Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Llanfair Unit, Meadow and Daffodil Wards, Cardiff and Vale University Health Board

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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 Meadow and Daffodil Wards, Llanfair Unit, Cardiff and Vale University Health Board on 08, 09 and 10 June 2026. The following hospital wards were reviewed during this inspection:

- Meadow Ward - 13 beds providing rehabilitation services
- Daffodil Ward – 11 beds providing rehabilitation services.

Our team for the inspection comprised 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 family/carers to complete a questionnaire to tell us about their experience of using the service. A total of 6 questionnaires were completed. We also spoke to staff working at the service during our inspection. Feedback we received appears 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, we found that staff treated patients with kindness, respect and compassion, responding promptly and appropriately to their needs. Patients were supported through structured and effective care processes, including comprehensive assessments, timely access to healthcare services and regular multidisciplinary reviews.

Patients were actively involved in decisions about their care and were encouraged to develop independent living skills. A wide range of therapeutic activities and facilities were available to support patients' wellbeing, with input from occupational therapy (OT). These contributed positively to patient experience and recovery.

The ward environments were generally well-presented; however, we identified environmental issues which undermined the delivery of dignified care and negatively affected patients' privacy, comfort and wellbeing. These included a lack of ensuite facilities and multiple communal toilets and bathing facilities out of order, including a specialist bath. Faulty bedroom observation panels further reduced assurance around patient privacy and safe observation. We also noted that the garden areas were poorly maintained.

Staff demonstrated a clear commitment to respecting patients' rights and individual preferences, supported by advocacy services and person-centred care planning. However, access to clear and up-to-date patient information was inconsistent, and clear information on restricted items and how informal patients could leave the ward was not readily available.

Additionally, staff compliance with Equality, Diversity and Human Rights and Welsh language training required improvement. Limited staff awareness of the Welsh language Active Offer reduced assurance that patients' communication needs could be consistently met across both wards.

This is what we recommend the service can improve:

- Maintain the ward garden areas to support a safe, therapeutic environment
- Ensure all bedroom observation panels are fully functional to support safe observations and protect patient privacy
- Ensure all patient information is clear, accessible and up to date, including information on restricted items and how informal patients can leave the wards
- Improve staff compliance with Welsh language training and strengthen staff understanding of the Welsh language Active Offer

- Ensure appropriate facilities, equipment and support for patients with mobility needs.

This is what the service did well:

- Consistently positive staff–patient relationships observed
- Staff treated patients with dignity and respect
- Patients were involved in decisions about their care
- A wide range of therapeutic and recreational activities was available
- A multi-faith room on Daffodil Ward supported religious and cultural needs
- Good access to gym facilities and exercise equipment to support physical health.

Delivery of Safe and Effective Care

Overall summary:

Some suitable governance arrangements, policies and processes were in place to support safe and effective care, including multidisciplinary working, discharge planning, audit activity and systems for reporting and managing incidents at ward level. However, we found persistently low staff compliance with safety-critical mandatory training and weaknesses in governance oversight of this area. This posed an immediate risk to patient and staff safety and required urgent action through our Immediate Assurance process.

Patient care was delivered in a coordinated and person-centred way, with staff demonstrating a good understanding of patients' needs and risks. Risk management was supported by individual safety plans, therapeutic observations and preventative approaches. Care and Treatment Plans were generally comprehensive; however, improvements were needed to ensure they were consistently completed to a high standard and reviewed within required timescales.

Medicines management and Mental Health Act processes were generally well managed; however, improvements were required in the re-explanation and recording of patient rights, the quality of leave documentation, and the provision of the Code of Practice on the wards.

IPC arrangements were well-established; however, the ward environment did not consistently support their effective application. We identified multiple longstanding estates and maintenance issues, some of which had been identified previously but remained unresolved, reducing assurance that environmental risks were being effectively managed. Additional IPC concerns were identified in relation to food labelling and temperature monitoring of communal fridges.

Immediate assurances:
During the inspection we identified significant concerns in relation to staff compliance with safety-critical mandatory training. Compliance was persistently low in key areas, including Strategies and Interventions for Managing Aggression (SIMA), Basic Life Support, Intermediate Life Support, Moving and Handling Level 2 and Safeguarding Level 3. In addition, no staff had received training in the safe use of portable British Oxygen Company (BOC) oxygen cylinders. Therefore, we were not assured that sufficient staff had the competencies required to manage risks safely, posing an immediate risk to patient and staff safety.

We also found evidence that staff who were not compliant with SIMA training had been involved in restraint interventions and identified a restraint incident where documentation lacked sufficient detail, reducing assurance regarding the safety and appropriateness of the intervention.

These concerns were addressed through our Immediate Assurance Process and are detailed in Appendix B of this report**.**

This is what we recommend the service can improve:

- Strengthen systems to identify, prioritise and fully resolve all outstanding estates and maintenance issues
- Improve food safety arrangements, including consistent labelling and temperature monitoring
- Strengthen Mental Health Act compliance in relation to patient rights, leave documentation and Code of Practice provision
- Ensure Care and Treatment Plans are completed to a high standard, regularly reviewed and reflect patients' current needs.

This is what the service did well:

- Personal safety alarms available and consistently carried by staff
- Individual patient safety plans in place where required
- Restrictive practices used as a last resort, supported by staff understanding of individual patient needs and risks
- Robust medicines management systems, including good support for patient self-administration
- Effective multidisciplinary team working
- Effective discharge planning with community services involvement.

Quality of Management and Leadership

Overall summary:

Governance arrangements included a range of oversight and assurance processes which generally supported the identification and escalation of risks at a local level. However, there was limited structured senior oversight to review incidents, identify themes and trends, and ensure learning informed service-wide improvement. Arrangements to strengthen oversight were in progress, but not yet embedded. In addition, several health board policies and procedures were in draft or overdue for review, resulting in a lack of current guidance to support staff in their roles.

Oversight also required strengthening in key areas to ensure risks were consistently identified, monitored and addressed, particularly in relation to the management of environmental and operational risks and oversight of staff training compliance. In addition to our Immediate Assurance findings, we found low compliance across multiple training areas. Training data was not consistently reliable, and staff were not always aware of mandatory training requirements. In addition, no staff had received training in the Duty of Candour, and there was no evidence that these responsibilities were understood by staff.

Staffing establishments were generally aligned with core requirements and sufficient to support patient safety, supported by the use of temporary staff. However, while staff reported sufficient resources overall, staffing pressures, vacancies and frequent redeployment affected the consistency of care delivery.

Some suitable arrangements supported staff development, including clinical supervision and high levels of appraisal compliance; however, improvements were required to ensure supervision processes were consistently documented. Staff demonstrated a strong commitment to delivering safe, person-centred care and described positive multidisciplinary working, although some reported limited visibility of senior managers on the wards.

While processes were in place to capture staff and patient feedback, we found these were not consistently implemented or documented. Staff meetings were not held in line with required frequency, and patient meetings were not consistently documented, reducing the service's ability to demonstrate effective engagement and learning from feedback.

This is what we recommend the service can improve:

- Improve senior management visibility and engagement, in response to staff feedback
- Ensure staffing arrangements consistently support effective patient care, including when staff are redeployed to other wards
- Strengthen recruitment to vacant posts to improve staffing stability

- Review incident management processes to ensure themes and learning are identified and used to drive service-wide improvement
- Maintain up-to-date policies and procedures, subject to regular review
- Formalise supervision arrangements, with clear records maintained
- Strengthen systems to accurately record, monitor and provide assurance on training compliance and ensure staff awareness of requirements and competencies
- Provide all staff with Duty of Candour training
- Embed regular staff meetings
- Strengthen processes for recording, reviewing and using staff and patient feedback to inform improvement.

This is what the service did well:

- Supportive ward cultures with good team collaboration
- Effective MDT and wider system partnership working
- Regular engagement between staff and patients about their care and experience
- A range of improvement initiatives completed and ongoing
- Staff were receptive and responsive to our inspection findings.

3. What we found

Quality of Patient Experience

Patient feedback

We invited patients, families and carers to complete HIW questionnaires, and spoke with patients on the wards where appropriate. Whilst the sample size was too small to draw robust conclusions, some feedback reflected our findings during the inspection, particularly in relation to the environment and infection prevention and control (IPC), which are outlined in this report.

The two patients who completed questionnaires provided positive feedback about their experiences and rated the care and services provided as very good. They told us they were given information about their stay, felt involved in their care and treatment, and were treated with dignity and respect by staff. However, feedback from family members and carers was mixed. All four respondents felt able to visit as often as they wished, and most (3/4) reported that staff discussed patients' care and treatment with them and encouraged questions. However, one respondent did not feel sufficiently involved in care decisions and was unaware of how to raise concerns, and two had not been offered an assessment of their own needs as carers.

