Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Ablett Unit, Betsi Cadwaladr University Health Board

Inspection date: 27 – 29 April 2026

Publication date: 30 July 2026

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our **website** or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or Via:

Phone: 0300 062 8163
Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-80853-093-7

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

Our Purpose

We check the safety and quality of healthcare across Wales.

Our Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

Our Values

We place people at the heart of what we do.

We are:

Independent – we are impartial, deciding what work we do and where we do it.

Objective - we are reasoned, fair and evidence driven.

Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find.

Inclusive - we value and encourage equality and diversity through our work.

Proportionate - we are agile and we carry out our work where it matters most.

Our Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued, and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.

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 Ablett Unit, Glan Clwyd Hospital, Betsi Cadwaladr University Health Board on 27, 28 & 29 April 2026. The following hospital wards were reviewed during this inspection:

- Dinas Female Ward - 10 bedded female acute admissions ward
- Dinas Male Ward – 10 bedded male acute admissions ward
- Tegid Ward – 10 bedded mixed gender older persons mental health ward.

Our team, for the inspection comprised of two HIW healthcare inspectors, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one patient experience reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. No questionnaires were completed by patients or their carers and two were completed by staff. Insufficient staff questionnaires were returned to report findings. We also spoke to staff working at the service during our inspection. 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:

Overall, patients reported positive experiences of care and described staff as kind, respectful and supportive. Patients felt listened to and told us they were treated with dignity, and inspection teams observed caring and compassionate interactions between staff and patients.

Dedicated activity co-ordinators were viewed positively by patients and staff, and activities were well attended where available. Advocacy services were visible and well established, supporting patients to understand their rights and raise concerns.

Patients also provided mixed feedback on food quality, noting limited variety due to a repetitive weekly menu.

Aspects of the ward environment impacted on patients' day-to-day experience. Patients were accommodated in shared bedrooms with limited access to bathroom and shower facilities, which reduced privacy and dignity, particularly for those with longer lengths of stay. In addition, the condition of some ward areas and furnishings detracted from the overall patient experience and did not consistently support comfort and wellbeing.

This is what we recommend the service can improve:

- Improve catering arrangements by reviewing menu provision and engaging with patients to increase variety and choice, particularly for those with longer lengths of stay
- Improve the ward environment to better support patients' privacy, dignity and wellbeing, including reducing the impact of shared facilities, enhancing the condition of ward areas and furnishings.

This is what the service did well:

- Activity co-ordinators were highly valued by patients and staff and provided a range of meaningful activities that supported patient engagement and wellbeing
- Patients consistently described staff as caring, respectful, and responsive, and inspection teams observed positive and compassionate interactions throughout the inspection
- Advocacy services were well embedded, accessible, and actively supported patients to understand their rights and raise concerns.

Delivery of Safe and Effective Care

Overall summary:

Overall, the inspection team found that staff were committed to providing safe care and were responsive to patients' needs. Risk management and safeguarding arrangements were in place, and patient records reviewed showed evidence of ongoing assessment and monitoring, including physical health checks and risk assessments when patients' needs changed.

However, the delivery of safe and effective care was significantly impacted by environmental and system pressures. The physical environment of the wards did not align with expectations of modern mental health inpatient settings and was not fit for purpose. This was of particular concern given that, following the previous HIW inspection, the health board had indicated that a new facility would be developed.

The inspection team found that patients continued to be cared for within the existing environment, with no evident progress in addressing these long-standing limitations. Limited space on the wards continued to affect how care was delivered, including the need for some activities and medicines management to take place off the ward.

Environmental constraints also affected support functions. The laundry room serving the wards was cramped and disorganised, with unlabelled patient clothing observed and staff reporting ongoing issues with washing machine reliability. These issues, in the context of an outdated and constrained environment, reduced assurance that care could be delivered consistently, safely and with dignity.

Pressures on bed capacity further affected care delivery and patient flow. The Section 136 suite was being used to accommodate a patient awaiting a psychiatric intensive care unit bed, meaning it was not available for its intended purpose.

Staff also reported that some patients who were clinically ready for discharge experienced delays due to a lack of suitable onward placements, which impacted patients' recovery and wellbeing and contributed to pressures within the inpatient environment.

While care records reflected ongoing assessment, care plans did not consistently capture the specific ward-based interventions being delivered or the outcomes of assessments. This reduced assurance that patient records consistently reflected the care provided and the effectiveness of ongoing interventions.

This is what we recommend the service can improve:

- Take sustained action to address environmental limitations, including ward space and support facilities such as laundry provision, to ensure the environment is fit for purpose and supports safe, dignified, and effective care

- Ensure the Section 136 suite is used only for its intended purpose and is not routinely used to accommodate patients awaiting alternative beds, through strengthened escalation and capacity management arrangements
- Improve the quality and consistency of care planning documentation so that patient records clearly reflect ward-based interventions and the outcomes of ongoing assessment and review.

This is what the service did well:

- Staff demonstrated commitment to patient safety, with clear awareness of risk management and safeguarding arrangements
- Patient records showed evidence of ongoing physical health monitoring and review when patients' needs changed
- Staff worked flexibly within a constrained environment to maintain care delivery, including supporting activities and patient needs despite space and capacity pressures.

