Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report
(Unannounced)
Kestrel Ward, Abergele Hospital, Betsi Cadwaladr University Health Board

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of Abergele Hospital, Betsi Cadwaladr University Health Board, on 13, 14 and 15 January 2025. The following hospital ward was reviewed during this inspection:

- Kestrel Ward – a 12-bedded mixed gender ward providing Children and Adolescent Mental Health Services (CAMHS) for young people aged between 12 and 18 years.

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

During the inspection we invited young people or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of four questionnaires were completed by young people and their family/carers, and two were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Throughout our inspection, we witnessed staff treating young people with respect and kindness and supporting them in a dignified and sensitive way. However, improvements were required to ensure the privacy and dignity of young people from the external areas of the ward.

We identified effective processes in place to support the physical and mental health of young people, with thorough assessments and access to healthcare services. The ward provided a pleasant, therapeutic environment of care. Young people had ensuite bedrooms and could access the communal areas and secure garden areas of the ward. However, some outdoor areas required minor weeding and general maintenance.

The hospital's Nant-y-Bryniau Education Centre provided tailored education for the young people, and various therapeutic and leisure activities were also available. However, there was no structured programme of individualised therapeutic activities to support their health, wellbeing and rehabilitation, an issue we also found during our previous inspection in 2018.

We found satisfactory arrangements in place to promote and protect the rights of young people. A wide range of relevant and appropriate information was displayed or provided to help young people and their families understand their care. A mental health advocate was available to provide support and information.

We were informed that the religious needs of the young people were respected and accommodated, and the ward had a designated therapy faith room. However, the room lacked appropriate multifaith facilities.

Delivery of Safe and Effective Care

Overall summary:
Policies, processes and procedures were in place to support risk management and safeguard young people, with a suitable governance structure for discussing incidents and issues. Staff had a good understanding of safeguarding procedures and reporting arrangements. However, improvements were required to maintain the safety of young people, staff and visitors, including implementing a personal safety alarm policy and ensuring the safe storage and regular maintenance review of oxygen cylinders.

The ward was clean and tidy, with effective infection prevention Control (IPC) measures in place. A programme of anti-ligature work was in progress and the imminent construction of the Extra Care Area would further enhance the therapeutic environment. However, several environmental issues required improvement, including damaged fixtures and outstanding ligature risks. Some outstanding estates issues were not suitably recorded or addressed, raising concerns about the effectiveness of estates management processes.

The general standard of record keeping required significant improvement. Navigation of young people's records was challenging due to the volume and disorganisation of the paper records. The Care and Treatment Plans (CTPs) generally reflected the needs and risks of the young people, but improvements were required to ensure they aligned with Mental Health Wales Measure 2010 domains and were promptly shared between community and ward teams. Ward-based care plans did not always reflect the voice and involvement of the young people nor identify a full range of interventions, and care plan audits were not completed within set timescales.

Young people had individualised medication management plans and the Medication Administration Records were completed to a good standard. However, improvements were identified in relation to poorly organised medication records and improperly stored pharmaceutical waste. Appropriate resuscitation equipment was in place, but the echocardiogram (ECG) equipment required calibration.

Robust procedures were in place for the Mental Health Act (MHA) and all records were compliant with the MHA and Code of Practice. The MHA administrator had created a comprehensive series of bi-lingual and easy-read leaflets to aid young people in understanding the MHA. However, improvements were required to ensure mental capacity assessments were undertaken and recorded where appropriate.

Restrictive practices were used as a last resort, but staff compliance with Restrictive Physical Intervention (RPI) training was low. The health board must ensure staff are supported to complete training in a timely manner and that there are sufficiently trained staff members to manage incidences of restraint.

The arrangements for admission and discharge were robust, and staff worked collaboratively across services, engaging with the young people, their families, and carers to ensure the best outcomes.

Immediate assurances:

During the inspection we were not assured that the medicines management processes in place were sufficiently robust and safe to protect young people from potential harm in the event of an emergency. The following issues required immediate action to be taken by the health board:

- Emergency medication stored in a sealed case within the medication room had expired in September 2024
- There was no documentary evidence to indicate that regular checks of the emergency medication were being carried out to ensure the items were present and in date. The staff we spoke with during the inspection confirmed that checks were not being undertaken
- No additional seals were being stored on the ward for the purpose of routinely checking and resealing the emergency medication case
- Expired Fortisip medication was being stored within the fridge in the medication room
- The health board's Medicines Policy was out-of-date.

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

Quality of Management and Leadership

Overall summary:
Staff provided positive feedback about their immediate line managers and felt supported in their roles. We were told that the existing governance and leadership structures were recently improved, leading to positive changes in staff culture and morale.

We found high staff compliance with annual appraisals, and suitable arrangements in place for senior staff to monitor compliance with mandatory training. Overall mandatory training compliance rates were high, though improvements were needed in training for Restrictive Physical Intervention, Safe Administration of Medications and Duty of Candour (DoC).

Staffing levels met the core establishment throughout our inspection, with suitably trained staff available to meet the needs of the young people. However, the ward faced significant staffing pressures, with high vacancies and long-term sickness absences. Robust recruitment processes were in place, but fluctuating demands required a high use of bank and agency staff.

Good processes were in place to record and investigate concerns and complaints. Daily 'Young Persons' meetings provided a platform for young people to offer feedback and suggest improvements. A bi-weekly supportive staff meeting process

captured staff feedback, though these meetings were not minuted to record the discussions or actions taken.