Views on the ward environment were mixed. Two respondents felt that infection prevention and control measures were being followed, while one felt they were only followed 'sometimes'. Perceptions on cleanliness also varied, with one respondent describing the setting as 'fairly clean' and another as 'not very clean'. Concerns were also raised regarding maintenance and housekeeping, including unresolved environmental issues and the availability of clean bedding.

Three respondents raised concerns regarding the management of patients' personal belongings, with reports of missing clothing and footwear. Some reported concerns regarding patient safety and staff supervision, including patient falls, unsafe patient behaviour and incidents between patients.

Despite these concerns, most respondents (3/4) rated the overall quality of the setting as good or very good, whilst one rated it as very poor.

The health board must review the feedback provided by family and carers and consider improvements to address concerns raised relating to communication and involvement in care, patient safety and supervision, and the management of patients' personal belongings.

Person-Centred

Health promotion

We found effective processes in place to promote and maintain patients' physical and mental health needs. We reviewed a sample of patient records across both wards and found that patients' physical health was suitably monitored. Care and treatment plans demonstrated multidisciplinary input and evidenced ongoing review of patients' needs and progress.

Facilities were available to support patients' physical health, including access to exercise equipment and communal garden areas. While the garden areas provided a pleasant therapeutic space, they were overgrown and required tidying and general maintenance.

The health board must ensure that the ward garden areas are appropriately maintained to provide a safe and therapeutic environment for patients.

Occupational Therapy (OT) provision was in place across both wards. Patients were supported to engage in a range of activities which contributed to their physical and mental wellbeing, including recreational and structured activities such as games, arts and crafts, and planned outings, subject to staffing levels. A range of self-directed activities was also available, including access to televisions, games and puzzles. Patients were able to access a range of information to support their health and wellbeing, including information relating to healthy eating, nutrition and smoking cessation.

Dignified and respectful care

Throughout the inspection, we observed staff engaging with patients appropriately and treating them with dignity and respect. Staff interacted with patients in a calm, considerate and professional manner, contributing to a positive and supportive ward environment. An appropriate mix of staff was in place across both wards to meet patients' needs.

The ward environment generally supported patients' dignity. Communal areas were available for social interaction, alongside quieter spaces where patients could spend time alone. All patients had their own bedrooms and were able to personalise their rooms. Staff were observed to knock before entering bedrooms and respected patients' privacy.

However, we identified environmental issues that undermined the service's ability to consistently deliver dignified and respectful care. Observation panels were fitted to bedroom doors; however, in several rooms, the key mechanisms to operate the panels were missing, meaning they could not be opened or closed. This meant staff could not safely undertake observations as intended and, in some cases, left openings through

which patients could be seen, compromising their privacy and dignity.

The health board must ensure that all patient bedroom observation panels are fully functional to enable staff to undertake observations safely while maintaining patients' privacy and dignity.

Only four patient bedrooms on each ward had en-suite facilities, with most patients reliant on communal bathing facilities. At the time of inspection, several communal toilet and bathing facilities were out of order on both wards, including male urinals and a female toilet, requiring patients to use alternative facilities. This reduced assurance that patients could consistently access facilities that were clean, functional and supported their privacy and dignity. Further information on these findings is set out in the Risk Management and Infection Prevention and Control sections of this report.

Patient information

A range of suitable patient information was displayed across the wards. This included information on the Mental Health Act, advocacy services, how to raise a concern or complaint, how to contact HIW, and staff pictorial identification boards.
However, the availability and quality of information was not consistent across both wards. On Daffodil Ward, some key information was missing, including details of legal representatives for detained patients, service user and carer information booklets, and visiting times. In addition, whilst a service user information booklet was available on Meadow Ward, it required updating.

The health board must ensure that clear, accessible and up-to-date patient information is consistently available and clearly displayed across all wards.

We also identified inconsistencies in the information available to support patients' understanding of ward restrictions. Both wards operated locked doors and accommodated informal patients; however, clear written information was not available to explain how informal patients could leave the ward. In addition, information regarding restricted or prohibited items was not readily available. This reduced transparency and may impact patients' understanding of the restrictions in place.

The health board must ensure that clear, accessible written information is consistently available to patients regarding ward restrictions, including how informal patients may leave the ward and any restricted or prohibited items.

Individualised care

Staff demonstrated a good understanding of patients' individual needs and described how care was tailored to support personal preferences, abilities and levels of

independence. We found that patients were supported to make decisions about their care, promoting independence and quality of life. Patients had access to a range of aids and resources to support this, including internet access and digital devices used for therapeutic purposes, such as structured Cognitive Behavioural Therapy (CBT) exercises with staff.

Patients were encouraged to undertake activities of daily living to develop and maintain independent living skills, including laundry, personal hygiene and managing their own rooms, with support from staff where required. They were also supported to make choices about their daily lives, including selecting clothing and participating in activities. We identified good practice in relation to patient engagement through cooking activities, which promoted independence and skills development.

Patients had individualised, person-centred Care and Treatment Plans (CTPs), which documented their involvement in decisions about their care. Further findings relating to care planning are detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Timely

Timely care

During the inspection, we observed staff responding promptly to patient needs and providing reassurance and emotional support where required. Care and Treatment Plans generally reflected patients' assessed needs and supported the ongoing management of care. We saw strong evidence that discharge planning was considered throughout the patient pathway, supporting continuity of care and patient flow through the service.

Established meeting processes supported the delivery and oversight of patient care. These included daily handovers, ward rounds, referral meetings and bed management processes. Staff described a range of additional ward-level, multidisciplinary, and governance meetings that supported communication and coordination of care delivery.

Equitable

Communicating and language

We observed staff communicating with patients in a clear, respectful and supportive manner. Patients appeared comfortable approaching staff, and staff responded promptly and attentively to requests and concerns. Private rooms were available on each ward, enabling confidential discussions between patients and staff.
Patients were supported to maintain contact with family members and others outside the service through access to digital technology, including ward telephones and personal devices.

Information for patients was primarily available in English, with bilingual signage and information materials available on the wards. Staff told us that information could be provided in other languages where required, and translation services were available. Our review of patient records confirmed that language preferences were recorded and, where required, arrangements were made to support patients' communication needs. Welsh language training was available to staff, and Welsh-speaking staff wore identifiers to indicate their ability to speak Welsh. However, compliance with Welsh language training was low across both wards, and some staff demonstrated limited awareness of the Welsh language Active Offer. This reduced assurance that patients' language needs could be consistently met.

The health board must ensure that all staff complete mandatory Welsh language training, have a good understanding of the Active Offer, and that effective oversight arrangements are in place to monitor and improve compliance.

Rights and equality

We reviewed the records of five patients detained under the Mental Health Act and found that documentation was compliant with relevant legislation and aligned with the Mental Health Act Code of Practice for Wales (2016). Further detail on these findings is provided in the Mental Health Act Monitoring section of this report.

All patients had access to an independent mental health advocate who provided information and support regarding their care and treatment. The involvement of advocacy services was clearly evidenced within the patient records reviewed. Staff demonstrated a clear commitment to upholding patient rights and respecting individual preferences. Policies and processes were in place to promote equality and protect staff and patients from discrimination. Staff described how concerns relating to discrimination or harassment would be escalated appropriately, including to management and external agencies where required.

However, overall staff training compliance for Equality, Diversity and Human Rights was variable, with high compliance on Daffodil Ward, but lower compliance on Meadow Ward at 77.8%. Further detail in relation to staff mandatory training compliance is outlined within the Workforce section of this report.

Reasonable adjustments were in place to support equitable access to services. Both wards were accessible to wheelchair users, and specialist equipment was available to support individual patient needs where required. We also identified good practice on Daffodil Ward, where a multi-faith room supported patients' religious and cultural needs.

However, some bathing facilities on Meadow Ward, including a specialist bath, were out of order. This meant that patients requiring this equipment could not be fully supported on the ward, reducing equitable access to care.

The health board must ensure that appropriate facilities, equipment and support are available to enable patients with mobility difficulties to access care equitably.

Delivery of Safe and Effective Care

Safe

Risk management

There were established policies, processes and audits in place to support the management of risk, enabling staff to provide safe and clinically effective care. We reviewed arrangements in place to manage risks and maintain the health and safety of patients, staff and visitors, and found the following suitable measures in place:

- Personal safety alarms were available for all staff and we observed staff carrying them throughout the inspection
- Staff demonstrated awareness of individual patient risks and were able to describe how these were managed
- Safety plans were in place for patients who required them
- Therapeutic observation records were appropriately completed and maintained contemporaneously
- Up-to-date ligature audits were in place, and ligature cutters were readily available, with staff able to describe their location
- Regular checks of emergency resuscitation equipment were undertaken to ensure items were present and within date.

However, we identified significant concerns in relation to staff compliance with safety-critical mandatory training. Compliance was persistently low in key areas, including Strategies and Interventions for Managing Aggression (SIMA), Basic Life Support, Intermediate Life Support, Moving and Handling Level 2 and Safeguarding Level 3. In addition, no staff had received training in the safe use of portable BOC oxygen cylinders.