Quality of Management and Leadership

Overall summary:

Overall, the inspection team found that ward-level leaders were visible, and staff described feeling supported in their day-to-day roles. Governance structures were in place to review incidents, risks and safeguarding concerns, and staff were able to describe escalation routes and lines of accountability. Local leaders were working to maintain safe care delivery within a constrained and pressured environment.

However, weaknesses in organisational governance reduced assurance. Several policies reviewed were out of date and had not been updated to reflect current practice, despite similar issues having been raised in previous HIW inspections across the health board. This indicated that actions arising from earlier inspections had not been consistently implemented or sustained, and that stronger oversight was required to ensure policies remain current and fit for purpose.

The inspection team also identified governance concerns relating to the management of the Section 136 suite. The use of the suite to accommodate a patient awaiting a psychiatric intensive care unit bed indicated a lack of effective oversight and escalation to protect the suite's intended function. This raised concerns about how system pressures, including bed capacity, were being managed at an organisational level.

In addition, long-standing environmental limitations had been highlighted in previous inspections, and while expectations of improvement had been set, the existing environment remained in use and was not fit for purpose. This reduced assurance that there was effective strategic planning and governance oversight to address environmental risks and progress longer-term solutions to support safe, dignified, and therapeutic care.

This is what we recommend the service can improve:

- Strengthen governance arrangements to ensure policies are reviewed, updated, and implemented in a timely way, with effective oversight to provide assurance that staff are guided by current, approved documentation
- Improve strategic oversight and planning in relation to the ward environment, including clear governance arrangements to address long-standing environmental risks and progress future improvement or redevelopment plans
- Ensure actions arising from previous HIW inspections are monitored, implemented, and sustained across the organisation to prevent recurrence of identified issues.

This is what the service did well:

- Ward-level leaders were visible and accessible, and staff reported feeling supported by local management teams
- Governance forums were in place to review incidents, safeguarding concerns and risks, supporting escalation and learning at a local level.

3. What we found

Quality of Patient Experience

Person-Centred

Health promotion

Patients had access to a range of activities to support their wellbeing. Dedicated activity rooms were available on the unit, and patients spoke highly of the activity's coordinators, who were described as approachable and supportive. Inspection teams observed good levels of engagement during activity sessions.

Health promotion information was displayed across wards, including advice on healthy eating and smoking cessation. Smoking cessation services attended the unit weekly, and patients were offered nicotine replacement therapy following admission. Patients were also supported to access outdoor space daily, with garden areas available on each ward and access to escorted or unescorted leave where appropriate.

Dignified and respectful care

Throughout the inspection, staff were observed interacting with patients in a calm, compassionate, and respectful manner. Patients told us that staff listened to them and spoke to them appropriately.

Staff were seen knocking before entering bedrooms and bathrooms, and observation windows were managed in a way that maintained privacy while supporting safety. Patients had access to private spaces to meet with visitors, including a family room suitable for children.

Staff wore personal alarms while working on the wards, and these were available for visitors if needed. Ward entrances were secured with locked doors to control access.

We saw staff take time to speak with patients and respond to their needs or concerns. Despite working in busy wards, staff remained attentive and responsive, ensuring patient needs were met. This showed a professional and caring approach.

The inspection team found that aspects of the ward environment impacted on patients' experience of care. Patients were accommodated in shared bedrooms with limited access to bathroom and shower facilities, which reduced privacy and dignity, particularly for those with longer lengths of stay. Limited space on the wards also meant that some activities and clinics took place off the ward, which disrupted patients' routines and reduced opportunities for consistent therapeutic engagement.

In addition, the condition of some ward areas and facilities, including damaged furnishings in lounge area in Dinas female ward, kitchen cupboards and worktops damaged in Dinas male ward, and the overall environment did not consistently support comfort, dignity or wellbeing.

The health board must ensure that the ward environment supports patients' privacy, dignity and wellbeing, including providing appropriate bedroom, bathroom and maintaining ward furnishings and communal areas to an acceptable standard,

and ensuring sufficient on-ward space to support therapeutic activities and minimise disruption to patients' routines.

Individualised care

Patients were supported to make choices and maintain independence wherever possible. Patients were able to decide how they spent their day, including attending activities, accessing outdoor space, and making meal choices, subject to individual risk assessment.

Care records showed evidence that families engaged in care planning where appropriate, with clear documentation in place when patients chose not to involve family members. Patients attended ward rounds and were supported to discuss their care and treatment with the multidisciplinary team.

Advocacy services attended the unit several times each week and supported patients to understand their care, their rights, and available options.

Timely

Timely care

Patients told us that staff responded promptly when they required support. Enhanced observation levels were implemented where patients presented with increased risk, and staff were accessible and available to patients when needed.

However, the inspection team identified an instance where documentation for continuous one-to-one observations was incomplete, including a prolonged gap with no recorded rationale. Staff confirmed that the observations had continued during this period but were not recorded as required. This issue was raised with the nursing team during the inspection, and an incident form was completed to support review and learning.

