Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Bronglais Hospital - Enlli Ward, Hywel Dda University Health Board

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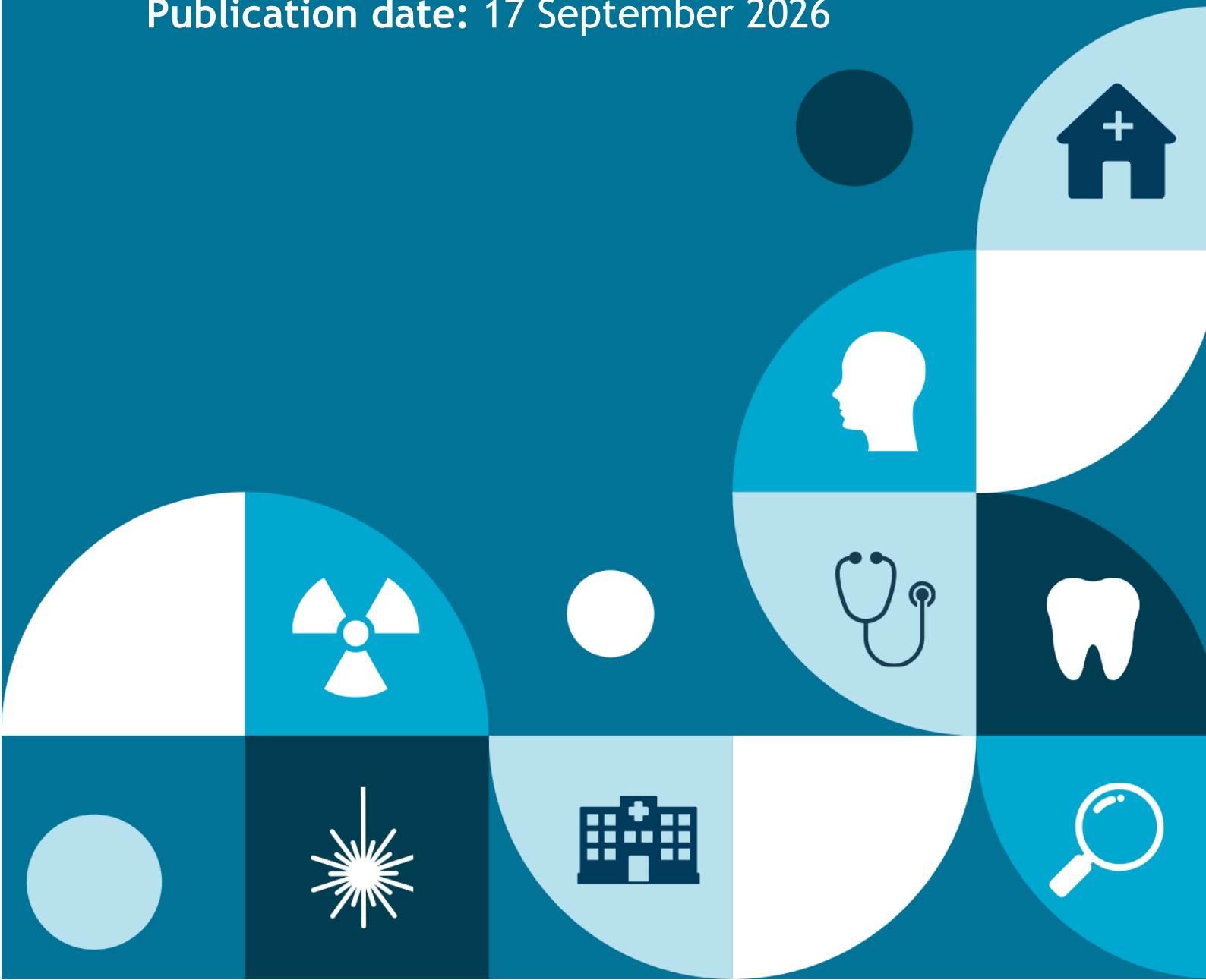

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

Our Purpose

We check the safety and quality of healthcare across Wales.

Our 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 Vision

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

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.

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1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Bronglais Hospital, Enlli Ward, Hywel Dda University Health Board on 15, 16 and 17 June 2026. The following hospital wards were reviewed during this inspection:

- Enlli Ward - 11 beds providing older adult mental health care.

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 reviewers.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of two questionnaires were completed by patients or their carers and nine were completed by staff. 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:

We found that patients on Enlli Ward were cared for in a compassionate and supportive environment, where staff treated patients with kindness, dignity, and respect. Patients spoke positively about their care and described staff as attentive, responsive, and aware of their emotional needs. There was strong evidence of person-centred care in practice, with patients supported to engage in a range of meaningful activities and maintain independence wherever possible.

The ward provided a clean and well-maintained environment, with access to therapeutic spaces, including outdoor areas, and activities designed to support patients' wellbeing. Health promotion was encouraged, and we saw examples of support being provided to help patients make positive lifestyle changes. Information for patients and families was accessible and clearly displayed, and systems were in place to support effective communication.

Staff demonstrated a good understanding of the importance of communicating with patients in their preferred language. Welsh language provision was well supported, with Welsh-speaking staff available across the ward and clear arrangements in place to promote patient choice and support effective communication. Staff also recognised the importance of providing care in a patient's preferred language, particularly for patients living with cognitive impairment or dementia.

Patients were supported to maintain contact with family and carers, and advocacy services were available and actively promoted. Feedback mechanisms were visible throughout the ward and there was evidence that patient and carer feedback was welcomed and used to support service development.

While patients generally reported feeling involved in decisions about their care, some opportunities were identified to further enhance patient participation and choice.

This is what we recommend the service can improve:

- How best to support patients to participate in formal meetings, particularly where anxiety may impact their involvement
- Whether additional recreational resources, such as a second television, could enhance patient experience and increase choice in meaningful activities.

This is what the service did well:

- Staff demonstrated a compassionate and person-centred approach, with patients reporting that they felt listened to, supported, and treated with dignity and respect
- The ward provided therapeutic opportunities tailored to patients' individual needs, including access to outdoor spaces and interventions that supported wellbeing, recovery, and independence
- Information for patients and families was accessible and well presented, with strong communication practices, including effective Welsh language provision, visible advocacy information, and accessible feedback mechanisms.