It was evident that the health board was continuously reviewing the provision of the service to drive quality improvement. We observed strong interagency collaboration between ward staff and key stakeholders to support the care of young people. Established governance arrangements provided oversight of clinical and operational issues, ensuring incidents or issues were identified, investigated and monitored to prevent recurrence. However, several health board policies or procedures were past their review dates. Given the number of improvements we identified during our inspection, the management and leadership systems must be strengthened at ward and senior levels, and all governance oversight processes must be reviewed to ensure robustness.

3. What we found

Quality of Patient Experience

Patient feedback

We invited young people, family and carers to complete a HIW questionnaire to obtain their views on the service provided on the ward. Two questionnaires were completed by young people and two were completed by family/carers. The sample size was therefore too small to draw robust conclusions on themes or trends within the ward.

For those who responded, the feedback on the standard of care and treatment provided was generally good. All young people and family/carers rated the care and service as 'good' or 'very good' and told us that staff treated them with dignity and respect. Most agreed that young people were provided with care and treatment when they needed it. The young people told us that they felt involved in their Care and Treatment Plans and in meetings to discuss their care. However, one felt that staff did not listen to them nor understand their needs.

All young people confirmed that they were able to maintain contact with family and carers during their stay. The family/carers told us they felt welcomed and safe during their visits. They agreed that staff encouraged their involvement to care for the young people and that they were as involved as much as they wished to be in decisions about the care provided.

However, one young person felt dissatisfied with aspects of the ward environment, including their bedroom and outdoor spaces. In addition, one young person told us they felt unsafe on the ward and commented:

"Sometimes it (the environment) can become scary and stressful."

The health board may wish to reflect on these aspects of the feedback provided by the young people and consider whether any improvements could be made.

Person-centred

Health promotion

There were processes in place to help promote and maintain the physical and mental health needs of the young people being cared for on the ward. We reviewed three young people's records and found that they received appropriate

physical assessments on admission and had access to relevant primary healthcare services when necessary. Physical and mental health conditions were appropriately monitored, and staff demonstrated a good understanding of the young people in their care. The young people who completed our questionnaire felt they could access the right healthcare at the right time.

All young people had individual ensuite bedrooms, and they could access the communal areas of the ward throughout the day. The ward had secure garden areas which provided young people with access to fresh air and green spaces. Whilst we found that the outside areas required some weeding and general maintenance, staff told us that construction work would soon commence to create a sensory outdoor area.

The health board must ensure the ward garden areas are routinely maintained during the interim period, to support the physical and mental wellbeing of the young people.

The hospital's Nant-y-Bryniau Education Centre provided in-patient education tailored to the learning, health, and therapeutic needs of the young people. A dedicated team of teaching and support staff ensured these needs were met. Young people could also access a range of therapeutic and leisure activities including a sports hall equipped with gym facilities, games, books and art therapy equipment.

The ward had a dedicated Occupational Therapist (OT) and Activities Coordinator to support the provision of therapeutic activities. The young people who completed our questionnaire felt satisfied with the activities provided on the ward. However, we did not see evidence that the young people were provided with a structured programme of individualised therapeutic activities to support their health, wellbeing and rehabilitation. We also identified this issue during our previous inspection of the ward in 2018.

The health board must implement a structured programme of individualised therapeutic activities for young people on the ward, to support their health, wellbeing and rehabilitation.

Dignified and respectful care
Throughout our inspection we observed staff engaging with young people appropriately and treating them with dignity and respect. We witnessed positive interactions, which demonstrated their attentiveness to the individual needs of young people.

The ward's communal areas provided a pleasant and suitably decorated therapeutic environment tailored to the needs of the young people. Each young person had their own bedroom with ensuite shower facilities, supporting their privacy and dignity. Young people were able to store possessions and personalise their bedrooms with pictures and posters where appropriate. All bedroom doors had an observation panel, allowing staff to undertake therapeutic observations without opening the door and disturbing the young people. The staff members who completed a questionnaire felt that the privacy and dignity of young people were always maintained.

However, during the inspection we found that the windows in the main communal area of the ward were not fitted with privacy glass, which posed a risk of the young people being seen from outside. Staff had partially covered the windows with posters to help maintain the privacy of the young people, but this arrangement could potentially compromise their privacy and dignity during their stay.

The health board must implement suitable measures to ensure young people cannot be seen from the external areas of the ward, to protect their privacy and dignity.

Patient information

A range of suitable and relevant information was displayed to help young people and their families understand their care. These included details about how young people and their carers could access advocacy services, contact HIW, and raise a concern or complaint.

The ward displayed helpful pictorial information boards to identify staff members for the awareness of young people and visitors. Additionally, the ward had a notice board outlining which staff members were on duty each day.

In addition to the information displayed on the ward, a comprehensive information booklet had been developed to support young people and their family/carers, which we identified as an example of good practice.

Individualised care

We reviewed the Care and Treatment Plans (CTPs) of three young people and found that each had an individualised programme of care that reflected their needs and risks. However, improvements were required to ensure the CTPs reflected the voice and involvement of the young people. More findings on the CTPs can be found in the Monitoring the Mental Health (Wales) Measure 2010: Care Planning and Provision section of this report.

We found that young people were supported to make their own decisions about how to care for themselves wherever possible, promoting their independence and quality of life. This was supported by a range of suitable health promotion information on display. Young people also had appropriate access to aids which promoted their independence, such as hearing loops, headphones and restricted internet access.