We also identified examples where staff who were not compliant with SIMA training had been involved in restraint interventions. In one case, documentation relating to a restraint incident lacked sufficient detail, reducing assurance regarding the safety and appropriateness of the intervention.

As a result, we were not assured that sufficient staff had the competencies required to manage risks safely, presenting an immediate risk to patient and staff safety. Our concerns were addressed as part of our Immediate Assurance Process and are detailed in Appendix B

The wards operated a daily environmental checklist process intended to provide assurance that ward environments were safe and well maintained. Our review found that the checks were undertaken and recorded appropriately. However, we identified multiple, longstanding environmental risks across both wards. Key issues included:

- Mould present in bathroom areas on both wards
- Multiple toilet, shower and bathing facilities out of order, including male urinals, a female toilet, defective showers and specialist bathing equipment
- Areas of damp, peeling paint and stained ceiling tiles
- A loose accessible shower grab rail on Meadow Ward, rectified by staff during the inspection
- Detached fixtures, including toilet roll holders
- A range of outstanding maintenance issues, including leaking taps, blocked or non-functioning sinks, faulty urinals, lack of hot water, and defective shower controls (including anti-ligature fixtures)
- Ongoing unresolved ceiling leaks, which worsened during periods of heavy rain, were observed during the inspection.

The health board had an electronic system in place to log and monitor maintenance issues. However, staff reported that issues were often closed on the system without being addressed. These findings demonstrated a persistent failure to address environmental issues, limiting assurance that the ward environments were safe and supported the delivery of effective care.

The health board must:

- **Address all outstanding estates and maintenance issues across both wards within appropriate timescales**
- **Implement effective systems to identify, prioritise and manage estates and maintenance issues**
- **Strengthen oversight arrangements to ensure issues are not closed until they have been fully resolved.**

Infection prevention and control and decontamination

Infection Prevention and Control (IPC) arrangements were well-established across both wards. The ward environments were generally clean and tidy, with structured daily and weekly cleaning schedules supported by documented environmental checks. Staff followed appropriate IPC practices, including safe sharps disposal, effective equipment decontamination and correct use of PPE, with good access to hand hygiene facilities and clear signage in place.

An IPC lead structure was in place, led by ward managers with support from IPC champions. Staff demonstrated a good understanding of their responsibilities and escalation processes. Training compliance was high across both wards, and regular audit activity provided ongoing oversight of IPC practices.

However, the overall environment did not consistently support effective IPC due to

unresolved estates and maintenance issues. We also identified gaps in IPC practice, including unlabelled communal patient food in the kitchen on Meadow Ward.

The health board must ensure that all patient food is appropriately labelled to ensure it is used within safe timeframes and to support patient safety.

In addition, we found that temperature monitoring of communal patient fridges was not being undertaken or recorded, increasing the risk of food spoilage and infection. This was addressed by staff during the inspection.

Safeguarding of children and adults

Safeguarding incidents and concerns were recorded on the Datix electronic incident reporting system and monitored by the senior management team. Staff confirmed that safeguarding concerns were regularly reviewed to identify themes and support organisational learning.

Clear safeguarding and reporting processes were in place, with guidance accessible to staff via the intranet. Staff demonstrated a good understanding of safeguarding procedures and were able to describe how to identify and escalate concerns appropriately.

Training compliance with mandatory safeguarding Levels 1 and 2 was generally high. However, as outlined earlier in this report, compliance with Level 3 training was very low, with no staff compliant on Meadow Ward, and 33% compliance on Daffodil Ward. This reduced assurance that all staff had the knowledge and competence required to recognise and respond to complex safeguarding concerns and was addressed through our Immediate Assurance Process.

In addition, some senior staff were unclear about safeguarding training requirements relevant to their roles, further reducing assurance that training needs were fully understood and met.

The health board must ensure that all staff understand safeguarding training requirements relevant to their roles and complete the appropriate level of training to support the effective identification and management of safeguarding concerns.

Management of medical devices and equipment

Medical devices and equipment were generally well managed across the wards. Equipment was observed to be clean, appropriately stored, and readily available to support patient care. Suitable systems were in place to ensure equipment was routinely checked and maintained.

Medicines management

We reviewed the wards' clinic arrangements and found robust procedures in place for the safe management of medicines. Relevant policies were in place and were accessible to staff.

Medicines were stored securely in locked cupboards and refrigerators, medication trolleys were appropriately secured, and medication fridge temperatures were monitored in line with local procedures. We saw evidence that medication stock was accounted for when administered, and that stock checks were being undertaken as required. We found effective internal auditing arrangements, supported by good pharmacy involvement, which helped to promote the safe administration of medicines.

The wards used effective processes to administer medication via the recently introduced Electronic Prescribing and Medicines Administration (EPMA) system. Medication records were maintained to a good standard, with records completed appropriately when medication was prescribed and administered, and reasons recorded when medication was not administered. Patients' consent to treatment certificates were appropriately completed, and patients' Mental Health Act legal status was clearly recorded.

We observed safe and appropriate prescribing practices, with medications prescribed in line with individual patient needs and reviewed regularly to ensure continued appropriateness. High-risk medications, including high-dose antipsychotics, were appropriately prescribed and subject to enhanced monitoring.

We found that patients or their family and carers were involved in decisions about their medications wherever possible. Medications were routinely reviewed during ward rounds, and any changes were clearly documented. Patients were supported to understand their medication through discussions with staff, and information leaflets were available to support this.

There was a clear focus on promoting patient involvement and independence. Arrangements were in place to support self-administration, including purpose-built lockable storage within patient bedrooms. We identified this as an example of good practice.

Staff demonstrated appropriate knowledge and understanding of medicines management procedures. Systems were in place to ensure medication incidents and errors were reported and managed appropriately, including the use of Datix, with learning shared to support continuous improvement.

Effective

Effective care

We found that care was delivered in a coordinated and person-centred manner, with staff demonstrating a good understanding of patients' needs and risks. Staff described effective multidisciplinary team working across both wards, with regular ward rounds and input from a range of professionals supporting decision making and care delivery. We saw evidence that patients' needs were considered in the planning and delivery of care. Staff described how rehabilitation and recovery were promoted through structured processes, including the use of leave, therapeutic activities, and patient involvement in reviewing risks and care needs. Our records review evidenced regular MDT review of patient care, with care adjusted in line with patient presentation and risk profile.

Patient observation practices were appropriately implemented. Staff demonstrated a clear understanding of their roles and responsibilities when undertaking observations, and records confirmed that observations were completed in line with assessed need.

While Immediate Assurance concerns were identified in relation to staff compliance with SIMA training, staff demonstrated a good understanding of restrictive practices. We found a strong preventative approach to the management of behaviours that may challenge, with staff working proactively with patients to identify triggers and implement strategies to reduce escalation. Risk formulations were reviewed regularly, with specific intervention plans in place where required. Staff and patient interactions observed during the inspection were calm and supportive, and restrictive interventions were described and evidenced as a last resort.

Staff used the Datix system to record, manage and monitor incidents. A clear incident sign-off process was in place, and we saw evidence that incidents were reviewed and appropriately addressed by ward and senior staff. We reviewed a sample of incident records and found they had been suitably completed and investigated.

Nutrition and hydration

We found that patients' nutritional and hydration needs were assessed, recorded and monitored appropriately. Staff described access to dietetic services and Speech and Language Therapy (SALT) where required, and identified dietary needs were clearly reflected in patient care plans.

Patients were provided with appropriate diets in accordance with their clinical and nutritional needs. Menus offered options to meet individual preferences, as well as cultural and dietary requirements. Each ward had a dedicated dining area and suitable facilities to support patients' nutritional and hydration needs throughout the day. Meals were prepared in the main hospital and transported to Llanfair Unit, where they were served at set times. Patients could select meals from a menu which rotated

biweekly; however, they had limited opportunity to influence menu planning or make advance choices. Staff told us that meal provision was centrally coordinated, with limited flexibility at ward level. This reduced patients' ability to exercise meaningful choice over the food provided.

The health board must ensure that patients are provided with meaningful choice in relation to meals, including involvement in menu planning and selection where appropriate.

Patient records

Clinical records were maintained electronically and in paper format. Paper records were stored securely, and the electronic system was password protected to prevent unauthorised access. Clinical details were recorded contemporaneously and comprehensively, providing a detailed overview of the patients and their care. Further information on our findings regarding patient records and care plans is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Mental Health Act monitoring

We reviewed five patient records across the wards to assess compliance with the Mental Health Act (MHA). All patients reviewed were detained under the MHA, and we found that detention was lawful and in line with the legislation and the Code of Practice.

Robust auditing and monitoring arrangements were in place to support compliance with the MHA. The unit was supported by a dedicated and experienced MHA administration team, with clear processes in place to monitor compliance. MHA documentation was well organised, complete and easy to navigate, supporting effective oversight and review.