Delivery of Safe and Effective Care

Overall summary:

We found that patients on Enlli Ward received care within a generally safe and well-maintained environment, supported by established systems for risk management, safeguarding, and oversight of care. The ward was clean, organised, and fit for purpose, and staff demonstrated a good understanding of patient needs, risk management processes, and safeguarding responsibilities. There was evidence of effective multidisciplinary working, with comprehensive care planning, regular reviews, and strong involvement from families and advocacy services.

Patient records were generally well maintained, and care plans were detailed, person-centred, and reflective of patients' needs. Patients' nutritional and hydration needs were appropriately assessed and met, and there were effective arrangements in place to support timely care and treatment. Infection prevention and control practices were well embedded, and no significant concerns were identified in this area.

However, the inspection identified several areas where assurance was reduced.

During the inspection, it was identified that the medicines trolley was not secured to the wall and that the lock on the medicine's fridge was broken. These issues were raised with the senior nurse and were addressed immediately during the inspection.

Significant gaps in compliance with safety-critical training, including Physical Intervention, Immediate Life Support (ILS), and Basic Life Support (BLS), present a potential risk to patient and staff safety. Similar concerns have been raised by HIW during previous inspections within the health board. While actions have been taken to improve training compliance, the findings from this inspection demonstrate that the required level of sustained improvement has not been achieved. This raised concerns that learning from previous inspections has not been fully embedded and that governance arrangements have not been sufficiently effective in securing compliance with mandatory and safety-critical training requirements.

We also found gaps in temperature monitoring records for the medicines fridge and clinical room, along with a small number of missed checks of emergency equipment, including the resuscitation bag. In addition, some gaps were identified in observation records, indicating that documentation was not always completed consistently. While staff advised that observations were taking place, incomplete recording reduced assurance that patient monitoring requirements were fully evidenced.

We also identified weaknesses in medicines governance, including, temperature monitoring, and the availability of consent to treatment documentation.

Overall, while systems were in place to support the delivery of safe and effective care, improvements are required to strengthen monitoring processes, governance

arrangements, and compliance with safety-critical training requirements.

HIW required immediate assurances in relation to:

- Compliance with Physical Intervention training was 43%, meaning HIW is not assured that sufficient staff have up-to-date training to safely manage restrictive interventions
- Compliance with Immediate Life Support (ILS) and Basic Life Support (BLS) training remained low at approximately 50%, representing a continued and previously identified risk across the health board, with insufficient evidence of sustained improvement.

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

This is what we recommend the service can improve:

- The health board must strengthen medicines management arrangements, including, consistent monitoring of temperatures and equipment checks, and appropriate documentation to support safe and lawful administration
- The health board must ensure that clinical documentation, including observation records, is consistently completed to provide a clear and accurate record of patient care and safety.

This is what the service did well:

- The service demonstrated strong multidisciplinary working, with comprehensive, person-centred care planning and clear involvement of families and advocacy services
- The ward environment was clean, well maintained, and supported effective infection prevention and control practices
- Staff demonstrated a caring and professional approach, with a good understanding of patient needs, risk management, and safeguarding responsibilities.

Quality of Management and Leadership

Overall summary:

We found that Enlli Ward was supported by visible and approachable leadership, with staff describing a positive, collaborative, and supportive working environment. There were established governance systems in place to oversee service delivery, including regular staff meetings, daily health board operational meetings, and structured handovers, which supported the sharing of information relating to incidents, risks, and patient care.

Staff told us they felt supported by the ward manager and senior nursing team and were confident in raising concerns. There was evidence of good team working and a generally positive culture that promoted openness, learning, and continuous improvement. Systems were in place to capture and respond to feedback from patients, families, and staff, and learning from incidents and complaints was shared across the ward and wider health board.

The service demonstrated a commitment to quality improvement, with a range of audits and initiatives in place. This included monitoring of key risks such as falls, and ongoing environmental improvements, including plans to continue the development of a dedicated palliative care room to better support patients and families at end of life.

However, we identified areas where governance and oversight required strengthening. In particular, gaps in compliance with safety-critical training, including Physical Intervention, Immediate Life Support (ILS), and Basic Life Support (BLS), reduce assurance that staff are fully equipped to respond to emergency situations. In addition, some policies were out of date at the time of inspection, and supervision arrangements were not always delivered consistently.

Overall, while leadership was supportive and systems were in place to promote safe and effective care, improvements are required to ensure that governance processes are consistently applied and that risks are effectively mitigated.

This is what we recommend the service can improve:

- The health board must ensure that governance arrangements are strengthened, including keeping policies up to date and ensuring consistent delivery of staff supervision.

This is what the service did well:

- Staff described a positive and supportive culture, with strong teamwork and visible, approachable leadership

- There were effective systems in place to share learning from incidents, complaints, and audits, both within the ward and across the health board
- The service demonstrated a proactive approach to improvement, including monitoring key risks such as falls and developing initiatives to enhance patient experience.

3. What we found

Quality of Patient Experience

Person-Centred

Health promotion

We found that the ward promoted patients' health and wellbeing through a range of accessible information and meaningful activities. Health promotion information was clearly displayed throughout the ward, including in communal areas and corridors, where it was well-presented and encouraged engagement. Patients and relatives were also provided with an information pack on admission, supporting understanding of the ward and available health interventions.

Patients had access to a wide range of therapeutic and recreational activities which supported both physical and mental wellbeing. These included the use of an occupational therapy room, access to books and games, and structured group activities such as a choir. The ward environment further supported health promotion through access to well-maintained outdoor spaces, including courtyard areas with seating and planting. Patients were encouraged to engage with these spaces, including participation in gardening activities such as maintaining raised herb beds.

We identified positive examples of staff supporting individual health outcomes. For example, one patient described successfully stopping smoking with support from staff, demonstrating the effectiveness of health promotion interventions. Patients and relatives also provided positive feedback regarding the care received, highlighting that their needs were listened to and met.

Staff were described as attentive and responsive, recognising when patients required emotional support and engaging with them in a timely and compassionate manner. Feedback systems, including QR codes and visible feedback boards, were in place and demonstrated a culture of openness and engagement, with messages of appreciation from patients and families displayed on the ward.

