occurred. Staff were informed of the need to adhere to policy requirements.

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. Staff described using individual logins and accessing policies through the health board intranet and key safety information was cascaded through established channels.

Senior nursing staff completed digital audits and areas for improvement were identified through this process. Quality of care was also monitored through audits. Staff confirmed reportable data and notifications were submitted to external bodies as needed.

Learning, improvement and research

Quality improvement activities

The service demonstrated a commitment to learning and improvement. Staff described regular quality and safety meetings, routine audit activity and access to clinical guidelines. Feedback from concerns, complaints and incidents was used to inform change, with actions tracked through Datix and escalation routes in place via performance reporting to the clinical board and director of nursing.

Learning from incidents and reviews was shared with staff through feedback sessions and emails, and staff told us this approach was generally effective. Relevant staff and partner organisations were involved in investigations where required to support service improvements.

There was an Occupational Health and Staff Wellbeing Service at the health board which aimed to support employees and volunteers with their health and wellbeing. This included support with musculoskeletal and emotional health in the workplace.

Staff could self-refer to the service. Wellbeing information was circulated to staff, including details of the employee assistance programme.

While the ward did not currently participate directly in research activity, staff received updates related to investigations and reviews within the wider directorate. The inspection found enthusiasm for contributing to improvement efforts, but insufficient protected time limited the ability to embed learning systematically.

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. There was evidence of constructive engagement, coordinated planning, capacity management and cross-service escalation processes that directly affected both staff experience and patient care.

Many patients on the ward required complex referrals on discharge. Referrals to primary care, other hospitals for rehabilitation, social care requirements and ongoing care with specialist teams within the hospital were often made. Staff reported appropriate use of district nursing services where wound care or follow-up support was needed.

Partnership working contributed to promoting health and reducing inequalities, including involvement with DoLS, liberty protection safeguards (LPS) and the Court of Protection. Multidisciplinary collaboration was strong, with daily huddles informing shared care planning and discharge considerations.

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
Housekeeping areas were not always secure, chemicals on housekeeping trolleys were left unattended. The tea trolley with boiling water was also left unattended.	These all posed significant health and safety risks to the patients if ingested.	The ward manager and housekeeping staff were informed.	The chemicals were secured on the ward and the tea trolley was moved to a safe location outside the ward.

Appendix B – Immediate improvement plan

Service: Ward D, Morriston Hospital
Date of inspection: 17 and 18 March 2026

The table below includes any immediate non-compliance 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 found that patient identification bands were not in place for all patients. Given that a significant proportion of the patient group had cognitive impairments, this presented a risk to patient safety, particularly in relation to the administration of medication, delivery of treatment and identification of allergy status.	The health board must ensure that all patients have patient identification bands, or where this is not possible, this must be risk assessed and mitigation of risk recorded.	Safe and Effective Care Medications Management	• Ensure 100% compliance with patient ID bracelet use. • Embed ID checks into everyday nursing practice. • ID bracelet presence and accuracy to be checked at every handover and documented in WNCR. • Ward Manager/ Sister to conduct weekly spot checks with monthly formal audits on AMaT.	Ward Manager & Matron	Completed 1st April 2026 1st April 2026

				• For patients with dementia or confusion who are unable to tolerate a name bracelet on their arm, consider an alternative location such as the ankle. If the patient will not tolerate wearing it at all, secure the bracelet to the bed frame. This must be clearly documented in WNCR and reviewed daily.		
2.	HIW was not confident that patient safety was consistently upheld. The ward was regularly operating above its intended capacity, reaching 116%. For example, one bay contained six beds instead of the usual four and another bay had seven beds rather than six. This adjustment increased the ward's total capacity from 25 to 29 beds. While a basic	The health board must • Review the use of surge beds on the ward to ensure that patients' privacy, dignity and safety are maintained and that infection prevention and control arrangements are effective • Ensure that staffing levels consistently meet	Safe and Effective Care – Risk Management and Effective Care	• Risk assessments were previously completed for the two additional bed spaces used as surge capacity in Bay 2 and Bay 4. These bed spaces have now been removed from the list of acceptable surge capacity options. • A daily safe-staffing assessment is undertaken	HoN Ward Manager	Complete Complete