The health board must ensure that continuous one-to-one observations are consistently recorded in line with policy, and that any gaps in documentation are promptly escalated, reviewed, and addressed through incident reporting and learning processes.

Equitable

Communicating and language

Information was available to patients in accessible formats, including posters and leaflets explaining how to access advocacy services, raise concerns and contact Healthcare Inspectorate Wales. Patients were also supported to communicate with staff, advocates, families, and carers, including using digital technology where appropriate.

Staff who were able to speak Welsh made this visible by wearing “Iaith Gwaith” badges. Inspection teams observed that there were both staff and patients who spoke Welsh on the wards.

We observed staff communicating clearly and respectfully with patients, using appropriate language, avoiding jargon, and allowing patients time to express themselves.

Rights and equality

Patients were supported to understand their rights and how to raise concerns or complaints. Advocacy services were actively promoted and well established on the unit, supporting both detained and informal patients.

Patients had access to telephones and, where appropriate, personal mobile phones, subject to individual risk assessment. No concerns were raised with the inspection team regarding discrimination or inequitable access to care.

We observed staff supporting equality and inclusion in practice, including making reasonable adjustments for patients with mobility needs using appropriate equipment and aids. Staff had completed equality and diversity training and were able to explain how they would respond to discrimination or concerns about patients’ rights.

Overall, systems were in place to promote equality, protect human rights and support patient choice.

Delivery of Safe and Effective Care

Safe

Risk management

The service had systems in place to identify, record and review incidents. Staff described using an electronic incident reporting system, with oversight and daily review of new incidents and allocation for investigation. Themes and trends were monitored through established governance meetings, and learning was shared with staff through handovers, emails, and meetings.

The service completed environmental and ligature risk assessments and held regular forums to review ligature risks and actions. Staff were able to confirm the location of ligature cutters and escalation arrangements, including access to on-call support.

The inspection team found that the physical environment of the wards was not fit for purpose and did not align with expectations of modern mental health inpatient settings. The wards were small and compact, with shared bedrooms, limited bathroom and shower facilities and no en-suite provision. Due to limited space on the wards, some activities were undertaken off the ward, and on Dinas ward the medicines room was also located off the ward. These environmental constraints impacted on patient privacy, dignity, and the therapeutic quality of the ward environment, and presented challenges for staff in delivering care safely and effectively, including reducing staff availability on the ward when supporting activities or accessing medicines.

The health board must ensure that the ward environment is fit for purpose and supports the delivery of modern mental health inpatient care, including providing sufficient on-ward space and facilities to enable activities and medicines management to take place safely on the wards, minimise unnecessary staff movement off the ward, and support patient privacy, dignity and therapeutic engagement.

Infection prevention and control (IPC) and decontamination

Most areas of the unit were observed to be clean and tidy and staff described active monitoring through audits. Hand hygiene audits were completed, and personal protective equipment was available and accessible.

However, the inspection identified IPC-related issues that required improvement. The laundry room serving the wards was untidy, with unlabelled patient clothing observed, and staff reported ongoing issues with washing machine reliability. Patients did not have access to appropriate facilities for managing soiled clothing. It is concerning that these issues mirror findings from the previous inspection, where actions were identified to improve housekeeping checks, signage, and laundry arrangements. The absence of sustained improvement reduced assurance that previously agreed actions had been embedded and maintained.

The health board must ensure that previously identified actions to improve laundry arrangements are fully implemented and sustained, with clear oversight to maintain a tidy environment and ensure patient clothing is appropriately labelled,

stored, and managed.

Routine ward cleaning checklists were not consistently completed, with gaps identified in daily cleaning documentation, and an infection prevention and control protocol relating to cleaning and decontamination was past its review date. Although staff described ongoing cleaning activity, these issues reduced assurance that infection prevention arrangements were consistently supported by robust processes and current documentation.

The health board must ensure that routine ward cleaning documentation is completed consistently and maintained as an effective audit trail, and that infection prevention and control protocols, including those relating to cleaning and decontamination, are kept up to date and subject to effective governance oversight.

Safeguarding of children and adults

Staff described clear safeguarding arrangements, including training compliance, processes for reporting concerns and escalation routes. Safeguarding concerns were reported through the incident reporting system, referred to the local authority when required, and discussed through governance forums. Staff reported good working relationships with safeguarding teams and confirmed that safeguarding issues were included in daily discussions.

The unit had arrangements in place to support children and families visiting, including the use of a family room and controls over where children could access within the unit**.**

Management of medical devices and equipment

The inspection team saw evidence of routine checking of resuscitation and emergency equipment, including documented checks to confirm equipment was present and in date.

The inspection identified a safety issue relating to oxygen cylinder storage in a clinical area covering Dinas wards, which was not in line with safety requirements. This was immediately resolved during the inspection, and cylinders were secured and stored appropriately in line with relevant oxygen safety guidance.

The health board must ensure that oxygen cylinders are stored securely, safely and in line with national guidance, including being appropriately secured to prevent movement or damage, clearly segregated from other equipment, and subject to routine checks.

Medicines management

Medicines were stored securely and staff described effective systems for medicines storage and administration, including arrangements for controlled drugs and temperature monitoring of medicines fridges. Pharmacy support was described as regular, with routine visiting and timely access to medication supplies.