Dignified and respectful care

We found that patients were treated with dignity and respect. Staff were observed interacting with patients in a kind, professional, and compassionate manner, and patients were supported with personal care in a sensitive and appropriate way.

The ward environment supported privacy and dignity. All patients had access to single bedrooms, which could be personalised with their own belongings, supporting independence and a sense of identity. Bedroom doors included observation panels fitted with blinds, allowing staff to maintain patient safety while preserving privacy. Patients were also able to lock their rooms from the inside, with staff able to override access where necessary.

Confidential information was stored securely, with patient information boards located within staff-only areas and designed to prevent unauthorised visibility. Bathroom and washing facilities supported dignity, with a mix of en-suite and individual-use shared facilities available.

Patients had access to communal areas within a mixed-gender environment, and while there were no designated single-sex lounges, alternative spaces were available to support patient preference where required.

Individualised care

We found that patients were supported to maintain independence and make decisions about their care. Patients had access to aids to support mobility and independence and were encouraged to undertake daily living activities where appropriate, including cooking and personal tasks.

There was evidence that patients were actively involved in decision-making. Patients were able to make choices about their daily activities, meals, and level of engagement, with a range of activities available to suit individual preferences. Patients reported feeling involved in their care, although one patient described feeling anxious when attending formal meetings, indicating that additional support may be required to ensure all patients feel comfortable participating.

The health board should consider how best to support patients to participate in formal meetings, particularly where anxiety may impact their involvement.

Information about external support services was available through welcome packs, display boards, and visitor areas, enabling patients to access additional support where required.

The ward demonstrated flexibility in supporting individual needs, including enabling meaningful personal experiences, such as facilitating visits from patients' pets. This reflects a person-centred approach that recognises the importance of individual wellbeing.

Some patients suggested that additional resources, such as a second television, would improve their experience by providing greater choice in activities.

The health board should consider whether additional recreational resources, such as a second television, could enhance patient experience and choice.

Timely

Timely care

We found that patients received care and support in a timely manner. Staff were observed to be responsive to patients' needs, providing prompt emotional support and recognising when patients required assistance.

Patients reported receiving timely access to medication when required. For example, one patient described being offered medication promptly following a request, demonstrating responsiveness to patient needs.

Overall, the ward demonstrated an appropriate level of responsiveness in meeting patients' care and treatment needs, with staff maintaining awareness of patients' conditions and responding accordingly.

Equitable

Communicating and language

We found that communication systems on the ward supported patients to access information in a clear and appropriate manner. A wide range of written information was available and clearly displayed, including details about the service, visiting arrangements, advocacy services, and how to raise concerns. Information was accessible in both Welsh and English, and display boards were well maintained and regularly updated.

Patients were able to communicate with family, carers, and professionals using ward-based telephones or personal mobile devices, subject to risk assessment. Measures were in place to ensure safety, including supervised charging of devices, while maintaining patients' ability to communicate privately within their bedrooms or designated family areas.

Staff demonstrated an understanding of the importance of communicating in patients' preferred language. Welsh language provision was well supported, with several Welsh-speaking staff available across different roles and visible identification through "Iaith Gwaith" indicators. Staff recognised the importance of language in supporting patient care, particularly for patients with cognitive impairment who may revert to their first language.

Where additional communication needs were identified, staff took appropriate action, including accessing interpretation services to support effective communication.

Rights and equality

We found that patients' rights were upheld and that systems were in place to support equality and diversity. Patients had access to private spaces for visits and communication, including a dedicated visitors' room, which supported contact with family and carers in a comfortable environment.

Information about patients' rights and how to raise concerns was readily available through posters, leaflets, and digital access points. Advocacy services were clearly promoted, with details of advocates displayed on the ward, including their availability.

The service demonstrated an inclusive approach to care, supported by equality and diversity policies and staff training. The ward environment was adapted to meet the needs of the patient group, including accessible design features and clear, pictorial signage to support those with cognitive or sensory impairments.

Staff demonstrated awareness of how to support patients with diverse needs, including those requiring language support or cultural considerations. Examples were provided of staff adapting communication approaches and accessing interpreters where required.

Patients' individual preferences and rights were respected in practice, including enabling personal requests such as family visits involving pets, reflecting a flexible and person-centred approach to care.

Delivery of Safe and Effective Care

Safe

Risk management

We found that the health board had systems in place to identify, monitor, and manage risk. The ward environment was clean, well maintained, and generally free from hazards, with regular environmental and ligature risk assessments undertaken and reviewed. Staff demonstrated awareness of risk management processes, including escalation pathways and the use of Datix for incident reporting. Learning from incidents was shared through staff meetings and governance structures.

However, assurance was reduced due to a combination of environmental and workforce-related risks. One external garden area was not fully accessible due to an unused staircase, limiting its safe use. In addition, significant gaps were identified in compliance with safety-critical training, including Physical Intervention, ILS and BLS. These gaps present a potential risk to patients and staff, particularly in emergency situations, and reflect a lack of sustained improvement across the health board.

The health board must ensure that environmental risks are addressed in a timely manner and that compliance with safety-critical training is improved urgently, with clear arrangements in place to mitigate risk in the interim.

Details of remedial action taken by the health board are provided in Appendix B

Infection prevention and control (IPC) and decontamination

We found that IPC arrangements were effective. The ward was visibly clean, tidy, and well organised, with cleaning schedules in place and adhered to. Domestic staff supported cleanliness, and staff demonstrated good understanding of IPC responsibilities.

Equipment was appropriately cleaned between use, with systems in place to evidence this. Hand hygiene facilities were readily available, and patients were supported to maintain good hygiene practices. PPE was available and used appropriately, and staff had received relevant training.

There were suitable arrangements for isolation and barrier nursing, and governance systems, including IPC leads, policies, and audits, were in place to monitor compliance. Overall, IPC standards were maintained and provided assurance that patients, staff, and visitors were protected.

Safeguarding of children and adults

We found that safeguarding systems were well established and embedded in practice. Staff demonstrated a clear understanding of their responsibilities and were able to describe how to recognise and escalate concerns. Safeguarding issues were recorded and monitored via Datix, with oversight through governance meetings and multidisciplinary team discussions.