	risk assessment had been conducted, which highlighted that patients in these bays were subject to Do not attempt cardiopulmonary resuscitation (DNACPR) orders and that beds six and seven were sharing access to oxygen and suction equipment, significant safety concerns remained. The use of surge beds undermined the ward's ability to maintain patient privacy, dignity and safety. This included an ongoing risk of patient falls due to the reduced space between beds. We observed that some bays were managed under the 'Baywatch' system, where specific staff members are assigned to remain	agreed safe staffing requirements		across all clinical areas, supported by internal directorate huddles each morning to review risks, patient acuity and staffing gaps. This enables early redeployment and timely mitigation. • This intelligence informs the twice-daily site staffing meetings, a designated Matron for AECHO attends covering staffing for that day. The hospital-wide position is reviewed alongside flow pressures. This process supports coordinated actions such as staff reallocation, escalation to the Head of Nursing for bank approval and where required, escalation to the Health Board executive team for consideration of agency use. A hospital-wide action plan underpins this process, ensuring consistent risk oversight and a real-time response to emerging pressures. Any outcomes are	Matron Lead for Staffing	Complete

	within a ward bay to closely monitor patients who have been identified as being at high risk of falling. However, these bays were not always adequately staffed, which meant that staff could not consistently supervise these patients, thereby increasing the risk to their safety.			fed back to Ward Managers via the staffing Matron identified for that day. • The Head of Nursing undertakes weekly scrutiny of all staff unavailability, including sickness, annual leave, study leave and other absences, to ensure early identification of risks to safe staffing. • A formal monthly workforce review is led by the Head of Nursing, focusing on recruitment, retention, vacancies and trends in absence. This enables proactive workforce planning and timely mitigation actions to maintain safe staffing levels.	Head of Nursing Head of Nursing	Complete Complete
		• Ensure that student nurses are only used for their intended purposes		• Student Nurses are rostered to work alongside their designated registrant mentors. Student nurses are not rostered to cover staffing	Ward Manager	Complete

				gaps or replace substantive roles. • Student nurses on induction to the ward to be made aware to escalate to the Nurse in Charge/Ward Manager if they feel they are being expected to work inappropriately outside of their scope as a student nurse. Concerns will be addressed in real time. • Student nurses participate in the delivery of fundamental care to support their ongoing skills development, as per NMC requirements. • Encourage feedback from student nurses – ward to develop a feedback tool to monitor student nurse experiences on Ward D. Information to be collated by Ward Manager and fed back through AECHO governance meetings.	Ward Manager Ward Manager Ward Manager	1st April 2026 Complete 26th April 2026

		• Ensure that comprehensive and documented risk assessments are in place to manage overcrowding, including consideration of patients' DNACPR status and other identified risks.		• Endeavour to ensure that student nurses are allocated across all shifts, avoiding clustering multiple students on any one shift where possible, while also taking into account student preferences and ensuring they work alongside their assigned mentors. • A risk assessment has been completed for the additional capacity on Ward D. All rooms are now 6 beds, with no additional patients in non-defined bed spaces. Room 1 was reduced to 4 patients when setting up the ward (25 pts in total) to create more space, however, the room is set up to accommodate 6 patients with bed head services for 6 beds. The 2 additional surge patients for Ward D will be housed in Room 1	Ward Manager Head of Nursing Ward Manager	Complete Complete Complete