The inspection team found that medicines management policy required improvement. A medicines management policy reviewed was overdue for update in July 2022 and did not reflect current practice, including the introduction of electronic prescribing and medicines administration. Subsequently, we were not assured that staff are supported by up-to-date guidance and policy aligned with current systems.

The health board must ensure that medicines management policies are reviewed and updated in a timely way to reflect current practice, including electronic prescribing and medicines administration systems, and provide staff with clear, up-to-date guidance to support safe and effective medicines management.

Effective

Effective care

Overall, we found appropriate governance arrangements in place to support the delivery of safe and clinically effective care. Systems for managing incidents and physical interventions were well embedded.

Staff confirmed that debriefs take place following incidents, and inspection evidence showed that all incidents and physical interventions (such as restraint) were reviewed and supervised.

We observed positive examples of staff using redirection and de-escalation techniques during the inspection. These interventions were delivered respectfully and in a supportive manner, demonstrating a commitment to least restrictive practice.

An established electronic system was in place for recording, reviewing, and monitoring incidents. All incidents were entered onto the health board's reporting system (DATIX), and there was a clear hierarchy for sign-off to ensure timely review and management of the incident management process. Incident reports were regularly analysed, and lessons learned from complaints and incidents were shared with staff and the wider organisation through meetings and supervision.

During the inspection, we did not observe a consistent occupational therapy presence on the wards, and there was limited visibility of psychology input within the unit. The health board has advised that occupational therapy provision is available through a referral-based model; however, this was not clearly evidenced within the care records reviewed, and care and treatment plans did not consistently demonstrate how patients were accessing therapeutic input.

As a result, HIW was not fully assured that therapeutic needs were consistently met in practice.

The health board must ensure that patients have timely access to appropriate therapeutic input, including occupational therapy and psychological support, and

that this is clearly evidenced within care and treatment plans, including the nature of interventions and multidisciplinary input provided.

During the inspection, the team was informed of pressures on bed capacity which affected care delivery. The Section 136 suite was being used to accommodate a patient awaiting a psychiatric intensive care unit bed, and staff reported that this was not an isolated incident. This meant the suite was not available for its intended purpose, and the health board was asked to strengthen escalation and capacity arrangements.

The health board must ensure that the Section 136 suite is used only for its intended purpose and is not routinely used to accommodate patients awaiting alternative beds, including psychiatric intensive care unit provision. Consideration must be given to escalation and bed capacity management arrangements.

Nutrition and hydration

Nutrition and hydration needs were assessed, monitored and met, and all patients had a nutritional assessment on admission. Patients were supported to meet their dietary needs, and specific requirements were accommodated as appropriate. All patients were supported with food and fluid intake, and records demonstrated consistent monitoring.

Patients provided mixed views on food quality, with some noting that the menu was repetitive because it followed the same weekly rotation.

The health board must ensure that catering and menu arrangements are reviewed in partnership with patients to provide sufficient variety and choice, particularly for patients with longer lengths of stay.

Patient records

The inspection team reviewed a sample of patient records and found evidence of ongoing physical health monitoring and completion of risk assessments when there were changes in patient presentation. The service also described the use of audits to monitor record quality, with oversight and discussion through governance processes.

As noted above, the quality of care planning documentation required improvement to ensure it consistently reflected ward-based interventions and outcomes, and that enhanced observation recording was completed consistently.

Mental Health Act monitoring

We reviewed statutory detention documents for five patients which were compliant with the Mental Health Act 1983 (revised Code of Practice for Wales, 2016). All records confirmed legal detention, and showed patients were informed of their rights, with signed acknowledgements present.

Statutory documentation was completed correctly, stored securely and clearly organised. Patients' legal status was accurately recorded in paper records, and patients had access to advocacy services and information about their rights.

Monitoring the Mental Health (Wales) Measure 2010: care planning and provision

We reviewed the Care and Treatment Plans (CTPs) of six patients. Care records reviewed showed that care planning reflected the domains of the relevant Welsh legislative framework. Discharge planning systems were described as in place, and documentation showed involvement of families in care arrangements when appropriate, with clear recording when patients did not wish family involvement.

However, care plans did not consistently capture the specific ward-based interventions being provided or the outcomes of assessments, including physical health monitoring and other identified needs. This reduced assurance that patient records consistently reflected the care delivered and the outcomes of ongoing assessment.

The health board must ensure that care plans consistently record the specific ward-based interventions being provided and clearly document the outcomes of assessments, including physical health monitoring and other identified needs, so that patient records accurately reflect the care delivered and ongoing review.

There was evidence of active discharge planning for patients requiring long-term placements. However, staff indicated that discharge planning and patient flow were not always as effective as intended. Delays in accessing appropriate onward services and placements meant that some patients experienced extended hospital stays. Staff described occasions where prolonged admission may have had a negative impact on patients' wellbeing, which in some cases affected their suitability for the originally identified placement. We were therefore not assured that discharge arrangements consistently supported timely progression of care.