We generally found effective processes in place to support patients' rights. Patients were provided with appropriate information regarding their detention, including access to advocacy services, appeals and complaints processes. Staff demonstrated a good understanding of their responsibilities in supporting patients to exercise their rights under the MHA. However, we noted one record where patient rights had not been re-explained within the required timescale, with no evidence of this being completed in May following a review in April.

The health board must ensure that patient rights are re-explained at the required intervals and that this is consistently recorded across all patient records.

We also identified inconsistencies in the documentation of Section 17 leave

arrangements. Whilst leave was appropriately authorised and processes were understood by staff, some records did not evidence whether patients had received copies of their leave forms or clearly evidence patient involvement and agreement.

The health board must ensure that Section 17 leave documentation consistently includes clear evidence of patient involvement, agreement and confirmation that patients have received copies of their authorised leave forms.

In addition, copies of the Mental Health Act Code of Practice were not available on the wards.

The health board must ensure that up-to-date copies of the Mental Health Act Code of Practice are available and accessible on all wards.

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

Alongside our review of statutory detention documentation, we considered the application of the Mental Health (Wales) Measure 2010. We reviewed six patient records across the wards and generally found a good standard of clinical record keeping. Records were well organised, easy to navigate and reflected patients' identified needs and risks.

Care and Treatment Plans (CTPs) were in place for all patients and aligned with the domains of the Mental Health (Wales) Measure 2010. Most provided a comprehensive overview of patients' presentation and the interventions being delivered. Care planning was supported by a range of detailed assessments, including comprehensive risk assessments. The Wales Applied Risk Research Network (WARRN) framework was embedded across the wards and used consistently to support structured risk identification and management.

Clear evidence of ongoing physical health monitoring was recorded within patient records. Patients had access to ward-based nursing and medical staff, alongside advanced nurse practitioner (ANP) and General Practitioner (GP) services based at the Hafan y Coed site, to meet their physical healthcare needs.

We saw evidence that patients were involved in the development of their care planning wherever possible. Records demonstrated that the patient voice was central to assessments and care plans, with involvement from families, carers, and representatives where appropriate. Regular multidisciplinary team (MDT) reviews supported the ongoing review of care, including input from relevant professionals and external agencies.

While the overall quality of CTPs was good, some inconsistencies were identified. On Daffodil Ward, one patient CTP lacked clearly defined actions and interventions to support the patient in achieving identified goals. Although additional intervention plans were available elsewhere in the patient records, this information was not consistently reflected within the core CTP documentation.

The health board must ensure that all care and treatment plans are consistently completed to a high standard, including clearly defined actions and interventions.

Most CTPs were reviewed regularly, with strong MDT involvement. However, this was not consistent across all records. One CTP on Daffodil Ward had not been reviewed since 2024 and was therefore not compliant with required review timescales.

The health board must ensure that all care and treatment plans are reviewed regularly to ensure they reflect patients' current needs.

Efficient

Efficient

We found that patient care was delivered in a coordinated and structured manner. Our staff discussions and review of records indicated that care processes supported timely and appropriate care, with effective MDT working supporting continuity in planning and delivery.

A weekly prioritisation meeting process was in place, where patients were reviewed and risk assessed to support care planning and discharge pathways. In-reach work was also undertaken to proactively identify patients suitable for the rehabilitation service, supporting efficient use of the service.

We found effective discharge planning processes, supported through ward rounds, MDT meetings and care planning arrangements. There was evidence of appropriate involvement from community services, with consideration given to patients' ongoing support needs and relevant legal frameworks. This supported a coordinated approach to discharge and continuity of care.

Quality of Management and Leadership

Leadership

Governance and leadership

There was a clear organisational structure in place, with defined lines of management and accountability. Established governance arrangements and formal oversight and assurance processes were in place, including governance meetings, MDT meetings, escalation processes and incident review systems. These arrangements generally provided oversight of service delivery and supported the identification, monitoring and escalation of risks and concerns. However, we found that governance oversight required strengthening in key areas, particularly in relation to the management of environmental and operational risks, and staff training compliance.

Staff demonstrated a strong commitment to delivering safe, person-centred care and described positive multidisciplinary team working. Feedback regarding colleagues and immediate line managers was consistently positive, with staff reporting that they felt supported in their roles. However, some staff reported limited visibility of senior managers on the wards.

The health board must consider the staff feedback relating to senior leadership visibility and implement improvements to support a more collaborative and cohesive approach to patient care.

Governance arrangements included systems to report, discuss and manage incidents at a local level. However, we found limited evidence of structured senior oversight to review incidents, identify themes and trends, and ensure learning was used effectively across the service. Oversight was largely reliant on individual service areas reviewing incidents locally, with no consistent service-level governance reporting. Senior staff reported that arrangements to strengthen oversight, including the development of a Directorate Performance and Review Group, were in progress but not yet embedded. Therefore, we were not assured that themes, trends and learning were being systematically identified and used to inform service-wide improvement.

The health board must ensure that incidents are consistently reviewed through formal governance processes, with themes, trends and learning clearly identified and used to drive service-wide improvement.

In addition, we identified several policies and procedures that were overdue for review or remained in draft form. These included:

- Searches of patients' persons and belongings policy and procedure (draft)
- Mental Health Business Continuity Plans (draft)

- Infection Prevention and Control (IPC) procedure for infectious incidents - November 2024
- Recruitment policy- September 2025.

Staff also reported that the operational policy for the rehabilitation service remained in draft form and had not been formally ratified, despite being in development for an extended period.

The health board must ensure that all policies and procedures are kept up to date, formally ratified, and subject to regular review to support safe and effective service delivery.

Workforce

Skilled and enabled workforce

Staffing levels were adjusted in response to patient acuity and levels of observation, with escalation to senior staff where additional staffing was required. During the inspection, staffing levels appeared sufficient to meet patients' assessed needs, and most staff reported that they had adequate time and resources to deliver care and complete key clinical tasks. However, they told us that Llanfair Unit staff were regularly redeployed to support other wards, which impacted on their ability to deliver planned care, including rehabilitation activities and escorted leave.

The health board must ensure that staffing arrangements consistently support effective patient care, including when staff are redeployed to other wards.

We identified several staff vacancies across the service, including health care support worker and registered nurse posts. Some vacancies had not yet been advertised, while others were affected by internal promotions and secondments. Staff described additional pressures relating to staff sickness absence and redeployment. Temporary bank staff were routinely used to maintain safe staffing levels, with efforts made to utilise staff familiar with the hospital and patient group where possible. While staffing levels were maintained, these factors placed additional pressure on the workforce.

The health board must take action to ensure that vacant posts are recruited to in a timely manner to support a sustainable workforce.

Senior staff reported that annual appraisal compliance was high across both wards. Supervision arrangements were also described as being in place to support staff development and reflection. However, supervision processes were not consistently formalised, and records were not maintained to demonstrate that supervision was taking place as required.

The health board must ensure that supervision arrangements are formalised and consistently implemented, with clear and comprehensive records maintained to demonstrate that staff are appropriately supported.

Processes were in place for senior staff to monitor mandatory training compliance. However, in addition to our Immediate Assurance concerns regarding low compliance with safety-critical training, we found further examples of low mandatory training compliance across both wards. These included:

Meadow Ward:

- Equality, Diversity and Human Rights – 77.78%
- Information Governance (Wales) – 66.67%
- Paul Ridd Learning Disability Awareness Training – 70.37%
- Violence Against Women, Domestic Abuse and Sexual Violence – 66.67%
- Listening/Speaking Welsh – 59.26%
- Reading Welsh – 59.26%
- Writing Welsh – 59.26%.

Daffodil Ward:

- Safeguarding Children - Level 1 – 79.17%
- Violence Against Women, Domestic Abuse and Sexual Violence – 70.83%
- Welsh Language Awareness – 79.17%
- Listening/Speaking Welsh – 50.00%
- Reading Welsh – 50.00%
- Writing Welsh – 50.00%.

The health board must ensure that all staff complete mandatory training to the required levels to support safe and effective care delivery.

During our staff discussions, we were informed that training compliance data was not considered reliable, and staff reported difficulties in accurately establishing training compliance levels. This limited the ability of staff to effectively monitor and maintain oversight of workforce competencies. We also found that not all senior staff were aware of mandatory training requirements, reducing assurance that training was being effectively monitored.

The health board must ensure that robust systems are in place to accurately record and monitor mandatory training compliance, and that all staff are aware of training requirements to support effective oversight.

In addition, we found limited awareness of the Duty of Candour among staff. Most staff were unable to describe the requirements or their responsibilities, and there was no

evidence of training having been completed in this area. This reduced assurance that statutory responsibilities relating to openness and transparency were fully understood and embedded in practice.

The health board must ensure that all staff receive training on the Duty of Candour and understand their responsibilities, to support openness, transparency and compliance with statutory requirements.

Culture

People engagement, feedback and learning

Staff described a positive ward-level culture, with teams working collaboratively and supporting one another in day-to-day practice. Staff told us they felt able to raise concerns and described an environment where issues could be discussed and escalated appropriately within ward teams.