				2 Ward D is a 25b NSA ward and staffing/skill mix is reviewed formally twice per year. Daily staffing reviews of patient need with regards to staffing are escalated to the daily AECHO staffing huddle (as outlined above).		
3.	HIW was not assured that patient safety was always maintained due to immediate environmental and health and safety risks. Flooring throughout the ward was outdated, torn, lifted in places, damaged beyond basic repair and could not be cleaned effectively. This presented infection prevention and control (IPC) risks, as well as slips, trips and falls hazards. Given that a significant proportion of patients had cognitive	The health board must ensure that: • Estate requests are actioned and completed in a timely manner and must include repair or replacement of flooring, to an acceptable standard, allowing for effective cleaning and mitigation of the risk of slips, trips or falls • Receptacles to dispose of PPE are suitably placed to avoid	Delivery of safe and effective care – Environment and IPC.	• Proposed project plan received from Capital planning and Estates for flooring replacement. • Keep corridor area clutter free as possible given storage constraints to help minimise risk and support daily review of floor by Nurse in charge. • An order will be raised for additional PPE disposal receptacles via Oracle. In the meantime, as an interim	Service Manager Ward Manager Ward Manager	26th April 2026 Daily Review Complete

	impairments and mobility issues, this posed a significant risk to patient safety. Whilst personal protective equipment (PPE) was available and used correctly, there were no receptacles to 'doff' PPE other than in ward toilets. During our inspection there were several infectious patients and the lack of receptacles to 'doff' PPE increased the risk of cross-contamination. The proximity of patients in two of the bays meant an ongoing risk of cross contamination due to the reduced space between beds, which were positioned at less than an arm's length apart. Although evidence was provided that several	cross-contamination on the ward • Bed capacity must be re-visited to ensure IPC issues can be addressed due to proximity of beds • Housekeeping staff are enabled to clean the ward sufficiently to maintain appropriate IPC.		measure, we will seek to repurpose suitable bins from decommissioned or unused areas to ensure adequate provision across the ward. • Risk assessments have been completed and the number of surge beds has been reduced accordingly to ensure safety and compliance with IPC requirements. • Housekeeping staff will continue to be supported to clean the ward to the required IPC standard. This will be monitored via monthly environmental IP&C audits recorded on AMaT. A lack of suitable storage space on the ward and across the wider site, remains a challenge, with limited areas available to store essential equipment. As an interim measure, efforts will focus on reducing clutter, improving organisation and ensuring	HoN Ward Manager	Complete Complete

	concerns had been reported to the estates department, relating to IPC issues and patient safety issues, remedial actions had not been completed and the issues remained outstanding.			handrails and key circulation routes remain fully accessible to support both IPC compliance and patient safety.		
4.	Although staff indicated that tools such as 'This is Me' were available to help patients express their needs and preferences to healthcare professionals, these resources were not being utilised. In addition, risk assessments, including those for falls prevention, pressure area care, capacity and nutrition/hydration were accessible but were frequently not used. Upon reviewing patient records, it was evident that several risk	The health board must ensure that: • Assessments of need are completed on the admission of all patients and reviewed when required	Delivery of safe and effective care – Risk Management and Patient Records Management and Leadership - – Governance	1. Deliver short refresher training sessions (10–15 mins at handover or safety huddles) focusing on: • How to complete each assessment in the digital system. • Why accuracy matters for patient safety and flow. 2. Identify "Documentation Champions" within the ward to support colleagues.	Ward Manager Ward Manager	Partially complete 26th April 2026 26th April 2026 Complete

	assessments were either not completed at all or only undertaken between day three and day fifteen of admission. The inspection team also noted that paper patient records were stored and left unattended in various locations throughout the unit, including in an unlocked patient records trolley, at the bedside and on counter tops.			3. Ensure computers on wheels are available and functioning to allow real-time documentation. 4. Nurse in Charge to complete a quick daily review with a weekly spot audit capturing: • Percentage of patients with complete documentation. • Any omissions and reasons (e.g., IT issues, patient deterioration) • Real-time identification of gaps and ability to act quickly. • Share audit findings with staff at daily huddles. 5. Provide direct feedback to individuals where omissions are recurring: • Supportive discussion first • Escalate via line management if persistent	Ward Manager Ward Manager Ward Manager	12th April 2026 1st April 2026

				non-compliance despite support, 6. During handover, Nurse in Charge confirms all admission assessments are complete or identifies who will complete them promptly.	Ward Manager	1st April 2026
		Patient records are stored securely at all times.	General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018	• The notes trolley has been repaired and is now fully compliant for secure storage of patient records, ensuring confidentiality is maintained at all times	Ward Manager	Complete
				• Email communication will be issued to medical, nursing and administrative staff to reinforce the importance of GDPR compliance and ensuring all confidential patient information is securely stored at all times.	Ward Manager	Complete
				Regular audits and spot checks will be undertaken to ensure compliance with secure storage of patient	Ward Manager	1st April 2026

				records and GDPR requirements. Any gaps identified in the documentation will be addressed immediately.		