The health board must ensure that discharge planning is strengthened and commenced early, with effective coordination and escalation to support timely access to onward services and placements, and to minimise the risk of avoidable delays impacting patient outcomes.

Efficient

Efficient

The service described using staffing templates and escalation routes to secure additional staffing to meet increased observation levels, including use of bank shifts, overtime approvals and agency use when required. This supported the service to respond to changing patient acuity and risk.

However, the inspection team was told that some operational arrangements reduced efficiency and could impact on the effective use of staff time. location of some facilities off the wards meant staff needed to leave ward areas to support clinics and activities. In addition, limited administrative and reception cover was described as placing

additional non-clinical responsibilities on ward staff.

The health board must ensure that operational arrangements are reviewed and improved so that staff are able to maximise clinical time on the wards, including reducing the need for staff to leave ward areas to support clinics and activities and ensuring adequate administrative and reception support is in place.

Quality of Management and Leadership

Leadership

Governance and leadership

The service had governance arrangements in place to support oversight of incidents, complaints, and safeguarding, including structured daily and routine meetings to review activity and risks. Staff described visible and supportive senior nursing leadership on the wards and effective processes for monitoring and escalating issues.

However, policy governance required improvement. Several policies were found to be overdue for review, including the Physical Restraint Policy (due October 2022), Raise Concerns Policy (due October 2022), Escalation Policy (due February 2023), and IPC 39 protocol 'Which clean do I mean?' (due May 2025). In addition, there was no overarching Infection Prevention and Control (IPC) policy in place, with reliance on several individual IPC-related policies, some of which were also out of date, including those relating to MRSA, outbreak reporting, and the decontamination of beds.

During the inspection, the team also identified inconsistencies in policy versions, with different versions of the same policy being provided. For example, a Concerns Policy due for review in July 2025 was later seen with a revised review date of 2027. This highlighted a lack of clarity regarding the most current approved versions and reduced assurance that staff could consistently access and follow up-to-date guidance.

Similar issues relating to out-of-date policies have been identified in previous HIW inspections across the health board, indicating that earlier recommendations have not been consistently embedded and that stronger governance oversight is required.

The health board must ensure that actions arising from previous HIW inspections are implemented and sustained, particularly where issues relating to out-of-date policies have been repeatedly identified.

Workforce

Skilled and enabled workforce

Staff we spoke with were knowledgeable, compassionate, and clearly committed to delivering good quality care for a challenging patient group. Teams worked well together and demonstrated strong informal support for colleagues, particularly during periods of high acuity.

It was positive to find that mandatory training compliance was high across all three wards, with each achieving over 90% compliance. Appraisal compliance was also strong across all three wards, with each achieving over 90% compliance. The service described structured induction arrangements for new starters and local induction checklists.

The service described workforce planning arrangements that considered acuity and enhanced observation requirements, with processes to secure additional staff when required.

During staff discussions, the inspection team was advised that access to an NMC-approved prescribing programme, such as the Independent and Supplementary Prescribing (V300) qualification, had been made available to staff in other areas of the health board. However, nurses within the service who had requested access to this education and training reported there was no identified operational requirement.

Two members of staff expressed the view that, at times, limited medical cover impacted on service delivery, and suggested that access to nurse prescribing training could help mitigate this. We were informed that an incident report had been submitted in relation to this matter, and that senior management were reviewing the available evidence to assess the necessity and operational demand for staff to access this training.

The health board must ensure that the need for nurse prescribing within the service is formally reviewed, taking into account current operational demand, and the reported impact of limited medical cover, and that a clear, evidence-based decision is made on whether staff should be supported to undertake an NMC-approved prescribing programme.

The inspection team also identified areas requiring improvement in workforce communication. Staff meetings were reported as difficult to arrange and there was limited evidence of routine ward meetings taking place. This increased the risk that staff were inconsistently supported to access and discuss learning, receive policy updates, and informed of service changes promptly.

The health board must ensure that routine ward staff meetings take place to support effective communication, learning and engagement.

Culture

People engagement, feedback and learning

We found evidence of a positive and supportive ward culture. Staff spoke openly about pressures and challenges and described feeling supported by immediate ward leaders. Teams demonstrated good informal communication and a willingness to support each other during difficult shifts.

Patients and families were able to provide feedback through informal discussions with staff and through formal feedback processes.

Learning from incidents was described as shared through established governance processes, including review meetings and communication routes for staff.

Information

Information governance and digital technology

Patient records were appropriately stored and accessible to relevant staff. Regular training in information governance and GDPR, and access to records was appropriately The service used secure, password-protected electronic systems to support incident reporting and medicines administration, with processes in place to maintain oversight

and governance.

The inspection team also identified that governance documentation and policies had not kept pace with changes in digital systems, particularly for medicines management. As highlighted earlier, this reduced assurance that written guidance reflected current practice and systems.

Learning, improvement and research

Quality improvement activates

The service described quality improvement activity in practice, including work linked to observation approaches and physical health assessment processes. Governance meetings were also used to review audits and drive improvements.

We found evidence of effective partnership working at an individual patient level. Care records demonstrated good engagement with families, advocacy services, and wider multidisciplinary teams. Staff worked with services, including primary care, dietetics, speech and language therapy and pharmacy, to support patient needs.