The young people had individual personal profiles which outlined their interests and personal preferences for staff awareness. We saw evidence of young people making their own food and clothing choices and being supported to carry out everyday tasks. The young people and staff members who completed a questionnaire felt that young people were informed and involved in decisions about their care.

Timely

Timely care

Staff provided timely and effective care in accordance with clinical need. All young people were allocated a named nurse and a team of key staff members to support their care throughout their admission. The KITE Intensive Community Support Team, based within the hospital, offered a community-based alternative to inpatient admission, working with staff, young people and their families to prevent crises, admissions and relapse.

Established meeting processes supported the timely care of young people, including daily multidisciplinary team (MDT) ward round meetings and biweekly individual young person's progress and planning meetings. We attended a ward round and saw that staff demonstrated a good level of understanding of the individuals they were caring for, and that discussions focused on what was best for the young people.

We were told that any issues identified were raised and discussed during monthly Programme Team Meetings, where concerns and incidents were routinely discussed to identify trends and opportunities for wider service and organisational learning.

Equitable

Communication and language

The ward used paper record keeping systems to document and communicate patient care, supplemented by digital technology for online meetings, audit processes and electronic information sharing.

We were told that the young people had access to their own personal electronic devices, subject to individual risk assessment. Measures were in place to ensure the safe use of digital devices, including restricted internet access and a contract signed by the young people and their family/carers on admission.

There were suitable rooms where young people could spend time away from others and see their families in private, including a dedicated family bedroom for overnight stays. The young people who completed a questionnaire confirmed they were able to maintain contact with their friends and family since being admitted to the ward.

Staff demonstrated understanding of the importance of speaking with young people in their preferred language. We were told that language preferences were identified on admission, and translation services were utilised if required. Some ward staff were Welsh speakers, and we witnessed staff speaking to young people in Welsh during the inspection. We were provided with an example of how staff conversed with young people in Welsh to reduce or prevent challenging behaviours.

Bilingual information was displayed or provided throughout the ward. Whilst we found that Welsh speaking staff did not wear a 'Iaith Gwaith' badge to indicate that they were a Welsh speaker, we were informed that badges had been ordered.

Rights and equality

We reviewed the records of four young people who were detained under the Mental Health Act. The documentation was compliant with relevant legislation and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code). All young people had access to a mental health advocate who provided information and support to young people with any care-related issues. Our main findings on the quality of the documentation are detailed in the Mental Health Act Monitoring section of this report.

We found satisfactory arrangements in place to promote and protect the rights of the young people. Staff compliance with mandatory training for Equality, Diversity and Human Rights was high at 94%. Policies were in place to ensure everyone had equitable access to the same opportunities and fair treatment. Information to advise young people of their rights was clearly displayed throughout the ward. We were informed that the religious needs of the young people were respected and accommodated, and we noted that the ward had a designated therapy faith room. However, the room lacked appropriate multifaith decoration, information or equipment.

The health board should ensure the therapy faith room is suitably decorated to provide appropriate multifaith facilities and equipment for young people.

During our staff discussions, they demonstrated suitable regard for upholding the rights and individual preferences of the young people in their care. Staff referred to the young people by their preferred names and pronouns. Regular meetings were held to review and discuss practices to minimise the restrictions on young people, based on individual risks. Care was consistently provided in accordance with the age group and needs of the young people. However, our review of CTPs evidenced that their social, cultural and spiritual needs were not always recorded. Further information on our findings is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Reasonable adjustments were in place to ensure equitable access to, and use of services. The ward was accessible to wheelchair users, and additional specialist equipment was available for use if required.

Delivery of Safe and Effective Care

Safe

Risk management
There were established policies, processes and audits in place to support the management of risk, which enabled staff to provide safe and clinically effective care. We considered the processes in place to manage risks to help maintain the health and safety of young people, staff and visitors, and found the following suitable measures in place:

- The ward entrances were always secured throughout the inspection to prevent unauthorised access or egress
- The ward was accessible to all, including those with mobility difficulties
- The ward environment was clean, tidy and well-maintained
- All bedrooms and bathrooms were fitted with accessible call bells, so young people could alert staff in the event of an emergency
- Ligature cutters were available for use in the event of a self-harm emergency and staff knew where to find them
- There were regular audits of emergency resuscitation equipment to ensure that the equipment was present and in date.

However, we identified some issues that required immediate attention to maintain the safety of young people, staff and visitors.

During our evening tour of the ward, we saw two oxygen cylinders were inappropriately and insecurely stored flat on the floor of the clinic room, posing a potential safety risk. This issue was rectified during the inspection; however, whilst the oxygen cylinders were within their expiry dates, staff were unable to provide documentary evidence that regular service maintenance checks of the oxygen cylinders were being conducted.

The health board must ensure oxygen cylinders are stored securely within a designated cradle, and regular service maintenance checks must be conducted and documented, to maintain the safety of staff and young people.

We were told that staff carried personal safety alarms to use in the event of an emergency, and there were sufficient alarms available for all staff. However, during the inspection not all staff were carrying personal safety alarms on the ward. Additionally, there was no personal safety alarm policy in place to provide clear guidance to staff regarding the requirement to carry alarms. This issue was also noted during our previous inspection of the ward in 2018.

The health board must implement a personal safety alarm policy to provide clear guidance to staff regarding the requirement to carry alarms, to support the safety of staff and young people.