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): **Dr. Mark Ramsey**
Job role: **Service Group Director**
Date: **26th March 2026**

Appendix C - Improvement plan

Service: Ward D, Morriston Hospital
Date of inspection: 17 and 18 March 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.	Limited information was seen to support patients' health and wellbeing. Only minimal dementia and oral-health materials were visible. No patient-friendly information was seen to help individuals understand their care and no materials were available for patients or carers to take away.	The health board must ensure relevant information is displayed in the ward, including relating to how patients can maintain their physical and mental health along with other healthy living information.	Health promotion	• Materials will be obtained relevant to the Ward D cohort of patients to reflect health and wellbeing and a holistic approach to patient care. • To ensure continuity, this will be added to the monthly audit moving forward. Request to create a Ward Core Audit – Patient Information as part of monthly Ward Audit assurance checks	Ward Manager Head of QS&PE	31/05/2026 **Completed**

2.	The ward environment limited privacy and made discreet communication challenging. The lack of an appropriate room for confidential discussions meant that sensitive conversations often took place at the bedside, where the proximity of beds, the use of thin curtains and the fact that many patients were hard of hearing increased the likelihood of conversations being overheard. Staff handovers were undertaken at the central ward reception, which did not provide adequate privacy. Staff sought to protect privacy where	The health board must ensure: • The additional bed arrangements on the ward are reviewed to ensure patients' privacy and dignity are protected • Staff check the identity of the relative to ensure the correct information is supplied about patients, providing the patient has given authorisation for that discussion • Patients are dressed appropriately to maintain their dignity	Dignity and Respect	• Two beds removed as per the **Immediate Action** plan to support a greater distance between beds • Reinforce identity checking procedures for relatives before any info is shared. Ensure patient consent is recorded **Assurance checks undertaken as part of monthly Ward Audit Q89** • It is embedded practice to ensure all patients are dressed to support daily routine. Provide a short refresher briefing to reinforce patient dignity and appropriate dress – **Assurance checks undertaken part of monthly Ward Audit Q71 & Matron Audit Q16**	AECHO Head of Nursing Ward Manager Matron	**Complete** 31/05/2026 30/06/2026

	possible, for example by drawing curtains appropriately during personal care and closing doors to single rooms. We did notice some patients who were not wearing trousers or pyjama bottoms. Concerns were also identified regarding confidentiality and property management.	• Greater care is taken when transferring personal items between areas of the hospital.		• Property checklist is business as usual but will ensure greater focus in delivery – monthly assurance checks to be established • Request to include explicit check for Patient's Property List completion within Core Ward Audit - Governance	Ward Manager/ Matron Head of QS&PE	30/06/2026 **Completed**
3.	Initiatives intended to support personalised care such as 'This is Me' were available on the ward but not actively used. We did not see signage on toilet doors or within the ward	The health board must: • Complete documentation such as 'This is Me' and core instructions on urinary catheter care for relevant patients in full	Individualised Care	• 'This is Me' is in place but will be reviewed/ reinforced/ rejuvenated to include urinary catheter care bundle • Dementia friendly signage to be ordered and displayed	Practice Educator/Matron Elderly Care Service Manager	30/06/2026 30/06/2026