There was evidence of effective multi-agency working, including strong links with social services and safeguarding teams. Advocacy services were accessible, and patients were provided with information on how to raise concerns. Most patients reported feeling safe, although one patient highlighted anxiety relating to the mix of patient needs, which staff managed through observation and intervention.

The health board should consider how it can further support patients who may feel anxious about the ward environment to ensure they feel safe, supported, and able to engage in their care.

Appropriate arrangements were in place for visits, including safe access for families and children in designated areas. Deprivation of Liberty Safeguards were appropriately managed, with timely reviews and clear communication between teams.

Overall, safeguarding arrangements provided assurance that patients were protected from harm.

Management of medical devices and equipment

We found that appropriate systems were in place to manage medical devices and equipment.

We found evidence that routine checks of emergency and resuscitation equipment were generally being completed and recorded, providing assurance that equipment was available and fit for use. However, we identified some gaps in the recording of these checks, including missed checks of emergency equipment during the month of May and June. This reduces assurance that all checks are being completed consistently in line with local requirements.

The health board must ensure that checks of emergency and resuscitation equipment are completed and documented consistently in accordance with local policy, to provide assurance that equipment remains available and ready for use in an emergency.

Staff were aware of the location of key emergency equipment, including ligature cutters, and confirmed that these were accessible in the event of an emergency.

Overall, these arrangements provided assurance that medical equipment was

appropriately maintained and ready for use.

Medicines management

We found that staff demonstrated a good understanding of medicines management processes, including administration, error reporting, and patient involvement in decision-making. Controlled drugs were appropriately managed, and drug charts were completed to a good standard, with clear documentation of administration and omissions.

There was evidence that systems were in place to monitor medication storage, including temperature checks of the medication fridge and clinic room. However, we identified gaps in recording, with missing temperature checks between May and June.

The health board must ensure that robust systems are in place to monitor compliance with temperature recording requirements for medicines storage areas, including oversight arrangements to identify and address missed checks in a timely manner

In addition, consent to treatment documentation was not consistently available alongside medication charts, limiting assurance that medicines were being administered in accordance with legal requirements.

The health board must ensure that appropriate consent to treatment documentation is available, accurately completed, and maintained alongside medication charts to provide assurance that medicines are administered lawfully.

We also found that the Medicines Management Policy was out of date at the time of inspection and was due for review in March 2026.

The health board must ensure that medicines management policies are reviewed and updated within required timescales so that staff are supported by current guidance and best practice.

Effective

Effective care

We found that care was delivered through structured processes supported by multidisciplinary team working. Staff described a collaborative team environment and reported that they were generally able to provide safe care.

Regular MDT meetings were held, and audits were undertaken to monitor clinical practice. Staff had access to policies, guidance, and training relevant to their roles.

Nutrition and hydration

We found that patients' nutritional and hydration needs were appropriately assessed and met. Screening tools were used to identify risk, and there was evidence of input from dietetic and speech and language therapy services where required.

Patients were able to choose meals and were supported to maintain adequate intake. Food was reported to be of good quality, with a range of options available, and staff regularly offered drinks and snacks.

Overall, there was good assurance that patients' nutritional and hydration needs were met.

Patient records

We found that patient records were well maintained, secure, and accessible. Both paper and electronic systems were used effectively, and records were easy to navigate.

We found gaps in observation records, indicating that documentation was not consistently maintained. While observations were reported to be taking place, incomplete recording reduces assurance that patient monitoring and safety requirements are fully evidenced.

The health board must ensure that patient observations are completed and recorded consistently in accordance with local policy, providing assurance that patient safety and monitoring requirements are fully evidenced.

Documentation reviewed was clear, comprehensive, and up to date, supporting effective communication between members of the multidisciplinary team.

Mental Health Act monitoring

We reviewed a sample of patient records to assess the application of the Mental Health Act (1983) and Code of Practice for Wales (2016). Overall, we found that legal documentation was well organised, appropriately completed, and stored securely. Statutory forms were completed within required timescales and reflected that patients were lawfully detained.

We found that patients were provided with information about their rights both verbally and in writing. This was delivered in a format appropriate to individual needs, including the use of Easy Read materials where required. Patients were supported to understand their rights on an ongoing basis, and there was clear evidence that Independent Mental Health Advocates (IMHAs) were routinely involved, with referrals made on admission and regular access available.

We saw good evidence that Section 17 leave was appropriately managed. Leave arrangements were risk assessed, clearly documented, and included patient involvement in planning where appropriate. Outcomes of leave were recorded within patient records and reviewed through multidisciplinary team (MDT) discussions.

Capacity assessments were completed where required and recorded within patient records. These reflected the principles of the Mental Capacity Act, with evidence of decision-specific assessments and consideration of least restrictive options.

In relation to Deprivation of Liberty Safeguards (DoLS), we were informed that delays in assessments by the local authority can occur, and that patients may remain subject to expired urgent authorisations while awaiting assessment. This presents a risk that patients may be deprived of their liberty without appropriate legal safeguards in place.

We also found that documentation relating to DoLS applications was not always readily available, which reduces assurance in relation to governance and oversight. Staff described reliance on the local authority to progress assessments, with limited local escalation where delays occur.

Overall, while the application of the Mental Health Act was generally appropriate and patients' rights were supported, improvements are required to ensure legal safeguards under the MHA or DoLS are in place where required and that timely standard DoLS authorisation assessments take place.

The health board must ensure that DoLS authorisations are reviewed and progressed in a timely manner, with appropriate escalation where delays occur, to ensure patients are not deprived of their liberty without lawful authority.

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

We reviewed a sample of patient records and found that care and treatment plans (CTPs) were generally comprehensive, well structured, and person centred. Records were maintained using both paper and electronic systems, which were securely stored, accessible, and easy to navigate. There was evidence that multidisciplinary team (MDT) members contributed to a single patient record.

Initial assessments were thorough and completed in line with the Mental Health (Wales) Measure. These included comprehensive mental health and physical health assessments, supported by recognised tools such as MUST, WAASP, and falls and pressure area assessments. Risk assessments were in place, current, and supported by clear intervention plans.