An established process was in place for patients, families and carers to escalate concerns through the NHS Wales Listening to People process. Formal complaints were recorded on the Datix system and monitored by senior managers throughout the investigation process. Our staff discussions indicated that both informal and formal complaints were appropriately recorded and investigated; however, as noted earlier in this report, we found limited awareness of Duty of Candour requirements, reducing assurance that staff were fully supported to fulfil their responsibilities.

We were informed that a structured Quality and Safety staff meeting process was in place to engage staff and capture feedback. However, meetings were not held in line with the required frequency. No staff meetings were evidenced on Meadow Ward within the previous six months, and only one staff meeting was evidenced on Daffodil Ward during this period. Therefore, we were not assured that staff feedback was being consistently captured, reviewed and acted upon.

The health board must ensure that staff meetings are held consistently in line with required frequency, with clear records maintained to support the effective review of staff feedback and actions taken.

Systems were in place to routinely capture patient feedback. Staff reported that they regularly engaged with patients to discuss issues, resolve concerns and understand their needs and wishes. Regular community meetings were held for patients to share their views on their care, and actions from these meetings were used to inform activities and plans for the week ahead.

However, community meetings were not consistently minuted, limiting the service's ability to demonstrate how patient feedback was reviewed and used to support learning and improvement.

The health board must ensure that patient feedback is consistently recorded, reviewed and used to inform service improvement.

Information

Information governance and digital technology

We considered the arrangements for maintaining patient confidentiality and adherence to information governance requirements, including the General Data Protection Regulation (GDPR).

Paper records and data were securely stored in locked areas, ensuring confidentiality and protection. Information recorded on the hospital's electronic health record system was password-protected, with access restricted to relevant staff. Established processes were in place to ensure safe and secure information sharing with partner agencies.

While staff generally demonstrated a clear understanding of their role and responsibilities in managing personal and sensitive information, compliance with mandatory information governance training was low on Meadow Ward, as highlighted earlier in this report.

Learning, improvement and research

Quality improvement activities

Staff described a range of quality improvement activities being undertaken across Meadow and Daffodil wards. These included a variety of audit processes, risk assessments and daily environmental safety checks. Staff told us that findings from these activities were reviewed and acted upon, with significant concerns escalated to senior managers. Electronic systems, including the Tendable audit system and EPMA prescribing system, had been introduced to support staff practice and strengthen monitoring arrangements.

Additional quality improvement activity was focused on strengthening the rehabilitation model within the service. Staff described work undertaken to develop the unit as a specialist rehabilitation service, including the introduction of a structured needs assessment process and greater emphasis on collaborative care planning. This included work to enhance Care and Treatment Plans (CTPs) to better reflect the patient voice, supported by engagement with the Recovery College and individuals with lived experience.

While a range of audit and improvement processes were in place, we did not see sufficient evidence to demonstrate robust and consistent governance oversight and monitoring of key areas, as highlighted throughout this report. As a result, we were not assured that quality improvement activity was being effectively coordinated, monitored or embedded at a service-wide level.

Throughout the inspection, staff were receptive and responsive to our findings and recommendations. While some improvements were addressed during the inspection, further action is required from the health board to implement the recommendations set out in this report and ensure that improvements are sustained.

Whole-systems approach

Partnership working and development

Staff worked collaboratively with a range of partners to support patient care and discharge planning. This included engagement with housing services, third sector organisations, community mental health teams (CMHTs) and outreach services to support patients' transition from inpatient care to the community.

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
We found a lack of temperature monitoring of patient fridges created a risk of food spoilage and infection.	This posed a risk of food spoilage and infection, which could impact patient health and safety.	We raised our concerns with staff.	The matter was addressed by staff, with appropriate temperature monitoring implemented.
A loose accessible shower grab rail on Meadow Ward was identified.	This posed a risk of injury to patients and staff using the facilities.	We raised our concerns with staff.	The grab rail was removed during the inspection to mitigate the immediate risk, pending repair or replacement by the estates team.

Appendix B – Immediate improvement plan

Service: **Llanfair Unit, Daffodil and Meadow Wards**

Date of inspection: **08-10 June 2026**

Findings	We reviewed staff training compliance for Strategies and Interventions for Managing Aggression (SIMA), Basic Life Support (BLS) Level 2, Intermediate Life Support (ILS), Moving and Handling Level 2 and Safeguarding Level 3 across the two wards. The data showed the following compliance levels: • **BLS Level 2:** Daffodil: 58% Meadow: 57% • **ILS:** Following review, seven staff have been confirmed as ILS trained across the two wards. This remains below the level required to provide robust assurance, given the unit's remote location within the UHL site. • **Moving and Handling Level 2:** Daffodil: 21% Meadow: 30% • **Safeguarding Level 3:** Daffodil: 33% Meadow: 0% • **SIMA** Daffodil: 56%

	Meadow: 54% As a result of these findings, HIW is not assured that enough staff on these wards have the required up-to-date skills and competencies to respond safely and effectively to medical emergencies, undertake physical intervention, meet safeguarding requirements, or support patients using safe moving and handling techniques.

Improvement needed		Standard / Regulation
1.	The health board must: • Ensure that all staff complete and remain compliant with Strategies and Interventions for Managing Aggression (SIMA), Basic Life Support (BLS), Intermediate Life Support (ILS), Moving and Handling Level 2 and Safeguarding Level 3, to support patient and staff safety. • Provide assurance on how patients and staff will be protected from harm while these safety-critical training gaps are addressed, and how compliance will be monitored and sustained.	Safe and Effective Care

Service Action:	Responsible officer	Timescale
<u>BLS</u> Cascade trainers have been identified to deliver immediate BLS training. All staff have been booked onto training sessions, with an aim of completing all outstanding BLS training by the end of July 2026. Compliance will be monitored weekly and records updated. Any non-attendance will be escalated to the Ward Manager and Senior Nurse, with staff rebooked onto the next available session. <u>ILS</u> The health board has reviewed ILS compliance and confirmed that seven staff are currently ILS trained; however, further action is required to ensure sufficient and sustained ILS compliance across the wards. All registered nurses have been booked onto ILS training throughout July, except for two staff who are unable to attend and have been booked onto training in September. To mitigate the risk of low levels of	Ward Managers, overseen by Senior Nurse for Education, Quality, Safety and Patient Experience; Directorate Senior Nurse for workforce review.	July 2026 September 2026

compliance in the interim, ward managers will review rosters daily to ensure there is at least one ILS-trained member of staff available across the Llanfair Unit to provide initial emergency response cover for both Daffodil and Meadow Wards. <u>Safeguarding level 3</u> Safeguarding Level 3 training is mandatory for registered nurses at Band 6 and above. This equates to six staff across both wards, of whom five are currently non-compliant. Three are booked onto training on 15th July and two on 21st September. In the interim, all safeguarding issues will be overseen by the Senior Nurse. <u>Moving and Handling</u> All staff requiring Moving and Handling Level 2 training have been booked onto sessions scheduled between July and early September 2026, with attendance and completion monitored weekly. The UHB Health and Safety Team is undertaking an organisation-wide review of training requirements across all roles, which will strengthen the accuracy and reliability of compliance reporting. <u>SIMA</u> Meadow ward -13 staff (50%) are compliant. Of the remaining staff who are non-compliant one has completed training this week, two are booked for training on 13th August 2026 and the remaining staff member booked onto training on 7th September 2026. Daffodil ward –13 staff (54%) are compliant. Of the remaining staff who are non-compliant one is booked onto training on 17th July and the other on 7th September. There are eighteen staff across the two wards who are unable to undertake SIMA on the recommendations of Occupational Health. Rosters are arranged to ensure that there are always four SIMA compliant staff working across the two wards during the day shifts, however this arrangement is less resilient at night. An immediate review of night rostering is being undertaken to ensure adequate SIMA trained staff, this is likely to result in some changes to rostering practices and will be supported by People Services as required.		September 2026 September 2026 November 2026 September 2026 September 2026 July 2026

A further review of staffing will be undertaken to ensure everyone is supported to work safely but that capabilities due to ill health do not compromise the safe running of the two wards.		July 2026

Findings	Training compliance data recorded on the health board's training system was not considered by senior managers to be fully accurate, with staff identifying gaps in data quality and record keeping. In addition, we found limited evidence that ward-level staff were able to effectively interrogate the system to establish an accurate position on training compliance. This reduced assurance in the reliability of reported data and limited effective oversight of training.