	environment to support patients with sensory or cognitive difficulties. There were no dedicated spaces for physiotherapy or occupational therapy. This limited opportunities for structured rehabilitation and may contribute to deconditioning. Core instructions relating to urinary catheter care were not routinely completed, with documentation often limited to basic details such as catheter type and date of insertion.	• Ensure relevant signage is displayed to assist patients with sensory or cognitive difficulties • Make space available for physiotherapy and occupational therapy to ensure patients are not deconditioned.		• Overcrowding reduced due to the removal of two beds, increasing space for therapy colleagues to function and reduce de-conditioning **Ability to create dedicated space for reablement, within an acute care facility is limited and for Ward D is constricted by pre-exiting infrastructure** • HIW Observations to be shared across Health Board to inform bed rationalisation exercise being carried	AECHO Head of Nursing **Associate Service Director**	**Completed** 31/05/2026
4.	One patient reported waiting a prolonged period for a	The health board must ensure call bells and alarm bells are	Timely care	• Immediate action and resolution to patient reported issue	Matron	**Completed**

	monitoring machine to be turned off after it had been alarming, with staff unaware until the patient raised it. This occurred in an area where intentional rounding, a structured process of regular checks with patients, should have been undertaken.	answered promptly by staff.		• Reinforce intentional "rounding" process with staff along with visible leadership from nurse in charge. This will include monitoring of call bell response **Assurance checks undertaken as part of monthly Matron Audit Q14**	Ward Manager	31/05/2026
5.	The ward had limited resources to support people with hearing, visual or language needs. No hearing loop was available on the ward. There was no evidence that staff routinely asked patients about their preferred language and a Welsh-speaking patient said they were	The health board must ensure • The ward has access to a hearing loop for patients with hearing difficulties • Relevant staff wear a 'iaith gwaith' badge to identify them as Welsh speakers • More bilingual information is made available on the ward	Communication and language	• Hearing loop to be ordered **Assurance checks undertaken as part of monthly Matron Audit Q30** • Reinforced "Active Offer" of services and assessments in the Welsh Language including the use of a 'iaith gwaith' badge and bi-lingual public patient information including signage and posters	Service Manager Matron	30/06/2026 30/06/2026

	not asked this during admission. No 'iaith gwaith' badges or other visual indicators of Welsh-speaking staff were seen during the inspection and bilingual information on the ward was minimal.	to ensure Welsh signage has an equal status with English signage on the ward in line with the Active Offer.		**Assurance checks undertaken as part of monthly Matron Audit Q28**		
6.	The ward lacked a dedicated relatives' room, the ward manager's office was used for confidential discussions when required.	The health board must make a dedicated room available for confidential discussions when these are required for both patients and their relatives or carers.	Rights and Equality	**Ward D does not have the infrastructure to provided a dedicated relatives room within the ward.** Dedicated space for the bereavement service is available, and appropriate rooms can be booked. • Staff to be reminded that where possible confidential conversation should be planned and, in some cases, an appropriate room booked e.g. for	Matron	31/05/2026

				listening to people discussion or best interest meeting		
7.	Patients and relatives were generally unaware of the formal complaints process. Information on Putting Things Right was visible, although no information relating to Llais was seen.	The health board must ensure information on Llais, the patient voice in health and social care, is prominently displayed and available to patients and their carers.	Rights and Equality	• Listening to People process now in place – The Health Board has received national posters and leaflets (May 2026), which will be distributed across hospital site when made available • Health Board to make contact with Llais in order to access approved patient information, for public display	Head of QS&PE Head of QS&PE	30/06/2026 30/06/2026
8.	Some bed spaces lacked room for lockers, requiring relatives to store belongings under chairs. Visitors and relatives did not have adequate seating and frequently sat on patients' beds due to the limited number of	The health board must ensure: • There is sufficient space for safe access for patients and room for lockers to secure their personal possessions near their bed space	Risk Management	• Resolved by removing two beds from Ward D as part of the Immediate Actions • All beds have co-located lockers and chairs • All bed spaces have call bells as per Immediate Action	AECHO Head of Nursing Ward Manager Ward Manager	**Completed** **Completed** **Completed**