Whole-systems approach

Partnership working and development.

The service worked with external and internal partners to support patient care, including regular advocacy attendance and pharmacy input. Staff also described collaborative working with wider health services to support patient needs.

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
Oxygen cylinders were not stored appropriately in line with relevant safety guidance	Incorrect storage of oxygen cylinders increases the risk of injury to patients and staff, delays access to life-saving equipment in emergencies and reduces assurance that medical gases are managed safely and in line with national patient safety guidance.	Senior nurse notified	This was immediately resolved during the inspection, and cylinders were secured and stored appropriately in line with relevant safety guidance.

Appendix B – Immediate improvement plan

Service: **Ablett Unit**

Date of inspection: **27 – 29 April 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.

Findings	No Immediate Assurances		
Improvement needed		**Standard / Regulation**	
1.			
Service Action:		**Responsible officer**	**Timescale**

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):

Job role: **Date:**

Appendix C – Improvement plan

Service: **Ablett Unit**

Date of inspection: **27 – 29 April 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.	The condition of some ward areas and facilities, including damaged furnishings in lounge area in Dinas female ward and kitchen cupboards and worktops damaged in Dinas male ward, and the overall environment did not consistently support comfort, dignity or wellbeing	The health board must ensure that the ward environment supports patients' privacy, dignity and wellbeing, including providing appropriate bedroom, bathroom and , maintaining ward furnishings and communal areas to an acceptable standard, and ensuring sufficient on-ward space to support therapeutic activities and minimise disruption to patients' routines.	Dignified care	A full itinerary of damaged furniture and furnishings will be completed. Replacement of all damaged furniture and furnishings will progress through appropriate channels to ensure procurement and replacement to approved standard. Undertake and document annual review of ward furniture and furnishings to maintain a suitable ward environment, with results reported to Divisional Quality Delivery Group.	Ward Managers and Housekeepers Head of Operations Ward Manager	15th July 2026 30th July 2026 30th July 2026

2.	Documentation for continuous one-to-one observations was incomplete, including a prolonged gap with no recorded rationale.	The health board must ensure that continuous one-to-one observations are consistently recorded in line with policy, and that any gaps in documentation are promptly escalated, reviewed, and addressed through incident reporting and learning processes.	Safe Care	Ensure that, as a minimum, 85% of all staff have undertaken the Therapeutic Engagement and Observation Training, current compliance for Tegid 91%; Dinas Male 74%; Dinas Female 68% as of 28th May 2026).	Ward Manager, Acute Care Clinical Site Manager	1st August 2026
				Daily spot checks by Nurse in Charge put in place.	Acute Care Clinical Site Manager	Completed
				Any gaps will be escalated to the ward manager or duty nurse, if during weekends, and rectified on the same shift.	Head of Nursing	Completed
				Learning will be fed into supervision and team meetings.	Head of Nursing	30th July 2026
				Communication has been sent to all staff regarding expectations	Head of Nursing	Completed

				to complete observation documentation. An audit of compliance of completing the documentation for Therapeutic Engagement and Observation to be undertaken. Audit recommendations to be actioned and reported monthly to Divisional Quality Delivery Group.	Quality Practice Development Nurse and Head of Nursing Ward Managers	31st July 2026 30th August 2026

3.	The inspection team found that the physical environment of the wards does not align with expectations of modern mental health inpatient settings. The wards were small and compact, with shared bedrooms, limited bathroom and shower facilities and no en-suite provision. Due to limited space on the wards, some activities were undertaken off the ward, and on Dinas ward the medicines room was also located off the ward.	The health board must ensure that the ward environment is fit for purpose and supports the delivery of modern mental health inpatient care, including providing sufficient on-ward space and facilities to enable activities and medicines management to take place safely on the wards, minimise unnecessary staff movement off the ward, and support patient privacy, dignity and therapeutic engagement	Dignified Care	Updates on progress of the Health Board proposal for a new purpose-built mental health unit, to replace the Ablett Unit, to be delivered through the monthly Ablett Unit Redevelopment Project. A review will be undertaken to determine the feasibility of a medicine's clinic and dedicated therapeutic space within the ward environment.	Ablett Unit Redevelopment Project Director Acute Care Clinical Site Manager, Pharmacy Lead, Local Estates Lead	30th Sept 2026 31st July 2026

4.	The laundry room serving the wards was cramped and disorganised, with unlabelled patient clothing observed and ongoing issues with washing machine reliability. Previous improvement actions had not been sustained.	The health board must ensure that laundry arrangements are effectively managed and sustained, including maintaining an organised environment and ensuring patient clothing is appropriately labelled and stored, with governance oversight to embed previous improvement actions.	Safe Care	Declutter and reorganise the laundry room. Re-introduce the daily laundry room checklist (compliance to reach 95%), to be overseen by the Housekeepers to ensure the environment is kept in an organised fashion. Occurrences of any laundry room disorganisation will be corrected immediately on the same shift. Monthly reporting to local governance forum, Central weekly Integrated Concerns Operational Panel Faulty equipment has been identified and reported to estates colleagues. Any items requiring replacement	Ward Manager, Ward Housekeeper Housekeepers, Acute Care Clinical Site Manager Housekeepers, Acute Care Clinical Site Manager Acute Care Clinical Site Manager Acute Care Clinical Site Manager, Head of Operations.	Complete 15th July 2026 15th July 2026 15th July 2026 15th July 2026

				will be procured, and tracked via estates log with completion confirmation. Contingency arrangements will be implemented where equipment is unavailable.	Acute Care Clinical Site Manager, Head of Operations.	7th July 2026