Care and treatment plans were individualised and reflected patients' assessed needs. They included clear goals, interventions, and identified staff responsibilities, and covered all domains of the Mental Health (Wales) Measure. There was a strong focus on recovery, independence, and safety. Patients' preferences, including language needs, were recorded and considered.

We found good evidence of patient and family involvement in care planning. Patient views and wishes were clearly documented, and there was consistent involvement from relatives and advocacy services where appropriate. Records also demonstrated that consent, capacity, and information sharing arrangements were considered and recorded.

Patients' physical health needs were clearly identified and addressed, with evidence of access to a range of services and appropriate monitoring in place.

Care plans were reviewed through MDT meetings and ward rounds, and discharge planning was evident, with involvement from community teams, care coordinators, and families to support continuity of care.

However, we identified some areas for improvement. In one record reviewed, a care and treatment plan had exceeded its review date, which reduces assurance that all plans are consistently reviewed within required timescales.

The health board must ensure that all care and treatment plans are reviewed within required timescales to provide assurance that care remains current and reflective of patients' needs.

We also found that, although unmet needs were identified within the records, these were not always clearly documented. This reduces assurance that all patient needs are fully recognised, monitored, and addressed through care planning.

The health board must ensure that where unmet needs are identified, these are clearly documented within care records, including actions taken or plans for review, to demonstrate how patients' needs are being monitored and addressed.

Overall, patient records were of a good standard, demonstrating comprehensive assessment and person-centred care planning. However, improvements are required to ensure that all care plans are reviewed in a timely manner and that documentation clearly reflects all identified needs and planned actions.

Efficient

Efficient

We found that the service operated in an organised and coordinated manner, with systems in place to support effective admission, care planning, and discharge processes. There was evidence of thorough assessments and regular MDT reviews, supporting continuity of care.

Good communication between inpatient and community teams, alongside strong involvement from families and advocacy services, supported effective discharge planning and positive patient outcomes.

Overall, the service demonstrated an efficient approach to care delivery.

Quality of Management and Leadership

Leadership

Governance and leadership

We found that governance arrangements were in place to support the delivery of care on the ward. Senior staff were visible, approachable, and maintained regular communication with the ward team. Staff told us they felt supported and were able to escalate concerns when required.

There were established processes to ensure that senior managers were informed of issues affecting service delivery. Daily health board meetings were used to review bed capacity, patient flow, staffing levels, and risks. At ward level, structured handovers included discussion of incidents, safeguarding concerns, and complaints.

Regular staff meetings were held, with evidence of discussions around staffing, operational pressures, and areas for improvement. Learning from incidents, safety alerts, and policy updates was shared through meetings, handovers, email communication, and supervision.

However, we identified that some policies, including the Medicines Management Policy and Whistleblowing Policy, were out of date at the time of inspection. This reduces assurance that staff are working to the most current guidance.

The health board must ensure that policies are reviewed and updated.

We also saw evidence that risks, including inpatient falls, were escalated through governance processes such as risk registers and quality and safety meetings, demonstrating oversight at both ward and health board level.

Overall, leadership was visible and supportive, with established governance processes in place. Improvements are required to ensure governance systems, including policy review, are consistently maintained.

Workforce

Skilled and enabled workforce

We found that staffing levels were generally sufficient to maintain safe care. Staffing was reviewed regularly, considering patient acuity and observation levels. The ward used a small pool of bank staff and did not rely on agency staff, which supported continuity of care.

Staff told us they were able to deliver care safely and that the skill mix was appropriate to meet patient needs. However, some staff reported that they would welcome more time to undertake therapeutic engagement with patients.

The health board, based on staff feedback, should consider whether there are opportunities to increase the time available for staff to undertake therapeutic engagement with patients, to further enhance patient experience and support recovery-focused care.

Systems were in place to support workforce management, including supervision, appraisal, and regular staff meetings. Supervision was expected every eight weeks; however, we were told by staff and the ward manager that this was not always delivered consistently. A small number of staff questionnaire responses also suggested that some staff would welcome greater support and opportunities for feedback.

The health board must ensure that all staff receive regular supervision in accordance with local policy, to support professional development, wellbeing, and opportunities to discuss concerns and learning.

Mandatory training compliance was reported at 88.21%, and systems were in place to monitor and follow up non-compliance. However, compliance with some mandatory and safety-critical training remained below expected levels at the time of inspection. Staff reported difficulties accessing some training courses, which may have contributed to challenges in maintaining compliance.

The health board must ensure that compliance with mandatory and safety-critical training is improved and sustained. This should include ensuring that sufficient training opportunities are available, that staff can access required training within appropriate timescales, and that staff are provided with protected time to attend training and maintain compliance.

Overall, while staffing arrangements supported safe care delivery, improvements are required to ensure consistent supervision and full compliance with safety-critical training.

Culture

People engagement, feedback and learning

We found that the ward had a positive and supportive culture. Staff described good teamwork and a collaborative working environment, which was reflected in the interactions observed during the inspection.

There were systems in place to gather and respond to feedback from patients, relatives, and carers. Information about how to raise concerns was available, including bilingual complaints information. Complaints and feedback were reviewed through governance processes to identify themes and trends.

Learning from incidents and complaints was shared with staff through meetings, handovers, and supervision. Staff told us they felt able to raise concerns, and an open and transparent culture was promoted by the ward manager.

Staff were supported following incidents through debriefs and supervision, which supported staff wellbeing and learning.

Overall, the service demonstrated a positive culture, with effective engagement and learning processes in place

Information

Information governance and digital technology

We found that systems were in place to ensure that information was managed safely

and securely. Staff had received training in information governance, and a data retention policy was in place.

Patient information was stored securely, with electronic systems password protected and paper records held in secure locations. Information was shared appropriately using secure systems where required.

Records were accessible to relevant staff, supporting effective communication within the multidisciplinary team and continuity of care.

Overall, information governance arrangements provided assurance that data was managed in line with relevant legislation and standards

Learning, improvement and research

Quality improvement activates

We found that there were established systems in place to support quality improvement. A range of audits were undertaken, including infection prevention and control, medicines management, hand hygiene, and environmental checks. Audit findings were reviewed and shared with staff through governance meetings and ward-level discussions.

The ward had recently introduced additional audit processes, to strengthen monitoring of practice and improve oversight of compliance.