	chairs and a lack of space between beds. The absence of a ward dining room or day room, activity resources, televisions, or rehabilitation areas contributed to an environment that could promote deconditioning. Essential facilities such as call bells were missing from some of the additional beds. Equipment, including hoists, was stored in corridors, further reducing safe access, particularly for elderly patients with dementia who might wander.	• Patients have quick access to call bells at their bedside • Corridors are cleared of equipment to allow unrestricted movement for patients • Patients have access to facilities and space to allow for physiotherapy and occupational therapy.		• Additional storage solution installed since HIW inspection Please refer to Point 3 in relation to reablement capacity	Matron	**Completed**
9.	Toilets required attention, with one staff toilet found littered with used paper towels and an	The health board must ensure: • Staff toilets are cleaned regularly to	IPC	• The cleaning of Staff toilets on Ward D escalated to Facilities. **Ward Manager to maintain daily review**	Ward Manager	**Completed**

	overfilled orange clinical waste bag. Additionally, there were frequently issues with shortages of linen including towels and a lack of incontinence pads. The drug trolley was observed moving between areas without being cleaned after entering or leaving an infected bay. Some equipment in the storage area was not labelled as clean, creating uncertainty regarding readiness for use. We noted two patients with Clostridium difficile were nursed in single rooms. However, the doors to these rooms remained open for extended periods and one	ensure they do not pose an IPC risk • Medication trolleys are cleaned appropriately • The correct procedures are followed when nursing patients with infectious diseases • Regular items used on the ward are available at all times • Infection rate data is displayed in the ward for staff, patients and their carers to view.		• Re-enforce expected IP&C standards for equipment moved between clinical areas within the ward • Outcome from monthly IP&C assurance audits (Standard Precautions in Care Environment) to be monitored and actions taken in response to deficits • Routine IP&C equipment/stock checks in place **Assurance checks undertaken as part of monthly Matron Audit Q102** • Audit results and data to be displayed on our 'How Are We Doing' board. Info to be refreshed and maintained	Ward Manager Ward Manager Ward Manager Ward Manager	**Completed** **Completed** 31/05/2026 31/05/2026

	patient's relative was present without PPE. Limited cubicle availability (only three on the ward) complicated isolation arrangements for infected patients. No infection-rate data was displayed on the ward for staff or patients.			**Linked to actions within Point 1**		
10	A total of eight patients were reported to have a DoLS in place but several had expired. Staff reported the DoLS team had advised that extensions were unnecessary for standard-risk patients due to capacity issues and feedback had not been received. The ward highlighted shortages of DoLS	The health board must ensure DoLS documentation is completed when required in a timely manner. Any issues with lack of supervisory body response times must be added to the health board risk register.	Safeguarding	• Provide assurance of compliance with DOLS documentation, including expiry dates via census audit **Ongoing assurance via monthly Ward Core Audit (Governance) Q25** DOLS documentation is required to be lodged with the Supervisory Body (this function is performed by the Health Board Primary Community & Therapies (PCT) Service	Deputy Head of Nursing	31/05/2026

	assessors, with interim monitoring arranged via email over weekends. Only one mental capacity assessment best interest decision was found in patients notes.			Group), who will then provide confirmation of receipt • There is a risk already recorded within the PCT risk register. The Service Group will discuss and share information with colleagues in PCT to support update of the register entry, if required.	Deputy Head of Nursing	31/05/2026
11	Staff reported essential equipment was generally available, although frequent faults with air-flow mattresses caused repeated disruptions to patient comfort and required multiple replacements per shift. A sample review confirmed equipment labelling generally showed the most	The health board must: • Investigate the issues with air flow mattresses to ensure they do not cause repeated disruptions to patient comfort and avoid multiple replacements per shift • Ensure all equipment servicing is completed in a timely manner and that	Management of medical devices and equipment	Long-term HB wide Bed Contract has been delayed and as a result there have been failures in supply • Health Board wide Bed Contract to be progressed including Director of Finance sign-off which will enable timely replacement and servicing • Equipment requiring servicing, taken out of use and alternative	HB Procurement/ HB Finance Ward Manager	**Completed** **Completed**