	Improvement needed	**Standard / Regulation**
2.	The health board must: • Ensure training data is accurate, complete and reliable • Address weaknesses in training compliance record keeping • Provide targeted training and guidance to staff on monitoring and interpreting training compliance • Strengthen oversight arrangements to ensure effective monitoring of safety-critical training compliance.	Safe and Effective Care

Service Action:	**Responsible officer**	**Timescale**
A validation exercise will be completed to reconcile training compliance data held on ESR with ward-level records, booked training places and staff timetables. Weekly updates will be provided until compliance gaps are closed. Monthly compliance overviews will commence and continue as part of ongoing ward, directorate and MHCB Quality and Safety governance arrangements, with escalation where compliance, data quality or training access risks remain unresolved.	Practice Development Team, Ward Managers and Senior Nurse for	30th June 2026

The Director of Nursing for Mental Health Clinical Board is currently leading an exercise to establish the core functions of roles with each Lead and Senior Nurse. The purpose is to reinforce the leadership and accountability across these roles. This work will be extended to Ward sisters and charge nurses. The Senior Nurse for Education, Quality, Safety and Patient Experience will provide guidance to ward managers on how to interpret ESR compliance reports and will review progress regularly to ensure that data quality issues are identified and corrected. A link to all mandatory ESR training has been added to the Education SharePoint page to improve ease of access for staff. The Practice Development Team will provide a monthly compliance overview to all ward nurses and directorate clinical leads to support governance oversight. Training compliance trends will be mapped, reviewed and escalated through directorate leadership arrangements and to the Mental Health Clinical Board via Quality and Safety governance meetings.	Education, Quality, Safety and Patient Experience; directorate clinical leads for oversight and escalation.	30th September 2026 Completed Completed Completed Complete and ongoing

Findings	We reviewed incident records which confirmed that two restraint interventions had involved staff who were not compliant with SIMA training requirements, reducing assurance that the safety of patients and staff was maintained during restraint incidents. In addition, one restraint incident report lacked sufficient detail, including the duration of the incident and the position of the patient, limiting assurance regarding the safety and appropriateness of the intervention.

	Improvement needed	**Standard / Regulation**
3.	The health board must: • Take immediate action to address gaps in SIMA training compliance across the wards • Ensure enough staff compliant with SIMA are available on each shift, taking account of foreseeable absence, and mitigate risks if this is not possible at short notice	Safe and Effective Care

	• Set out clear procedures on the role of non-compliant staff in emergencies, including where involvement is required to prevent immediate harm • Strengthen governance oversight to ensure restraint practices are safe, appropriate and fully recorded.	

Service Action:	Responsible officer	Timescale
Meadow ward -13 staff (50%) are compliant. Of the remaining staff who are non-compliant one has completed training this week, two are booked for training on 13th August 2026 and the remaining staff member booked onto training on 7th September 2026. Daffodil ward –13 staff (54%) are compliant. Of the remaining staff who are non-compliant one is booked onto training on 17th July and the other on 7th September. There are eighteen staff across the two wards who are unable to undertake SIMA on the recommendations of Occupational Health. Rosters are arranged to ensure that there are always four SIMA compliant staff working across the two wards during the day shifts, however this arrangement is less resilient at night. An immediate review of night rostering is being undertaken to ensure adequate SIMA trained staff, this is likely to result in some changes to rostering practices and will be supported by People Services as required. A further review of staffing will be undertaken to ensure everyone is supported to work safely but that capabilities due to ill health do not compromise the safe running of the two wards. Restraint documentation will be reinforced to ensure records include duration, patient position, staff involved and post-incident review, with incident quality and restraint practice reviewed through ward, directorate and MHCB governance Work is being undertaken jointly between the Patient Safety Team and the Mental Health Clinical Board to improve the timely review of patient safety incidents and the effectiveness of responses. Incidents not reviewed within 7 and 30 days are monitored as performance indicators at Executive Performance Reviews	Directorate Senior Nurse and Ward Managers, with oversight and support from the Mental Health Clinical Board through directorate and MHCB governance arrangements.	September 2026 September 2026 Completed and ongoing Ongoing

Findings	We found that staff were not aware of the Regulation 28 report and Patient Safety Notice (PSN) 041 reminder issued by the Welsh Government on 30 August 2024 in relation to the correct operation of portable British Oxygen Company (BOC) cylinders. In addition, staff had not received training on their safe use in line with the recommendation in the PSN. Therefore, we were not assured that the risks of harm to patients were being appropriately managed.

	Improvement needed	**Standard / Regulation**
4.	The health board must ensure that all staff who use portable BOC oxygen cylinders receive competency-based training on their safe use across all health board services in line with PSN 041.	Safe and Effective Care

Service Action:	**Responsible officer**	**Timescale**
All staff currently working on Daffodil Ward have completed the Medical Gases training on ESR, which includes the correct use of portable oxygen cylinders. Two staff members are on long-term leave and will complete the training on their return. All staff on Meadow Ward who have not yet completed the Medical Gases training on ESR will complete the training by the end of July. In the interim, a video on the correct use of portable oxygen cylinders has been shared with staff for immediate completion.	Ward Manager	Completed 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): Tara Robinson

Job role: Director of Nursing Mental Health Clinical Board

Date: 19.06.2026

Appendix C – Improvement plan

Service: **Llanfair Unit, Meadow and Daffodil Wards**

Date of inspection: **08 -10 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.	Several carers raised concerns regarding the management of patients' personal belongings, patient safety and supervision, including falls, difficulties locating patients, and incidents between patients.	The health board must review the feedback provided by family and carers and consider improvements to address concerns raised relating to communication and involvement in care, patient safety and supervision, and the management of patients' personal belongings.	Patient feedback	All staff in both wards will be reminded of the importance of adhering to the patient property procedure. Ward managers to audit the ward patient property procedure to ensure the required standards are maintained Both wards to implement 'no decision about me without me' in ward rounds to support patient	Senior Nurse Manager Ward Managers Ward Managers	Complete October 2026 Complete

				involvement and communication. Compliance will be monitored monthly through the management performance reporting and Tendable audits.	Senior Nurse Manager	Complete and ongoing
2.	The garden areas were overgrown and required tidying and general maintenance.	The health board must ensure that the ward garden areas are appropriately maintained to provide a safe and therapeutic environment for patients.	Health promotion	A request for the lawn to be mown was outstanding at the time of the inspection. This has subsequently been completed. Service Manager to agree the schedule of lawn mowing with the Estates Team. Environmental checklist will now include outdoor spaces and will be checked daily.	Estates Service Manager/Estates Senior Nurse Manager	Complete Complete Complete

3.	Observation panels were not fully functional, affecting privacy and safe observation.	The health board must ensure that all patient bedroom observation panels are fully functional to enable staff to undertake observations safely while maintaining patients' privacy and dignity.	Dignified and respectful care	A maintenance request was completed to fix the viewing panels. All work to viewing panels has been undertaken with the exception of bedroom 17. This panel requires replacing and will be complete by 28 August 2026. While maintenance work to observation panels remains underway ward staff have been reminded to enter the room to undertake hourly checks	Estates Estates Ward Manager	Complete 28 August 2026 Complete and ongoing
4.	Patient information was not consistent, accessible or up to date across the wards.	The health board must ensure that clear, accessible and up-to-date patient information is consistently available and	Patient information	The patient information leaflet has been updated, which includes legal representation, visiting times and carers information.	Ward Managers	Complete

		clearly displayed across all wards.		The availability of the up-to-date patient information has been added to the daily checklist. Carers booklet to be developed for both wards. A CTP information guide is currently being developed for 1. Carers/Families 2. Service Users	Ward Managers Ward Managers Senior Nurse, Education, Quality, Safety & Patient Exp.	Complete October 2026 December 2026
5.	We also identified inconsistencies in the information available to support patients' understanding of ward restrictions.	The health board must ensure that clear, accessible written information is consistently available to patients regarding ward restrictions, including how informal patients may leave the ward and any restricted or prohibited items.	Patient information	The patient information leaflet has been updated since the inspection, to include information about ward restrictions and information on how informal patients can leave the ward.	Ward Managers	Complete

6.	We found low staff compliance with Welsh language training and limited awareness of the Welsh language active offer among staff.	The health board must ensure that all staff complete mandatory Welsh language training, have a good understanding of the Active Offer, and that effective oversight arrangements are in place to monitor and improve compliance.	Communicating and language	Listening, reading and writing Welsh competencies are not training programmes but are self-declarations of Welsh competencies that were included with ESR mandatory training compliance In February 2026. Staff complete and submit a self-declaration form which is then manually uploaded. To mitigate delays in the completion and upload of these forms, the ward manager on each ward will collate a single collective record of Welsh competencies for all staff which will be submitted to the UHB Welsh Language Officer	Ward Manager	September 2026