We saw evidence that incidents, complaints, and near misses were used as opportunities for learning. Lessons learned were shared through staff meetings, handovers, and health board forums, supporting a culture of continuous improvement. However, a small number of staff questionnaire responses suggested that staff experience of incident reporting, feedback, and learning was variable. Consideration should be given to engaging with ward staff to understand how consistency in incident reporting, feedback, and shared learning could be further strengthened.

The health board should consider engaging with ward staff to identify opportunities to improve the consistency of incident reporting, feedback, and communication of lessons learned, to support a positive learning culture.

Falls had been recognised as a risk at health board level and were being monitored through established governance processes, including risk registers and quality and safety meetings. The service had implemented initiatives to support falls prevention and reduce patient harm, with learning and good practice shared through health board governance forums to support wider organisational learning and improvement. This demonstrates a proactive approach to identifying, monitoring, and responding to

patient safety risks.

We observed positive work to improve both the ward environment and the experience of patients and their families. A dedicated palliative care room was in use and continued to be developed to provide a comfortable and supportive environment for patients receiving end-of-life care and their loved ones. We also noted that the ward had achieved a Silver Award for its work in supporting carers, demonstrating a commitment to recognising and responding to the needs of families and carers. These initiatives reflect a proactive and compassionate approach to improving patient and family experience.

Patients and families were supported to contribute to improvement through feedback mechanisms, including QR codes and community meetings.

Whole-systems approach

Partnership working and development

We found that the ward worked effectively with a range of external partners to support patient care. Patients had access to community services, including GPs, dentists, and third sector organisations such as advocacy services.

There was evidence of effective collaboration with community mental health teams, social services, and other agencies, particularly in relation to discharge planning and ongoing care.

Patients were supported to access community-based services where appropriate, and partnership working supported continuity of care and positive outcomes.

Overall, partnership working was well established and supported coordinated care across services.

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
Medicines trolley was not secured to the wall.	Unsecured medicines storage increased the risk of unauthorised access to medicines and reduced assurance that medicines were being stored securely in accordance with local medicines management requirements.	The concern was raised immediately with the senior nurse during the inspection.	The medicines trolley was secured to the wall during the inspection, providing assurance that medicines were stored more securely.
Lock on the medicine's fridge was broken.	A damaged lock reduced assurance that medicines requiring secure storage were adequately protected from unauthorised access.	The concern was raised immediately with the senior nurse during the inspection.	The faulty lock was replaced during the inspection and the fridge was secured.

Appendix B - Immediate Improvement Plan

Service: Bronglais Hospital – Enlli Ward

Date of inspection: 15 -17 June 2026

Findings	The inspection team identified that compliance with mandatory Physical Intervention training was 43% on Enlli Ward. As a result, HIW is not assured that sufficient staff have up-to-date training. This presents a potential risk to the safety and wellbeing of patients and staff. Immediate action is required to ensure robust oversight and demonstrable progress in mitigating this risk.

	Improvement needed	Standard / Regulation
1.	The health board must take urgent steps to improve compliance with Physical Intervention training, ensuring all relevant staff are appropriately trained and up to date. This must include strengthened oversight, clear accountability, and evidence of sustained improvement. The health board must provide assurance on how patients and staff will be protected from harm while these safety-critical training gaps are addressed and set out clear arrangements for how compliance will be monitored and sustained.	Safe And Effective Care

Service Action:	Responsible officer	Timescale
1. To ensure that a local RPI training session scheduled for 10 July 2026 is delivered for Enlli Ward, with 9 staff places made available, to improve Physical Intervention training compliance from the current 43% position and address the immediate training gap identified by HIW. Until compliance is restored, the Senior Nurse will maintain daily managerial rostering oversight to ensure each shift has at least one registrant on duty with up-to-date RPI training. 2. To ensure that Enlli Ward Physical Intervention training compliance is reviewed as a standing agenda item at each Ward Managers Forum (WMF), with current compliance rates, actions to address gaps, and evidence of progress recorded and escalated through the MH&LD CCG Integrated Governance Group update paper until compliance reaches and is sustained at the required level. 3. To implement a monthly review of training compliance and forward booking plans with Team Managers through supervision sessions, using compliance data and expiry dates to identify staff due to fall out of compliance within the next three months, agree booking actions, and reduce the risk of multiple staff becoming non-compliant at the same time.	1. Senior Nurse 2. WMF chair 3. Senior Nurses	1. 11th July 2026 2. 31st July 2026 3. 31st July 2026

Findings	Compliance with Immediate Life Support (ILS) and Basic Life Support (BLS) training remains low on Enlli Ward, with current compliance at approximately 50%. The current position demonstrates that sufficient and sustained progress has not been achieved. This issue has been identified in previous HIW inspections across the health board, including Morlais (2024) and Cwm Seren (2025), where similarly low compliance levels were reported, alongside staff-reported difficulties in accessing training due to limited availability of sessions and challenges with course delivery. The recurrence of this issue, despite previous findings and identified actions, indicates that learning has not been fully embedded and that the health board has not driven sustained improvement in this area.	
	Improvement needed	**Standard / Regulation**
2.	HIW is not assured that all relevant staff have up-to-date training, which presents a potential risk to the safety and wellbeing of patients. The requirement for immediate assurance reflects the lack of sufficient progression in improving staff training compliance despite this issue being previously identified. The health board must take urgent and proactive steps to improve compliance with ILS and BLS training. This must include ensuring sufficient and accessible training provision, supporting staff to attend training, and implementing robust oversight arrangements to demonstrate clear and sustained progress in addressing this ongoing issue.	Safe and Effective Care

Service Action:	Responsible officer	Timescale
1. To deliver an extraordinary local training session which will offer 9 places for ILS training for the ward team to address the immediate requirement to resolve training compliance. Current interim mitigation is based on managerial rostering oversight to ensure that all shifts have at least one registrant on duty with the required training. 2. To undertake a multifactorial review of the ILS and BLS training compliance in Mental Health and Learning Disabilities **(**MHLD), in order to achieve and sustain ≥85% compliance with a focused analysis of the underlying causes of below-target compliance across MHLD services. 3. To review the training compliance and seek assurance is a standing agenda item for Ward Managers Forum (WMF) and reported via the update paper to the MH&LD Clinical Care Group's Integrated Governance Group.	1. Senior Nurse 2. Head of Nursing MH&LD 3. WMF chair	1. 31st July 2026 2. 30th October 2026 3. 31st July 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): Rebecca Temple Purcell