	recent service dates, although one item, a hoist, was overdue a service since January 2026, the ward manager was aware of this.	broken air flow mattress are appropriately bagged and tagged as broken or faulty.		equipment access put into place • Escalate Hoist Servicing requirement to HB Manual Handling Lead and seek assurance in relation to service monitoring	Head of QS&PE	**Completed**
12	One medication dose was not administered on an empty stomach as required, as breakfast had already been provided. Medication patients brought with them was not always returned on discharge, including controlled drugs, which were held in a separate register for residents' own items. Pain management was inconsistently	The health board must ensure: • Time bound medication is given when prescribed		• Ensure that the administration of timed medications is included within base-line medicines management education packs **Reinforced through written guidance** • Remind all Ward managers of the importance of including critical medications within clinical handover and daily huddles. • Reinforce the Patients Own Medication (POM) process from admission	Practice Development Nurse Deputy Head of Nursing AECHO Matron/Ward Manager	31.05.2026 31/05/2026 31/05/2026

	monitored. As required (PRN) prescriptions lacked meaningful instructions and pain assessment tools were rarely used due to accessibility challenges within a separate electronic system. Although analgesia was given, documentation did not consistently record the rationale, location of pain, or effectiveness.	• Patients' own medication is returned to them on discharge • Pain management is monitored including PRN medication pain assessment tools.		to discharge. Including clear documentation of patient own Controlled medication. Ensure discharge checklist is complete, which includes the return of POM's. **Assurance checks undertaken as part of monthly Ward Audit Q82** • Include targeted education supported by PDN also reinforcing pain assessment tools available through WNCR and NEWS. • Patient safety incidents involving medicines management included in monthly Q&S Reporting	Practice Development Nurse Head of QS&PE	30/06/2026 **Completed**
13	The ward did not undertake pressure area audits, despite these being essential for assuring compliance with recognised standards	The health board must ensure pressure area audits are completed regularly on the ward.	Preventing pressure and tissue damage	As part of the monthly Core Ward (Nursing Standards/Documentation) Audits there is a requirement to review 5 sets of patient notes to establish "Have patients been assessed for their risk of pressure damage	Ward Manager/ Matron	**Completed**

	and supporting early identification of risks.			on admission/transfer to the ward/unit and appropriate action taken?" Q79 **Assurance check undertaken via monthly Matron Audits Q52**		
14	The sepsis pathway booklet was not always completed thoroughly, with some actions lacking clarity.	The health board must ensure the sepsis pathway booklet is completed thoroughly.	Preventing pressure and tissue damage	As part of the monthly Core Ward (Acute Deterioration Early Warning Chart Review) The following test is required "Was a sepsis screening form completed appropriately as indicated on chart?" Q17 **Assurance check undertaken via monthly Matron Audits Q52, Q98, Q100**	Ward Manager/ Matron	**Completed**
15	The patient status at a glance board was broken, two screens at reception were normally used instead. The daily multidisciplinary huddle was held in a public area, raising concerns about confidentiality, as	The health board must ensure the patient status at a glance board is repaired and the daily multidisciplinary huddle is held in a confidential area.	Effective Care	• Escalate to IT colleagues to fix / replace the screen	Service Manager	31/07/2026

	patient information could be overheard.					
16	Tables were not cleaned or cleared prior to serving and not all patients were appropriately positioned upright for eating, despite meals being placed within reach. Hand wipes or handwashing prior to meals were not witnessed, which may affect mealtime hygiene standards. Additionally, we were told there was frequently a shortage of plates or cutlery to feed patients. Meals were served by nursing staff, who dispensed food as quickly as possible on arrival of the food	The health board must ensure: • Patients' tables are cleaned and cleared prior to food serving • Hand wipes are made available and handwashing is encouraged • Food is served in a timely manner to ensure the food is hot, ideally by housekeeping staff or HCSW • Sufficient cutlery and plates are available for patients at mealtimes	Nutrition and hydration	• Introduce a premeal checklist to include, decluttering and cleaning patient tables. Offering handwashing wipes pre meals. • Review staffing tasks during mealtimes to reduce competing priorities. Reinforce protected mealtimes. • Liaise with Catering colleagues to ensure that sufficient cutlery and plates are available at mealtimes • Escalate HIW finding related to dietary requirements to HB Nutrition & Hydration Improvement Group.	Ward Manager Ward Manager Ward Manager Head of QS&PE	30/06/2026 30/06/2026 31/05/2026 **Completed**

	trolley. We were told despite these efforts, meals were not always served in a timely manner, as staff were often managing competing care pressures. Patient feedback on meal quality was mixed. Some patients reported meals were satisfactory, while others commented certain items, such as chips, were consistently cold. Observations indicated some dishes appeared unappetising, although alternatives such as jacket potato and beans were more acceptable. We were also told there were instances where insufficient sandwiches were provided for the	• Food is provided as required and requested for patients on the ward.				