We were told that an external health board review of the ligature attachment points throughout the mental health inpatient estate was commissioned in August 2023. Following this, capital funding was approved for a programme of anti-ligature works throughout the ward. This programme was ongoing at the time of our inspection, with some actions already completed. Additionally, the construction of an Extra Care Area (ECA) was soon to commence, providing an additional safe, therapeutic area for young people requiring additional support.

The ward's fixtures and fittings were generally well maintained and suitable for the young people. A monthly programme of ligature point risk assessments was being undertaken, which detailed the actions taken to mitigate or minimise the risk of ligature. Staff confirmed that daily reviews of young people's observations levels were conducted, to manage any changes or emerging risks.

Whilst we were assured that young people were receiving safe care on the ward, we noted several environmental risks awaiting remedial action by the estates team:

- Correct screws and anti-pick sealant required for all wall and ceiling fittings
- Weight testing required for curtain rails, coat hooks, curtains and shower curtains, to ensure they were safe for low-weight young people
- The ward bathroom had been out of use for over a year whilst awaiting anti-ligature work
- No protective cover on the light switch outside the clinic room
- A missing fence within the family therapy garden
- A pantry cupboard door damaged since August 2024.

The ward had an electronic tracker process and a hand-written logbook to record outstanding estates and maintenance issues. However, some estates issues were recorded in the logbook but not within the electronic tracker. Additionally, several outstanding estates issues did not appear to have been addressed or signed off within the records we viewed. Therefore, we were not assured there was an effective process in place which ensured that outstanding estates issues were being identified, addressed and signed off as complete for the awareness of all staff.

The health board must:

- **Ensure the ward's ongoing programme of anti-ligature works is robustly addressed to ensure the safety of the young people**
- **Implement a programme of governance oversight which ensures that the hospital's estates maintenance issues are promptly and effectively recorded, addressed and signed off.**

Infection, prevention and control and decontamination
We considered the ward environment, clinical areas and the wider hospital, and found they were clean, tidy and uncluttered. Suitable Infection Prevention Control (IPC) policies, procedures, staff training and governance arrangements were in place to maintain the safety of staff, young people and visitors. Appropriate signage, facilities and equipment were in place to support effective cleaning of the ward and encourage good hygiene among staff and young people.

Staff we spoke with during the inspection demonstrated a good understanding of their role and responsibility in upholding IPC standards. Overall staff compliance with mandatory IPC training was high at 97%. Cleaning schedules and IPC audits were being completed to ensure compliance with IPC procedures. We saw evidence that shared equipment was decontaminated between uses.

The staff members who completed a questionnaire provided positive feedback about the IPC arrangements in place. They confirmed that an effective IPC policy and cleaning schedules were in place. They agreed that appropriate PPE was supplied and used, and that the environment allowed for effective infection control.

During our staff discussions, we were informed that the ward's appointed IPC lead had recently left the service, and noted there was some confusion amongst staff regarding the identity of the current IPC lead.

The health board should ensure a nominated IPC lead is appointed to the ward, to provide clear guidance and support for staff.

Safeguarding of children and adults
We found appropriate safeguarding measures in place to protect young people. Staff could access the health board's safeguarding policy and Wales Safeguarding Procedures via the intranet. Our staff discussions highlighted a good knowledge and understanding of the safeguarding procedures and reporting arrangements. We found an overall high staff compliance with mandatory training for safeguarding adults and children.

The ward had a dedicated specialist CAMHS Social Worker who was supported by the senior management team, to ensure the ward's safeguarding responsibilities

were met. We were told that the ward worked closely with the local authority safeguarding team and saw evidence that safeguarding incidents and concerns were appropriately recorded, investigated and monitored by senior staff. Additionally, safeguarding concerns were regularly reviewed to identify any themes and lessons learned.

Management of medical devices and equipment
We found appropriate resuscitation equipment in place on the ward, with regular checks conducted to ensure that the items were present and in date.

The medical devices within the clinic room displayed stickers indicating their service due dates. During the inspection we found that the ward's echocardiogram (ECG) equipment was due for calibration in July 2023 and highlighted this issue to staff. We were told that the ward's medical equipment was maintained by the health board's medical devices team and that the records were not held on the ward. Staff we spoke with during the inspection were unable to provide evidence that the ECG equipment was in date. Following the inspection, senior staff confirmed that the ECG equipment had since been calibrated and an asset register would be implemented to ensure ongoing staff awareness and oversight of the ward's medical devices and equipment.

The health board must implement reliable systems to ensure the ward's medical devices and equipment are routinely checked, maintained and calibrated to support staff and young people's safety.

Medicines management
We reviewed the ward's clinic arrangements and found some suitable processes in place for the safe management of medicines, but robust improvements were needed in some areas.

All prescribed medications were securely stored in the medication fridges and in locked cupboards. We found evidence of regular temperature checks of the clinic room and medication fridge to ensure medication was being stored at the correct temperature. However, we saw a blue pharmaceutical waste box that was insecure and contained medication, sharps and butterfly cannulas. We highlighted this issue to staff as a potential safety risk. Following the inspection, we were informed that the box had been replaced and stored within a locked cupboard in the medication room as appropriate.

Auditing systems were in place to support the safe administration of medication, with weekly pharmacy involvement. We reviewed eight Medication Administration Records (MAR charts) and found they were completed to a good standard. The records were consistently signed and dated when medication was prescribed and

administered, and a reason recorded when medication was not administered. However, we found the paper medication records were poorly organised, being entirely filed in one single folder rather than in one folder for each young person. Additionally, some of the medication records and accompanying documents were torn or damaged, which posed a potential risk of them being mislaid or misfiled within the folder.