Job role: Assistant Director of Nursing, MHLD **Date:** 26/06/2026

Appendix C – Improvement plan

Service: **Bronglais Hospital – Enlli Ward**

Date of inspection: **15 – 17 June 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.	Patients reported feeling involved in their care, although one patient described feeling anxious when attending formal meetings, indicating that additional support may be required to ensure all patients feel comfortable participating.	The health board should consider how best to support patients to participate in formal meetings, particularly where anxiety may impact their involvement.	Patient Experience.	Undertake a review of MDT Documentation and Care & Treatment Plan review processes and include a Patients Voice section. This will be evidenced in an updated template document in the electronic care record and monitored through the Record Keeping audit Offer patients pre-meetings, advocacy support, and	Ward Manager / Senior Nurse Ward Manager/ QAPD Lead	30th November 2026 30th November 2026

				attendance supported by an allocated nurse to reduce anxiety and improve participation. The offer will be monitored within the Record Keeping audit programme.		
2.	Some patients suggested that additional resources, such as a second television, would improve their experience by providing greater choice in activities.	The health board should consider whether additional recreational resources, such as a second television, could enhance patient experience and choice.	Patient Experience.	A standardised agenda item for additional resources / requests will be added to the Inpatient Community Meeting to receive feedback from existing cohort on an ongoing basis for continuous monitoring. A second screen is available for patients to access	Ward Manager / Occupational Therapy	1st Sept 2026
3.	One external garden area was not fully accessible due to an unused	The health board must ensure that environmental risks are addressed in a timely manner.	Environment.	Complete environmental risk assessment and implement controls to ensure safe access to	Ward Manager / Estates Department	1st Sept 2026

	staircase, limiting its safe use.			external space. Escalate any estates requirements through Health Board processes.		
4.	Most patients reported feeling safe, although one patient highlighted anxiety relating to the mix of patient needs, which staff managed through observation and intervention.	The health board should consider how it can further support patients who may feel anxious about the ward environment to ensure they feel safe, supported, and able to engage in their care.	Safe & Effective Care.	The service will present a paper to the MH&LD Integrated Governance Group for Business, Planning, Performance and People to consider and explore the challenges and opportunities in relation to the development of ward-based services for Older Adults. The paper will consider the future model of care for patients with a functional or organic illness.	Senior Nurse / Head of Service	30th Oct 2026
5.	HIW identified some gaps in the recording of the emergency bag checks, including missed checks	The health board must ensure that checks of emergency and resuscitation equipment	Medicines Management.	Provide feedback from ongoing managerial monitoring systems and reinforce record	Ward Manager / Senior Nurse	Completed

	of emergency equipment during the month of May and June. This reduces assurance that all checks are being completed consistently in line with local requirements.	are completed and documented consistently in accordance with local policy, to provide assurance that equipment remains available and ready for use in an emergency.		keeping requirements with staff through a standard agenda item for Staff Meetings and explore systems for maintaining consistent records. Reinforce weekly management audit of emergency equipment checks and review compliance through ward governance meetings.	Ward Manager / Senior Nurse	Completed
6.	Gaps were identified in recording, with missing temperature checks between May and June.	The health board must ensure that robust systems are in place to monitor compliance with temperature recording requirements for medicines storage areas, including oversight arrangements to identify and address missed	Medicines Management.	Provide feedback to staff from ongoing managerial monitoring systems and reinforce record keeping requirements with staff through a standard agenda item for Staff Meetings and explore systems for maintaining consistent records.	Ward Manager / Medicines Management Lead / Senior Nurse	Completed

		checks in a timely manner.		Reinstate daily monitoring, implement weekly oversight checks, and escalate missed checks through governance processes.	Ward Manager / Medicines Management Lead / Senior Nurse	Completed
7.	Consent to treatment documentation was not consistently available alongside medication charts, limiting assurance that medicines were being administered in accordance with legal requirements.	The health board must ensure that appropriate consent to treatment documentation is available, accurately completed, and maintained alongside medication charts to provide assurance that medicines are administered lawfully.	Records.	Audit all medication charts to ensure consent documentation is present and correctly completed. Standard clinical audit programme to be reviewed and updated Reinforce requirements with staff through a standard agenda item for Staff Meetings and explore systems for maintaining consistent records.	Ward Manager Head of Nursing MH&LD Ward Manager / Senior Nurse	1st Sept 2026 30th Oct 2026 1st Sept 2026
8.	Medicines Management Policy was out of date at the time of inspection and	The health board must ensure that medicines management policies are	Governance, Leadership, and accountability.	Full oversight of the review timeline was maintained by the	Clinical Written Document Control Group	1st Sept 2026

	was due for review in March 2026.	reviewed and updated within required timescales so that staff are supported by current guidance and best practice.		Clinical Written Document Control Group (CWCDG) The approved policy has now been ratified and implemented.		
9.	HIW found gaps in observation records, indicating that documentation was not consistently maintained. While observations were reported to be taking place, incomplete recording reduces assurance that patient monitoring and safety requirements are fully evidenced.	The health board must ensure that patient observations are completed and recorded consistently in accordance with local policy, providing assurance that patient safety and monitoring requirements are fully evidenced.	Records.	Provide feedback from ongoing managerial monitoring systems and reinforce record keeping requirements with staff through a standard agenda item for Staff Meetings and explore systems for maintaining consistent records. MH&LD CCG to implement a review of the existing Engagement and Observation policy to explore transitioning to a relational engagement approach, embedding the	Ward Manager Head of Nursing MH&LD	Completed 1st Sept 2026