5.	Routine ward cleaning checklists were not consistently completed, with gaps identified in daily cleaning documentation, and an infection prevention and control protocol relating to cleaning and decontamination was past its review date.	The health board must ensure that routine ward cleaning documentation is completed consistently and maintained as an effective audit trail, and that infection prevention and control protocols, including those relating to cleaning and decontamination, are kept up to date and subject to effective governance oversight.	IPC	Ward Managers and their deputies will ensure the completion of relevant ward cleaning documentation on a Nurse Cleaning Checklist daily/weekly/monthly basis, compliance to reach 95%. Report ward cleaning documentation and non-compliance as an escalation into Divisional Quality Delivery Group meeting. Occurrences of any ward cleaning discrepancy will be corrected and discussed in daily safety huddle. Continue review and approval of any out of date IPC Policies, providing status	Ward Manager, Housekeeper Head of Nursing Acute Care Clinical Site Manager Assistant Director of	15th July 2026 30th June 2026 7th July 2026

				progress via the Strategic Infection Prevention Group.	Infection Prevention	30th July 2026
6.	The inspection identified a safety issue relating to oxygen cylinder storage in a clinical area, which was not in line with safety requirements. This was immediately resolved during the inspection and cylinders were secured and stored appropriately in line with relevant safety guidance.		Safe Care	Incorporate checking the safe storage of oxygen cylinders into the Daily Clinic Checklist, monthly audit of clinic checklist compliance with escalations into the daily Safety Huddle. Any deviation identified will be corrected immediately and escalated same day. Monthly audits reported via governance routes	Acute Care Clinical Site Manager Acute Care Clinical Site Manager Head of Nursing	Complete 7th July 2026 15th July 2026

7.	Medicines management policy was overdue for update and did not reflect current practice, including the introduction of electronic prescribing and medicines administration. This reduced assurance that staff were being guided by up-to-date approved policy aligned with current systems.	The health board must ensure that medicines management policies are reviewed and updated in a timely way so that they reflect current practice, including electronic prescribing and medicines administration systems, and provide staff with clear, up-to-date guidance to support safe and effective medicines management.	Leadership & Governance	A review has been undertaken in relation to medicines management policy and confirmation received that they are reviewed and in-date. Inpatient staff to be supported with awareness of how to access up to date policies, through team meetings, supervision and email communications. Central pharmacy to provide regular ward presence, Pharmacist review of prescribing, immediate escalation of errors via datix and unit manager. Compliance with medicines management training will be reviewed by Central Quality Delivery	Medicines Management Lead Acute Care Clinical Site Manager Central Pharmacist Acute Care Clinical Site Manager	Complete and ongoing 15th July 2026 15th July 2026 15th July 2026

				Group on a monthly basis		
8.	During the inspection, we did not observe a consistent occupational therapy presence on the wards, and there was limited visibility of psychology input within the unit. This limited access to therapeutic interventions and did not fully meet patient need.	The health board must ensure that patients have timely access to appropriate therapeutic input, including occupational therapy and psychology, to meet identified needs and support recovery and therapeutic engagement on the wards.	Effective care	A therapeutic time table for on ward activity to be implemented by Activity Nurses. Head of Occupational Therapy to review workforce capacity and progress any vacancies to active recruitment. Head of Psychology to review workforce capacity and progress any vacancies to active and sustained recruitment.	Acute Care Clinical Site Manager Head of Occupational Therapy Head of Adult Mental Health Psychology & Psychological Services	31st July 2026 31st August 2026 31st August 2026

9.	During the inspection, the team was informed of pressures on bed capacity which affected care delivery. The Section 136 suite was being used to accommodate a patient awaiting a psychiatric intensive care unit bed, and staff reported that this was not an isolated incident. This meant the suite was not available for its intended purpose	The health board must ensure that the Section 136 suite is used only for its intended purpose and is not routinely used to accommodate patients awaiting alternative beds, including psychiatric intensive care unit provision, through strengthened escalation and bed capacity management arrangements.	Effective Care	A Task & Finish Group is in place to oversee any incidents arising from use of S136 suite. The MHLD Division will continue to utilise the current Divisional daily bed huddle to discuss and escalate any bed pressures / patient nursed in a 136 suite in the absence of a bed on a ward. Any delay in transfer from the 136 suite to be subject to Datix incident reporting and monitoring through locality ICOP.	Medical Director Acute Care Clinical Site Manager, Clinical Operational Manager Acute Care Clinical Site Manager	Complete 30th June 2026 30th June 2026