The health board must improve the organisation of MAR charts to ensure they are appropriately filed and securely stored, to support young people's safety and ensure ease of access for staff.

Consent to treatment certificates were appropriately completed and stored alongside the MAR charts where appropriate. However, we saw one example where the current Mental Health Act (MHA) legal status of a recently admitted young person was not recorded in their MAR chart. We also found that photos of the young people were attached to only two of the eight medication records we reviewed. These issues posed a potential risk of medication being administered to young people in error.

The health board must ensure the MHA legal status of young people is clearly recorded within their MAR charts, to provide clear guidance to staff.

The health board should consider attaching photographs of young people to their MAR charts, to reduce the risk of medication errors and support the safe administration of their medicines.

We observed safe and appropriate prescribing of medications in accordance with the needs of the young people. All young people had individualised medication management plans, and each were involved in decisions about their medications wherever possible. Medications were routinely discussed during daily ward rounds, and any updates or changes to their medication were recorded.

However, during the inspection we were not assured that the medicines management processes in place at the setting were sufficiently robust and safe to protect the young people from potential harm in the event of an emergency. The following issues required immediate action to be taken by the health board:

- Emergency medication was being stored in a sealed case within the medication room. We found that the emergency medication contained inside had expired in September 2024
- There was no documentary evidence to indicate that regular checks of the emergency medication were being carried out to ensure the items were present and in date. The staff we spoke with during the inspection

confirmed that checks were not being undertaken of the emergency medication
- No additional seals were being stored on the ward for the purpose of routinely checking and resealing the emergency medication case
- In addition, we found expired patient Fortisip medication was being stored within the fridge in the medication room
- The health board's Medicines Policy was out-of-date, according to its review date of February 2023.

Our concerns regarding these issues were dealt with under our immediate assurance process. Further information on the improvements we identified, and the actions taken by the health board, are provided in **Appendix B**.

Effective

Effective care

Staff used the Datix system for recording, managing and monitoring incidents. There was an incident sign-off hierarchy in place, with regular incident reports produced to establish any themes and trends. Senior staff confirmed that any relevant learning was shared with staff both verbally and electronically.

We found that staff numbers to care for the young people met the ward's core staffing establishment during the inspection. Most staff we spoke with and who completed our questionnaire felt there were enough staff to meet the needs of the young people. However, there were significant staffing pressures on the ward due to a high number of staffing vacancies and recent instances of long-term staff sickness absence, resulting in a 28% nursing staff shortfall.

To support the vacancies and unplanned absences, we noted a heavy reliance on temporary staff to cover any staffing shortfalls. We were told that the ward actively sought to block-book temporary staff who were familiar with the ward and the young people wherever possible. Due to the staffing pressures, staff from the KITE Team provided support with therapeutic observations.

We observed staff responding to the needs of the young people in a timely manner throughout the inspection. The therapeutic observation levels for individual young people were regularly reviewed to ensure they were safe and appropriate. We were told that daily audits were also completed to ensure therapeutic observations were appropriately completed.

During our discussions with staff, they showed an understanding of restrictive practices, including appropriate preventative measures to reduce the need for restrictive responses to challenging behaviour. Principles of positive behavioural

support (PBS) were being used as a method of de-escalation. When physical interventions were identified as potentially necessary, the Physical Interventions Team supported staff in creating individualised care plans documenting suitable strategies for managing challenging behaviours. We saw evidence of restrictive practices being used as a last resort, with thorough monitoring around therapeutic effect and risk. Staff reported that 30 incidents of restraint were recorded within the six months prior to our inspection.

We reviewed staff training records, staffing rotas, and incident forms for Kestrel Ward. Overall, staff compliance with Restrictive Physical Intervention (RPI) training was low at 65%. Incidents of restraint on young people were recorded on the Datix system and within RPI records. Our review of these records evidenced that one incident of physical restraint had involved an agency staff member who had not completed the health board's RPI training. Senior staff confirmed that it was not always possible for temporary staff to complete the health board's RPI training prior to them commencing work on the ward.

The health board must:

- **Ensure all staff on Kestrel Ward are compliant with their RPI training to ensure the safety of staff and young people is maintained**
- **Implement measures to ensure there are sufficiently trained staff members to manage incidences of restraint until all staff have received their training**
- **Review the existing temporary staff booking process for bank and agency staff to ensure staff are suitably skilled to care for the young people**
- **Ensure our findings in relation to restraint training compliance are not systemic across other areas of the organisation.**

Nutrition and hydration

The nutritional and hydration needs of the young people were assessed using the Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP). Our review of clinical records identified that young people were provided with an appropriate diet in accordance with their needs. A specialist dietician worked closely with ward staff and the catering team to ensure young people received suitable diets, and access to Speech and Language Therapy (SALT) was available if required.

There were set times for meals throughout the day and young people could choose from weekly set menus which rotated every three weeks. They could also access additional drinks and snacks throughout the day and store personal food on the ward. We observed food being served to young people during the inspection and found it appeared to be appetising and appealing.

There were good processes and procedures in place to help support young people during mealtimes. The ward had introduced communal mealtimes where young people and staff ate together, which we identified as an example of good practice. The young people we spoke with felt happy with the quality of the food provided, although some staff felt that more choice was needed for young people following vegan or plant-based diets. The health board may wish to conduct further discussions with staff and young people regarding this matter.