				principles of Safewards standards. Audit of observation records takes place every week by the ward manager and monthly by the senior nurse.		
10.	HIW were informed that delays in assessments by the local authority can occur, and that patients may remain subject to expired urgent authorisations while awaiting assessment. This presents a risk that patients may be deprived of their liberty without appropriate legal safeguards in place. HIW also found that documentation relating to DoLS applications was not always readily available, which reduces assurance in relation to governance and oversight. Staff	The health board must ensure that DoLS authorisations are reviewed and progressed in a timely manner, with appropriate escalation where delays occur, to ensure patients are not deprived of their liberty without lawful authority**.**	Records.	The weekly Pathway of Care Delays POCD meeting will add a Standing Agenda item to identify potential delays and enable escalations and resolution. The head of service will present a paper to Mental Health Legislation group to consider standardised Escalation processes to avoid future delays. All current DoLS applications are in date.	Head of Service Head of Service	1st Sept 2026 30th October 2026

	described reliance on the local authority to progress assessments, with limited local escalation where delays occur.					
11.	In one record reviewed, a care and treatment plan had exceeded its review date, which reduces assurance that all plans are consistently reviewed within required timescales.	The health board must ensure that all care and treatment plans are reviewed within required timescales to provide assurance that care remains current and reflective of patients' needs.	Records.	Provide feedback from ongoing managerial monitoring systems and reinforce record keeping requirements with staff through a standard agenda item for Staff Meetings and explore systems for maintaining consistent records. Record keeping audits take place annually, annual data is also utilised to plan improvements in documentation for the following year.	Ward Manager / MDT Coordinator	Completed
12.	HIW found that, although unmet needs were identified within the	The health board must ensure that where unmet needs are identified, these	Records.	Provide feedback from ongoing managerial monitoring systems	Ward Manager	1st Sept 2026

	records, these were not always clearly documented. This reduces assurance that all patient needs are fully recognised, monitored, and addressed through care planning.	are clearly documented within care records, including actions taken or plans for review, to demonstrate how patients' needs are being monitored and addressed.		and reinforce record keeping requirements with staff through a standard agenda item for Staff Meetings and explore systems for maintaining consistent records. Record keeping audits take place annually, annual data is also utilised to plan improvements in documentation for the following year		
13.	HIW identified that some policies, including the Medicines Management Policy and Whistleblowing Policy, were out of date at the time of inspection. This reduces assurance that staff are working to the most current guidance.	The health board must ensure that the Medicines Management Policy and Whistleblowing Policy are reviewed and updated, and that robust systems are in place to monitor policy review dates and prevent policies from remaining out of date.	Workforce Culture, Leadership and Organisational.	Full oversight of the review timeline was maintained by the Clinical Written Document Control Group (CWCDG) The approved policy has now been ratified and implemented. The Whistleblowing policy has been superseded by Speak	Clinical Written Document Control Group Ward Manager	1st Sept 2026

				up Safely guidance which was implemented in 2024 and remains up to date. Current and up to date information relating to this is available on the HDUHB intranet. Information to raise awareness of this will be shared with staff through a standardised agenda item within Staff meetings.		1st Sept 2026
14.	Staff told us they were able to deliver care safely and that the skill mix was appropriate to meet patient needs. However, some staff reported that they would welcome more time to undertake therapeutic engagement with patients.	The health board based on staff feedback should consider whether there are opportunities to increase the time available for staff to undertake therapeutic engagement with patients, to further enhance patient experience and support recovery-focused care.	Workforce Culture, Leadership and Organisational.	MH&LD CCG to implement a review of the existing Engagement and Observation policy to explore transitioning to a relational engagement approach, embedding the principles of Safewards standards.	Head of Nursing MH&LD	1st Sept 2026

15.	Supervision was expected every eight weeks; however, we were told by staff and the ward manager that this was not always delivered consistently. A small number of staff questionnaire responses also suggested that some staff would welcome greater support and opportunities for feedback.	The health board must ensure that all staff receive regular supervision in accordance with local policy, to support professional development, wellbeing, and opportunities to discuss concerns and learning.	Workforce Culture, Leadership and Organisational.	Re-establish managerial supervision tracker, monitor compliance monthly, and escalate non-compliance through management supervision structures. All staff will be reminded of the offer of Restorative Supervision and how to request it at staff meetings through a standardised agenda item	Ward Manager / Senior Nurse Ward Manager	1st Sept 2026 1St Sept 2026
16.	Some mandatory and safety-critical training remained below expected levels at the time of inspection. Staff reported difficulties accessing some training courses, which may have contributed to challenges in maintaining compliance.	The health board must ensure that compliance with mandatory and safety-critical training is improved and sustained. This should include ensuring that sufficient training opportunities are available, that staff can access required training within appropriate	Workforce Culture, Leadership and Organisational.	Recognising the repeated challenges that have been noted during HIW inspection events in achieving and maintaining ILS BLS training compliance a Multifactorial Review of the training programme will be completed which will lead to further systemic organisational actions.	Head of Nursing MH&LD	30th Oct 2026

		timescales, and that staff are provided with protected time to attend training and maintain compliance. The health board must also ensure that training compliance is regularly monitored and reviewed through governance processes, with timely action taken where non-compliance is identified.		The review will include (but not be limited to) the following factors. • Booking systems via ESR and related managerial oversight • Training capacity including trainer and location resources • Competence allocation to specific staffing groups • Current Risk Register Mitigation plans • Governance and related scrutiny of compliance positions Trajectory for staff compliance achieved. Training compliance will be reviewed and assurance sought via a standardised agenda item for Ward Managers	Ward Managers Forum Chair	1st Oct 2026

				Forum and reported via the update paper to the MH&LD CCG Integrated Governance Group		
17.	A small number of staff questionnaire responses suggested that staff experience of incident reporting, feedback, and learning was variable. Consideration should be given to engaging with ward staff to understand how consistency in incident reporting, feedback, and shared learning could be further strengthened.	The health board should consider engaging with ward staff to identify opportunities to improve the consistency of incident reporting, feedback, and communication of lessons learned, to support a positive learning culture.	Workforce Culture, Leadership and Organisational.	A DATIX safety report identifying Themes and Trends will be shared with wards by MH&LD QAPD team each quarter Introduce learning from events as a standing agenda item at team meetings and provide regular staff feedback on outcomes and actions. Feedback via feedback field to be considered for learning to inform the reporter.	QAPD team Ward Manager	30th Oct 2026 30th Oct 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: Richard Williams

Name (print): Richard Williams

Job role: Head of Nursing Date: 27/07/2026