				A plan has been made to ensure all staff have completed Welsh Language Awareness training by October 2026. Welsh Language active offer posters have been displayed on each ward The Welsh Language procedure has been printed and displayed in e the ward offices on each ward. The Welsh language active offer is to be discussed in ward quality and safety meeting to ensure all staff are aware of their duty, and information shared with the ward teams.	Ward Managers Ward Managers Ward managers Directorate Manager	October 2026 Complete Complete September 2026
7.	A specialist bath on Meadow Ward was out of	The health board must ensure that appropriate	Rights and equality	Both Meadow and Daffodil ward have both	Service Manager	Complete

	order. This meant that patients requiring this equipment could not be fully supported on the ward, reducing equitable access to care.	facilities, equipment and support are available to enable patients with mobility difficulties to access care equitably.		standard and accessible showers available to support the bathing and hygiene needs of the entire patient group. There is a single bath available for use across the two wards. This bathroom will be refurbished with an accessible bath to meet the needs to the entire ward population.	Service Manager/Estates	December 2026
8.	Multiple environmental and estates issues remained unresolved, and staff reported that some issues were routinely closed without being addressed.	The health board must: • Address all outstanding estates and maintenance issues across both wards within appropriate timescales • Implement effective systems to identify,	Risk management	The Estates team have addressed the presence of mould in bathroom areas Water Ingress damage in Resource Room to be rectified by 28 August All outstanding repairs and maintenance to toilets and urinals is scheduled to be completed by the	Estates Estates Estates	Complete 28 August 2026 28 August 2026

		prioritise and manage estates and maintenance issues • Strengthen oversight arrangements to ensure issues are not closed until they have been fully resolved.		estates team by 28 August 2026 The disabled shower was inspected, and it was established that the water was draining appropriately. The male shower is working appropriately; however, an anti-ligature half door has been ordered to reduce the risk of water splashing out from under the shower curtain. The shower grab rails has been replaced by the estates team Toilet roll holders and other fittings were noted to be detached. These are Velcro ligature proof devices and are designed to be removable. Daily environmental checks	Estates Estates Ward Managers	October 2026 Complete Complete and Ongoing

				will include oversight of these devices to ensure they are attached to the wall as intended. A maintenance request was re-submitted to address leaking taps and hot water supply and the necessary work will be completed by Estates by 28 August A maintenance request has been raised to inspect the roof for leaks. A maintenance request for lawn mowing was re-submitted, and the Estates team have now completed this. Any future delays in addressing estates issues will be escalated to the Directorate	Estates Estates Directorate Management Team	28 August 2026 October 2026 Complete Complete and Ongoing

				Management Team following ward monthly quality and safety meetings. A structured Clinical Board oversight programme will be established to undertake walkarounds of all wards, ensuring three-monthly oversight of every ward area.	Clinical Board Triumvirate	September 2026
9.	We identified gaps in IPC practice, including unlabelled communal patient food in the kitchen on Meadow Ward.	The health board must ensure that all patient food is appropriately labelled to ensure it is used within safe timeframes and support patient safety.	Infection prevention and control (IPC) and decontamination	Ward cleanliness, food storage and food safety standards within dining and food preparation areas will be monitored through ward environmental checks and leadership walkarounds to support a positive patient dining experience. Night staff have been allocated a new job list	Ward Managers	Complete

				which includes checking the labels and expiry date of patient food each night. A poster has been added to the fridge to remind all staff to ensure a label is attached to all patient food.	Ward Managers	Complete
10.	Staff training compliance with mandatory level 3 safeguarding training was very low and some senior staff were unclear about the safeguarding training requirements relevant to their roles, reducing assurance that training needs were fully understood and met.	The health board must ensure that all staff understand safeguarding training requirements relevant to their roles and complete the appropriate level of training to support the effective identification and management of safeguarding concerns.	Safeguarding of children and adults	All Band 6 and 7 staff must be trained in Level 3 safeguarding. One member of staff is yet to complete their level 3 training as they are on leave. They have training scheduled for September 2026.	Ward Managers	September 2026
11.	Meal provision was coordinated centrally, with limited flexibility at ward level. This reduced patients' ability to exercise meaningful	The health board must ensure that patients are provided with meaningful choice in relation to meals, including involvement in menu	Nutrition and hydration	Ward managers will review the patient menu options for Llanfair Unit to support increased patient choice.	Ward Managers	September 2026

	choice over the food provided.	planning and selection where appropriate.		Ward Managers will reinforce and monitor compliance with the patient menu ordering process to ensure all patients are offered and supported to complete menu choice forms, enabling informed meal choices and improving catering planning. Compliance with menu completion will be reviewed through ward quality and safety arrangements, with shared learning disseminated across Adult Mental Health and MHSOP services. Ward managers will implement a process to generate a ward "shopping list" to maintain a stock of food that can be used	Ward Managers Ward Managers Ward Managers	September 2026 and ongoing September 2026 onwards Complete

				to support an individualised approach to food preparation, food choices and rehabilitation. A joint ward walk around has been arranged to review standards, gather feedback from staff and patients, and agree any further improvements required.	Ward Managers/Catering Service Managers	Complete
12.	We noted one record where patient rights had not been re-explained within the required timescale.	The health board must ensure that patient rights are re-explained at the required intervals and that this is consistently recorded across all patient records.	Mental Health Act monitoring	All patients have had their rights re-explained within required timescale. Oversight and actioning of Mental Health Act office prompts will be added to the Ward Managers weekly audits and checks	Ward Manager Senior Nurse Manager	Complete Complete
13.	We found inconsistencies in the	The health board must ensure that Section 17	Mental Health Act monitoring	Both wards to offer a copy of Section 17	Ward Managers	Complete

	documentation of Section 17 leave arrangements. Some records did not evidence whether patients had received copies of their leave forms or clearly evidence patient involvement and agreement.	leave documentation consistently includes clear evidence of patient involvement, agreement and confirmation that patients have received copies of their authorised leave forms.		leave forms, following completion at ward round, and for this process to be added to caseload supervision. Ward Managers to audit the Section 17 leave form where it is recorded and whether the form has been offered.	Ward Managers	September 2026 and ongoing
14.	Copies of the Mental Health Act Code of Practice were not available on the wards.	The health board must ensure that up-to-date copies of the Mental Health Act Code of Practice are available and accessible on all wards.	Mental Health Act monitoring	Two copies of the Code of Practice are now available in nursing offices.	Ward Managers	Complete
15.	One patient CTP lacked clearly defined actions and interventions to support the patient in achieving identified goals.	The health board must ensure that all care and treatment plans are consistently completed to a high standard, including clearly defined actions and interventions.	Monitoring the Mental Health (Wales) Measure 2010: care planning and provision	Training has been provided on co-produced CTP to the relevant staff member. A standardised CTP audit process within the Mental Health Clinical Board will be	Senior Nurse for Education, Quality, Safety and Patient Experience Senior Nurse for Education, Quality, Safety and Patient Experience	Complete October 2026 and ongoing

				implemented as part of the CTP Quality Improvement project, ensuring routine monitoring of CTP quality in addition to existing oversight through Ward Manager supervision and targeted audits undertaken as required.		
16.	One care and treatment plan on Daffodil Ward had not been reviewed since 2024 and was therefore not compliant with required review timescales.	The health board must ensure that all care and treatment plans are reviewed regularly to ensure they reflect patients' current needs.	Monitoring the Mental Health (Wales) Measure 2010: care planning and provision	All Daffodil care and treatment plans to be completed. Lead and Senior Audits to continue monitoring of care and treatment plans.	Ward Manager Senior Nurse manager	Complete September 2026 and ongoing
17.	Some staff reported limited visibility of senior managers on the wards.	The health board must consider the staff feedback relating to senior leadership visibility and implement improvements to support a more collaborative and	Governance and leadership	A structured programme of Clinical Board leadership visits will be implemented across all inpatient wards and community teams. Visits will include the Director of	Director of Nursing / Mental Health Clinical Board Leadership Team	September 2026 and ongoing

		cohesive approach to patient care.		Nursing, Lead Nurses, Senior Nurses and wider Mental Health Clinical Board leadership team, providing opportunities for staff engagement, discussion of service developments, escalation of concerns and sharing of good practice. A Mental Health Clinical Board SharePoint site will be developed and promoted as a central hub for staff information. The site will include details of Mental Health Clinical Board and Directorate structures, roles and responsibilities, key contacts, governance arrangements, improvement	Director of Nursing / Mental Health Clinical Board Leadership Team	October 2026

				programmes, meeting outcomes and staff engagement opportunities. Information regarding the Mental Health Clinical Board, Directorates and senior leadership team will be shared regularly through Viva Engage. Posts will include introductions to members of the MHCB leadership team, explanations of roles and responsibilities, service developments, key achievements and opportunities for staff feedback and engagement. A "Who's Who" resource will be developed and made available through	Director of Nursing / Communications Lead Mental Health Clinical Board Leadership Team	September 2026 and ongoing October 2026