Patient records

Clinical records were maintained in paper files and stored electronically in local shared drives. The paper records were stored securely, and the electronic system was password protected to prevent unauthorised access. We found clinical details were recorded contemporaneously and comprehensively to provide a detailed overview of the young people and their care.

However, we found robust improvements were required in the general standard of record keeping. Whilst the records were accessible to staff, navigation of the records was challenging and time consuming, due to the volume of documents in each record. The records were divided into relevant sections, but staff had difficulty in retrieving some documents we requested to review during the inspection.

We found unnecessary documentation stored within the paper records and noted an instance where documentation relating to one young person was incorrectly stored within the record of another. Additionally, some information stored within the ward's local shared drives was not always printed and filed within the paper records, preventing details being accessed in a timely manner. We also found that some records were difficult to review, due to the poor handwriting of the completing staff.

Staff told us the paper records system presented significant challenges and that their working practices would be improved with the introduction of a fully electronic health record system.

The health board must review the ward's record keeping arrangements to ensure young people's records are well-organised, accessible and easy to navigate, to support staff in their roles and ensure the timely care of young people.

The health board should review the current paper health record system with a view to implementing a fully electronic health record system on the ward.

Mental Health Act monitoring

We reviewed the statutory detention documents of four young people and discussed the monitoring and audit arrangements with staff. We were assured that the health board's responsibilities under the Mental Health Act (MHA) were being upheld. All records reviewed were compliant with the MHA and Code of Practice. Clear reasons were documented to evidence the decisions made in relation to the care and detention of each young person. During our discussions with staff, they demonstrated good knowledge of MHA processes. Overall staff compliance with mandatory MHA training was high at 83%.

The MHA files we viewed were generally well-organised, easy to navigate and contained detailed and relevant information. Statutory documentation was generally well completed. However, we found two errors within a professional report for a young person's Mental Health Review Tribunal, where the date of section and year of detention were incorrectly recorded.

The health board must ensure MHA statutory documentation is accurately completed.

The ward had a dedicated MHA administrator who provided ongoing support to staff. It was positive to note that the MHA administrator had developed a comprehensive series of bi-lingual and easy-read leaflets to support young people in understanding MHA processes. We identified this as an example of good practice.

There were processes in place to support the rights of young people and they were well-supported to access advocacy services. However, we saw no evidence that mental capacity assessments were routinely undertaken to ensure young people could appropriately make decisions for themselves about their treatment. Staff we spoke with told us that they did not routinely undertake or record mental capacity assessments, and that there were no prompts within the care records nor document templates to record this.

The health board must ensure mental capacity assessments are undertaken on the young people and suitably recorded within their records.

Young people's leave arrangements were suitably risk assessed, and the forms outlined the conditions and outcomes of the leave for each young person. However, we noted that the ward did not store photographs of the young people alongside their MHA records for easy identification of individuals.

The health board should consider adding photographs to the Section 17 leave forms, to help identify young people in the event of them not returning from leave.

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

Alongside our review of statutory detention documents, we considered the application of the Mental Health (Wales) Measure 2010. We reviewed the records of three young people and found improvements were required in respect of the organisation of the paper records, as outlined previously in this report. Navigation of the care plans was difficult, due to the disorganisation of the paper records and multiple recording formats. We were told that some information was not always immediately available to staff and identified that this could pose a potential risk to the safety of the young people, as any new or unfamiliar staff may not have prompt access to the records.

The health board must improve care planning processes to ensure information is captured and recorded in a clear and consistent way within young people's records, to support their safety and ensure efficiency and accessibility for staff.

All young people had a North Wales Adolescent Service (NWAS) Care and Treatment Plan (CTP) completed by community teams upon their admission, as well as a ward-based CTP. We were told that the NWAS CTP was led by the community and that components relevant to the ward inpatient setting were addressed by ward staff and incorporated into the ward care planning process.

We found the NWAS CTPs were well-completed and aligned with the Mental Health Wales measure 2010 domains. However, the ward CTPs did not clearly reflect these domains and were not directly correlated to the NWAS CTPs. Additionally, ward staff told us they did not contribute to nor review the NWAS CTPs, and there were sometimes delays in the ward receiving the NWAS CTP upon a young person's admission.

The health board must:

- **Review the current arrangements for completing and sharing care plans between community and ward teams to ensure prompt sharing, effective communication and alignment of young people's records across community and inpatient services**
- **Ensure all Care and Treatment Plans reflect the domains of the Mental Health Wales Measure 2010.**

We found appropriate arrangements in place to meet the physical and mental health needs of the young people. Each young person had an individual, up-to date CTP which assessed their needs and maintained their safety. To support the care

plans, there was a range of assessments to identify and monitor the provision of care, including risk assessments outlining the identified risks and how to mitigate them. The progress notes were effectively completed to provide a contemporaneous overview of care. However, the ward-based CTPs were not always person-centred and did not always reflect the voice and involvement of the young people. There was no evidence of young people being involved in co-producing their CTPs. Some ward-based CTPs were not holistic, and did not consider the social, cultural and spiritual needs of the young people, nor identify a full range of interventions, such as therapeutic and social activities.

The health board must ensure the CTPs reflect the voice and involvement of the young people, their social, cultural and spiritual needs, and identify a full range of interventions.