	patients in the evening.					
17	Records relating to continence needs were inconsistently completed on the two-hourly care documentation, making it difficult to assess whether appropriate support had been provided. A two-hourly safety-rounding tool was used to support routine care, although records were not always fully completed, with omissions noted in areas such as oral care and continence. Record keeping checked demonstrated clear accountability, accurate documentation and involvement of families where	The health board must ensure patient records are completed in full in a timely manner.	Patient Records	• Reinforce the requirement for contemporaneous documentation to ensure that current patient continence needs are adequately reflected As part of the monthly Core Ward (Nursing Standards/Documentation) documentation on patient's continence needs including evidence of co-production with the patient Q18, Q21, Q23 and Q25 **Assurance check undertaken via monthly Matron Audits Q52**	Ward Manager	31/05/2026

	appropriate. However, nursing electronic records were often updated late in the day. Paper and electronic systems caused confusion, with care plans completed retrospectively.					
18	Staff supervision and annual appraisals were in place, with completion monitored via ESR. Appraisal compliance was less than 65% at the time of the inspection, with completion rates confirmed to be 95% the week following the inspection.	The health board must ensure performance appraisals for staff are completed annually and in a timely manner.	Skilled and enabled workforce	• PADR plan put in place and Ward now at 95% compliance. Ensure a robust PADR plan is maintained, allocate protected time for good quality appraisals to be undertaken.	Ward Manager	**Complete**
19	Staff were required to complete e-learning for mandatory subjects, but no protected time was provided, meaning staff completed	The health board must ensure staff are given protected time to complete mandatory training.	Skilled and enabled workforce	Training Reports are routinely available monthly providing compliance against Mandatory Training • Mandatory training time to be rostered for each	Deputy Head of Nursing.	31.06.2026

	training at home without compensation.			individual member of staff to provide dedicated time for completion		
20	Staff were unable to demonstrate awareness of governance arrangements, reporting procedures, or training requirements relating to oxygen cylinder safety and there was no evidence clinical staff had completed the required British Oxygen Company (BOC) training.	The health board must ensure staff complete BOC oxygen cylinder training.	Skilled and enabled workforce	Use of oxygen cylinders within Ward D has been reduced following the removal of additional temporary bed capacity. All beds within Ward D now have bedside pumped oxygen With reference to **NHS Wales Patient Safety Notice PSN041(March 2018) Risk Of Death And Severe Harm From Failure To Obtain And Continue Flow From Oxygen Cylinders harm** • Confirm HB training programme in support of PSN041 and confirm compliance across Morriston Service Group	Head of QS&PE	31/05/2026
21	While basic feedback guidance was present, there was no evidence of recent patient or	The health board must ensure the results of patient feedback are displayed on a 'You	People engagement, feedback and learning	• Audit results and data to be displayed on our 'How Are We Doing'	Ward Manager	31/05/2026

	family feedback being gathered or acted upon and the ward no longer displayed a 'You said, We did' board, which previously demonstrated actions taken in response to service user views.	said, We did' board or similar.		board. Info to be refreshed **Linked to actions within Point 1**		
22	Some equipment was identified as not fit for purpose, including ripped office chairs and faulty patient lockers.	The health board must ensure equipment used by staff is serviceable.	People engagement, feedback and learning	• Service Manager in conjunction with Ward Manager to undertake a review of non-clinical equipment and replace as necessary.	Service Manager	30/06/2026

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): Ceri Matthews

Job role: Group Nurse Director, Morriston Service Group Date: 29th May 2026