				SharePoint and staff communication channels to improve understanding of leadership roles, responsibilities and points of contact across Mental Health Services. A regular Mental Health Clinical Board staff drop-in session will be established, providing opportunities for staff to meet members of the Mental Health Clinical Board leadership team, discuss concerns, share ideas and raise improvement suggestions in an open and supportive forum. Themes and actions arising will be monitored through	Lead Nurse for Adult Mental Health	Ongoing

				established governance arrangements. Existing HCSW and Band 5 Nurse Forums will be strengthened and supported to improve communication, engagement and professional connection across services. These forums will provide opportunities for staff to share experiences, discuss challenges, influence service developments and receive updates from senior leaders. Senior Nurses will continue to maintain a visible presence within inpatient services through regular ward visits, participation at Monday to Friday	Senior Nurse Team	In place and ongoing

				staffing huddles and direct support to ward teams. This will provide ongoing opportunities for staff engagement and operational support. Feedback regarding leadership visibility and staff engagement will be monitored through staff forums, leadership visits, staff surveys, Listening into Action processes and other engagement mechanisms to inform continuous improvement.	Director of Nursing /Lead Nurses	Ongoing
18.	We found limited evidence of structured senior oversight to review incidents, identify themes and trends, and ensure learning was used effectively across the service, with no	The health board must ensure that incidents are consistently reviewed through formal governance processes, with themes, trends and learning clearly identified	Governance and leadership	Weekly moderate and above incident tracker has been commenced August 2026, with themes disseminated within the monthly patient safety bulletin.	Director of Nursing/Lead Nurses	Complete and ongoing

	consistent service-level governance reporting.	and used to drive service-wide improvement.		A monthly patient safety review meeting attended by Clinical Board and Lead Nurses is undertaken to review incidents and themes are published in a monthly bulletin for all staff to read. A Datix delivery plan has been produced by the Adult Directorate and themes to be disseminated in quality and safety meetings, with ongoing monitoring.	Deputy Director of Nursing Mental Health Clinical Board Director of Nursing Mental Health Clinical Board and Lead Nurse for Adult Mental health	Complete and ongoing Ongoing
19.	Several policies and procedures were overdue for review or remained in draft form, including the operational policy for the rehabilitation service.	The health board must ensure that all policies and procedures are kept up to date, formally ratified, and subject to regular review to support safe and effective service delivery.	Governance and leadership	The following procedures are in the process of updating • Searches of patients' persons and belongings policy and procedure which is due to be	Lead Nurse Adult Mental Health	December 2026

				ratified in the Controlled Document Oversight Group September 2026 • Mental Health Business Continuity Plans to be completed by December 2026 • Rehabilitation operational policy (due to be completed December 2026) • The IP&C Incident and Outbreak Procedure is scheduled to be presented at the Infection Prevention Control Group in September 2026		

				and ratified in December 2026. • Recruitment & Selection Policy was due to be reviewed by 09/25. It is currently being reviewed in collaboration with Trade Union colleagues and the revised policy will need to be approved by the People & Culture Committee when they meet in November 2026. The current policy on the Intranet is still the extant procedure. • The Recruitment & Selection Procedure (non-		

				medical staff) was due to be reviewed by 18 January 2026. It is currently being reviewed and the target date for completion is October 2026.		
20.	Staff reported that Llanfair Unit staff were regularly redeployed to support other wards, which impacted on their ability to deliver planned care, including rehabilitation activities and escorted leave.	The health board must ensure that staffing arrangements consistently support effective patient care, including when staff are redeployed to other wards.	Skilled and enabled workforce	A review of the SafeCare system demonstrates that Meadow ward have had appropriate staffing on 83% of shifts in the past three months and Daffodil Ward 84% for the same period. Two red flags were reported on Daffodil and 10 red flags on Meadow Ward during this period. In the event of staffing shortfalls staff report a red flag and the directorate team will		

				work with them to mitigate this risk. Mitigation can include moving staff from another area to support on the ward, or pooling of resources across the two wards to deliver rehabilitation activities e.g. walking groups. An email has been sent to all staff to remind them of the importance of raising red flags on the SafeCare when clinically indicated. All red flags will be reviewed by the directorate team to ensure adequate mitigation. The Clinical Board Director of Nursing meets fortnightly with the Directorate team to review staffing	Directorate Manager Director of Nursing Mental Health Clinical Board	Complete and Ongoing Ongoing

				efficiency and activity of the ward to identify risk and agree mitigation principles. The nursing establishment is formally reviewed twice yearly by the Executive Director of Nursing, Director of Nursing and Deputy Director of Nursing. The Director of Nursing for the Clinical Board has been working in partnership with staff side to manage expectations of role and redeployment. Associated staff communication is being developed.	Director of Nursing Mental Health Clinical Board Director of Nursing Mental Health Clinical Board	Complete and Ongoing November 2026
21.	We identified several staff vacancies across the service. Some vacancies had not been	The health board must take action to ensure that vacant posts are recruited to in a timely manner to	Skilled and enabled workforce	The Directorate is currently holding two vacancies on Daffodil Ward while staff are on		

	advertised, and others were affected by internal promotions and secondments.	support a sustainable workforce.		secondment, however temporary staffing is being utilised to backfill these gaps. There is one whole time equivalent vacancy on Meadow Ward which is being held for a newly qualified streamliner Registered Mental Health Nurse. All vacancies will be filled or there will be a clear plan to fill by December 2026	Service Manager	December 2026
22.	Supervision processes were not consistently formalised, and records were not maintained to demonstrate that supervision was taking place as required.	The health board must ensure that supervision arrangements are formalised and consistently implemented, with clear and comprehensive records maintained to demonstrate that staff are appropriately supported.	Skilled and enabled workforce	A schedule will be developed to ensure all staff receive monthly caseload supervision which will be recorded / documented and subject to review and audit.	Senior Nurse Manager/Ward Managers	September 2026

23.	In addition to our Immediate Assurance concerns regarding low compliance with safety-critical training, we found further examples of low mandatory training compliance across both wards.	The health board must ensure that all staff complete mandatory training to the required levels to support safe and effective care delivery.	Skilled and enabled workforce	A plan has been developed to support staff in mandatory training with an aim to achieve 85% compliance by October 2026.	Ward Managers	October 2026
24.	We were informed that training compliance data was not always considered reliable, and staff reported difficulties in accurately establishing training compliance levels. We also found that not all senior staff were aware of mandatory training requirements, reducing assurance that training was being effectively monitored.	The health board must ensure that robust systems are in place to accurately record and monitor mandatory training compliance, and that all staff are aware of training requirements to support effective oversight.	Skilled and enabled workforce	Mandatory training compliance is automatically updated following completion of online digital training. Listening, reading and writing Welsh competencies are not training programmes but are self-declarations of Welsh competencies that were included with ESR mandatory training compliance In February 2026. Staff complete and submit a self-		

				declaration form which is then manually uploaded. This has been discussed with the Welsh Language Officer for the Health Board and at present this process cannot be automated on ESR. To mitigate delays in the completion and upload of these forms, the ward manager on each ward will collate a single collective record of Welsh competencies for all staff which will be submitted to the UHB Welsh Language Officer.	Ward Managers	September 2026
25.	We found limited awareness of the Duty of Candour among staff, and no evidence of training having been completed in this area.	The health board must ensure that all staff receive training on the Duty of Candour and understand their responsibilities, to support openness,	Skilled and enabled workforce	Duty of Candour will be raised at the September Quality and Safety meetings and all Registered health professionals will be asked to undertake to	Ward Manager	November 2026

		transparency and compliance with statutory requirements.		the All Wales Duty of Candour training hosted on ESR. There is a Duty of Candour (DoC) SharePoint page which provides staff with the resources and guidelines to raise awareness of the Duty of Candour and to manage the process. These resources include case studies, initial DoC process flow chart, levels of harm framework and letter templates. The Mental Health Clinical Board will direct staff to these resources to support increased awareness and understanding. Focused work is underway to review all.	Mental Health Clinical Board Mental Health Clinical Board	September 2026 October 2026

				outstanding incidents in Mental Health Clinical Board, to ensure systematic delivery of the Duty of Candour.		
26.	No staff meetings were evidenced on Meadow Ward within the previous six months, and only one staff meeting was evidenced on Daffodil Ward during this period.	The health board must ensure that staff meetings are held consistently in line with the required frequency, with clear records maintained to support the effective review of staff feedback and actions taken.	People engagement, feedback and learning	Ward Quality and Safety meetings will be undertaken monthly and documented with all staff invited to attend. The minutes of the meetings will be shared with all staff members. Agendas will include an 'Any Other Business' (AOB) item to encourage open discussion, and staff will have the opportunity to submit items for inclusion on the agenda in advance of each meeting.	Ward Managers Ward Managers	Ongoing Ongoing

27.	Patient community meetings were not consistently minuted, limiting the service's ability to demonstrate how patient feedback was formally recorded, reviewed and used to support learning and improvement.	The health board must ensure that patient feedback is consistently recorded, reviewed and used to inform service improvement.	People engagement, feedback and learning	Weekly patient community meetings are undertaken but were not being recorded. Minutes, including agreed actions and outcomes, will now be maintained to ensure patient feedback is documented, reviewed and used to support continuous service improvement. CIVICA patient experience data is shared and disseminated across the directorate and for consideration.	Ward Manager Lead Nurse	Complete and Ongoing Complete and Ongoing

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: Tara Robinson

Job role: Director of Nursing **Date: 14 August 2026**