Regular MDT reviews were being undertaken to review patient care, which included the involvement of family/carers, external agencies and community professionals as appropriate. However, the family/carers who completed our questionnaire were asked to provide service improvement suggestions and commented:

> *"Better and more consistent communication. Often I get quite a different description depending on the staff member I speak to."*

> *"Communication with the unit isn't always clear."*

The health board should reflect on this aspect of family/carer feedback and consider whether improvements in relation to communication with family/carers could be made.

We saw evidence that the ward-based CTPs were not always reviewed in a timely way. Weekly care plan audits were not being completed within set timescales, and there was no evidence to indicate which staff member had completed the review.

The health board must ensure that ward-based CTPs are reviewed in a timely manner and clearly identify the staff members involved.

Efficient

Efficient

We found the arrangements for discharge and admission to the ward to be robust and efficient. The KITE Team conducted pre-admission assessments for the young people and worked closely with them, their family/carers and ward staff throughout their stay. A clear discharge planning pathway was established, with

regular meetings held to discuss placements for the young people, with a focus on community reintegration.

We found strong evidence that staff worked collaboratively across services, engaging with the young people, their families and carers to ensure the best outcomes. Evidence of MDT and interagency involvement in the care of the young people was clear. Meetings with family/carers were held to establish their wishes and expectations throughout the admission process.

Quality of Management and Leadership

Staff feedback

We engaged with staff throughout the inspection and received two responses to our staff questionnaire. The response rate was too small to draw robust conclusions on themes or trends within the ward.

The two staff responses to the questionnaire were generally positive. They recommended the hospital as a place to work and told us they were satisfied with the quality of care they gave to the young people. In addition, they agreed that patient care was the health board's top priority and told us they were content with the health board's efforts to keep staff and young people safe. They stated they would be happy with the standard of care provided for themselves or friends/family.

One member of staff commented:

> *"I am proud to work in a unit alongside such dedicated and caring members of staff."*

Leadership

Governance and leadership

We observed strong team working on the ward and found staff were dedicated to delivering a high standard of care. We were informed that the health board had recently implemented changes to the North Wales Adolescent Services (NWAS) leadership model and organisational structure, adopting a more collaborative approach to crisis response in North Wales. Senior staff told us that changes to the existing governance and leadership structures had resulted in positive changes in staff culture and morale. We were told that the introduction of team-building activities and away-days for staff had strengthened communication between senior and ward staff, fostering a more cohesive and motivated team environment.

Staff we spoke with during the inspection and who completed our questionnaire provided positive feedback to us about their immediate line managers. All felt supported in their roles and confirmed that senior managers were visible and approachable. The respondents to our staff questionnaire agreed that their manager could be counted on to help with difficult tasks at work, and that they asked for their opinion before making decisions that affected their area of work.

We generally found suitable processes in place in relation to identifying and discussing issues and addressing improvements. However, the leadership and

management systems must be strengthened in respect of the improvements identified in this report.

Workforce

Skilled and enabled workforce

As highlighted earlier in this report, the ward was experiencing significant staffing pressures due to vacancies and sickness absence. The 28% core nursing staff shortfall included a vacant ward manager's post, although this was progressing through recruitment. Additional staff vacancies included psychology and family therapist posts, resulting in a 41% total workforce availability shortfall. We discussed these issues with staff and were told that robust recruitment processes were ongoing to fill vacant posts, with weekly leadership meetings being held to discuss and address these issues.

There appeared to be sufficient appropriately trained staff to meet the assessed needs of the young people throughout our inspection. Most staff reported feeling able to deliver safe and effective care, though some felt there was not always enough staff to meet fluctuating staff needs and increased acuity among the young people. We were told that any requests for temporary staff were granted by senior managers but noted a very high reliance on bank and agency staff to support the care of young people.

We found suitable processes in place to monitor staff compliance with mandatory training. Overall compliance rates were generally high in most areas, but improvements were required in compliance with Restrictive Physical Intervention and safe administration of medications training.

The health board must ensure all staff are supported to complete mandatory training in a timely manner, particularly Restrictive Physical Intervention and safe administration of medications.

We found that 83% of Kestrel staff had received their annual Performance Appraisal and Development Review (PADR). We were told that a regular formal and informal clinical supervision process was also in place for all staff.

Culture

People engagement, feedback and learning

An established process was in place for young people or their family/carers to escalate concerns through the NHS Wales 'Putting Things Right' (PTR) process. Senior staff confirmed that formal complaints were recorded on the Datix system and were monitored by senior managers throughout the investigation. Our staff

discussions evidenced that informal and formal complaints were appropriately recorded, investigated, and escalated when necessary. Any learning outcomes were shared with all staff.

Our staff engagement identified that they understood the Duty of Candour (DoC) requirements and felt encouraged to report errors, near misses or incidents. However, only one respondent to our staff questionnaire felt secure to raise concerns about patient care or other issues. Additionally, staff we spoke with during the inspection told us they had not received any DoC training to support them in their roles.

The health board must implement Duty of Candour training for staff to support them in their roles.

We found effective processes in place to routinely capture young person and family/carer feedback. Daily 'Young Persons' meetings involving young people, clinical staff and education staff provided a platform for young people to offer feedback and suggest improvements. Additionally, a fortnightly individual 'Young Person's Management Meeting' provided an opportunity for young people to raise any issues. A live survey poster with QR codes was displayed throughout the ward to encourage feedback from young people and their family/carers.

A bi-weekly supportive staff meeting process was in place to capture ward staff feedback. However, we were told that the meetings were not minuted to capture the matters raised or to record any actions required.