10.	Patients provided mixed views on food quality, with some noting that the menu was repetitive because it followed the same weekly rotation.	The health board must ensure that catering and menu arrangements are reviewed in partnership with patients to provide sufficient variety and choice, particularly for patients with longer lengths of stay.	Dignified Care	A review of patient menus will be undertaken with the Catering Department and the update shared with each ward staff/patient meeting. Achieve 80% patient satisfaction on food (survey quarterly). 6 monthly meetings to be established with the Catering Department and patient forum to review menu.	Acute Care Clinical Site Manager, Catering Manager Acute Care Clinical Site Manager	31st July 2026 31st July 2026

11.	Care plans did not consistently capture ward-based interventions or the outcomes of assessments, reducing assurance that records reflected care delivered.	The health board must ensure that care plans consistently record the specific ward-based interventions being provided and clearly document the outcomes of assessments, including physical health monitoring and other identified needs, so that patient records accurately reflect the care delivered and ongoing review.	Effective Care	Ward managers will confirm current care plans reflect ward based interventions or their outcomes. A monthly audit will be put in place to ensure Care Plans reflect ward based interventions, achieve 95% compliance. and reported into Central Quality Delivery Group, with action tracking.	Ward Manager, Acute Care Clinical Site Manager Acute Care Clinical Site Manager	30th June 2026 15th July 2026

12.	There was evidence of active discharge planning for patients requiring long-term placements. However, staff indicated that discharge planning and patient flow were not always as effective as intended. Delays in accessing appropriate onward services and placements meant that some patients experienced extended hospital stays	The health board must ensure that discharge planning is strengthened and commenced early, with effective coordination and escalation to support timely access to onward services and placements, and to minimise the risk of avoidable delays impacting patient outcomes	Effective Care	Each patient is given an estimated discharge date and discussed in the daily Acute Care Meeting. This requirement is captured in the daily Acute Care Meeting. Capture and escalate all patients identified as Pathway of Care Delays (POCD) to progress discharge plans in the weekly POCD meeting. POCD to then escalate any prolonged delays in discharge to the respective Head of Operations, and any exceptions to Divisional POCD meeting if no local resolve.	Acute Care Clinical Site Manager Ward Managers and Clinical Operational Manager	Complete Complete

13.	The location of some facilities off the wards meant staff needed to leave ward areas to support clinics and activities. In addition, limited administrative and reception cover was described as placing additional non-clinical responsibilities on ward staff.	The health board must ensure that operational arrangements are reviewed and improved so that staff are able to maximise clinical time on the wards, including reducing the need for staff to leave ward areas to support clinics and activities and ensuring adequate administrative and reception support is in place.	Safe Care	A Task & Finish Group set up to review operational and administrative arrangements across the unit, to ensure that nursing impact is minimised. Any daily operational issues will be escalated via safety huddle for immediate resolution.	Head of Operations Head of Operations	30th August 2026 30th June 2026

14.	Several policies were overdue for review, and during the inspection the team saw examples where different versions of a policy were provided. This highlighted a need for stronger oversight to ensure staff can access and follow the most up-to-date approved policies. Similar findings relating to out-of-date policies have been raised in previous HIW inspections across the health board, indicating that earlier recommendations have not been consistently implemented.	The health board must ensure that actions arising from previous HIW inspections are implemented and sustained, particularly where issues relating to out-of-date policies have been repeatedly identified.	Leadership & Governance	Ward staff to be reminded of accessing the most up to date policies and procedures via the Health Board Intranet via written control memo. Continue reporting into SQDG Policy Position paper, to ensure Divisional awareness of any policy updates. Continue to include "Policy of the month" in the MHLD Staff Briefing to raise staff awareness. Continue to utilise MHLD tracking mechanism to review out of date procedures, reported through to Divisional Quality Delivery Group.	Acute Care Clinical Site Manager MH&LD Policy Lead MH&LD Policy Lead Assistant Director of Nursing	7th July 2026 31st July 2026 31st July 2026 Complete

15.	During staff discussions, the inspection team was advised that nurse prescribing training had been made available to staff in other areas of the health board. However, nurses within the service who had requested access to this training had been advised that there was no identified operational requirement.	The health board must ensure that the need for nurse prescribing training is reviewed and assessed against current operational requirements, to determine whether staff should be supported to access this training.	Workforce & Training	A training needs analysis will be undertaken to determine required number of nurse prescribers. MHLD to follow the Health Board procedure for Nurse Prescriber approval ensuring the application aligns to operational and Central SLT training requirements. All Nurse Prescriber applications to be approved by the Assistant Director of Nursing for consistency across MHLD.	Head of Nursing Assistant Director of Nursing	30th June 2026 15th July 2026

16.	Staff meetings were reported as difficult to arrange and there was limited evidence of routine ward meetings taking place.	The health board must ensure that routine ward staff meetings take place to support effective communication, learning and engagement.	Leadership & Governance.	A regular timetable of monthly ward meetings to be put in place and the frequency of occurrence will be monitored in Central Quality Delivery Group. Achieve 90% completion of scheduled monthly meetings.	Acute Care Clinical Site Manager Acute Care Clinical Site Manager	15th July 2026 30th August 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): Zoe Prince

Job role: Director of Nursing **Date:18/06/2026**