The health board must ensure staff meetings are minuted to evidence and action matters discussed, to identify themes and drive quality improvement.

Information

Information governance and digital technology
Young people's records and data were being maintained in line with General Data Protection Regulation (GDPR) legislation. All clinical records were securely stored. The information was accessible to all relevant staff, and there were established processes to share information with partner agencies in safe and secure way. Staff compliance with mandatory information governance training was high at 90%. However, we found improvements were required in respect of the ward's record keeping and filing processes, as highlighted earlier in this report.

We found that several health board policies or procedures were past their review dates during our inspection. These included:

- Occupational Health and safety – December 2023
- Medicines - February 2023
- Guidelines for the use of Rapid Tranquillisation in children aged 12 years to 17 years – July 2022
- Procedure for NHS Staff to Raise Concerns – June 2024
- Business Continuity Plan – September 2024.

The health board must ensure key policies and procedures are reviewed and updated in a timely manner to ensure staff are appropriately supported in their roles.

Learning, improvement and research

Quality improvement activities

It was evident through our staff discussions that the health board was continuously reviewing the provision of the service on the ward to drive quality improvement. Good processes were in place to seek feedback from young people and their families, and staff demonstrated a strong commitment to making improvements based on the feedback provided. A new role, the Patient and Family Liaison Officer, had been developed from feedback to support young people and their families from admission to discharge.

Senior staff spoke positively of the ongoing processes in place to improve the compliance and efficiency of communication between staff and external agencies. In addition, quality improvement activities were being undertaken throughout the ward to help improve the care and safety of young people. Staff described the efforts being made to further improve the patient admissions process, and the ward was working towards achieving an Autism Accreditation by April 2025. This demonstrates a commitment to supporting the diverse needs of young people. Overall, we were assured that staff were committed to continuously improving the standard of care for young people.

During our staff discussions we were apprised of regular audit activities and meetings to discuss findings, incidents and other issues related to patient care. Processes were in place to ensure incidents or issues were identified, investigated, escalated and monitored to prevent reoccurrence. However, further work is required to address all recommendations highlighted in this report, and action must be taken to sustain the improvements made.

Whole-systems approach

Partnership working and development

We found that the service effectively considered the implications of their actions on other parts of the mental health service, and engaged well with various partners. We saw strong inter-agency collaboration between ward staff and key stakeholders to support the provision of care for young people, including KITE, education, CAMHS, crisis teams, social services, and police.

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
During our evening tour of the ward, we saw two oxygen cylinders inappropriately and insecurely stored flat on the floor of the clinic room.	This posed a potential risk to staff and young people's safety.	We highlighted our concerns to staff.	This issue was rectified during the inspection in that the cylinders were appropriately secured.

Appendix B – Immediate improvement plan

Service: Kestrel Ward, Abergele Hospital
Date of inspection: 13-15 January 2025

Findings
HIW was not assured that the medicines management processes in place at the setting were sufficiently robust and safe to protect the young people from potential harm in the event of an emergency. We identified the following issues which require immediate action to be taken by the health board:

- Emergency medication was being stored in a sealed case within the medication room. We found that the emergency medication contained inside had expired in September 2024
- There was no documentary evidence to indicate that regular checks of the emergency medication were being carried out to ensure the items were present and in date. The staff we spoke with during the inspection confirmed that checks were not being undertaken of the emergency medication
- No additional seals were being stored on the ward for the purpose of routinely checking and resealing the emergency medication case
- In addition, we found expired patient Fortisip medication was being stored within the fridge in the medication room
- The health board's Medicines Policy was out-of-date, according to its review date of February 2023.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
	The health board must:				
1a)	Dispose of and replace all expired medication at the setting, including emergency and patient medication	Medicines Management	15/1/2025 – At around 15:00hrs emergency Anaphylaxis medication noted to have expired by HIW inspector. The pharmacy was immediately contacted and they attended, all expired medication was	Head of Nursing	Immediate action and completed – 15.1.2025

			removed from site. At 16:45hrs a replacement Emergency Anaphylaxis medication box was received onto site. The checking of the Emergency Anaphylaxis medication has been included onto the weekly emergency equipment checks and all trained staff have been alerted to this via email (see evidence), via printed poster in the clinic area and via the daily 10am meeting and at every shift handover for a 30-day period to ensure all staff are captured. Checklist produced to support daily checks	Advanced Nurse Practitioner Medicines Management Nurse CIHC	Immediate action and completed – 20.1.2025 Checklist shared by 25.1.25
1b)	Implement a reliable audit system to ensure emergency and patient medications remain in date and available for use	Medicines Management	The Anaphylaxis box is now included in the weekly checks this will have oversight by the Ward Manager. Medicines management audits compliance will be monitored through the Safer Medicines Practice Group and escalated through to the Central IHC Quality and Safety Forum.	Interim Clinical Service Manager Interim Clinical Service Manager	Completed Ongoing

1c)	Provide additional training and guidance to ensure all staff are aware of their role and responsibilities in relation to medicines management	Medicines Management	Period of enhanced audit and observation of the unit by the Medication Management Nurse The unit has been visited CIHC Medicines Management Nurse and Laura Johns, Advanced Nurse Practitioner met to take forward agreed plans: • To introduce the designated emergency stations for anaphylaxis and hypo management. • To ensure stock lists reflect stocks required for anaphylaxis and hypo management • Implement daily check list that corresponds to the emergency stations	Medication Management Nurse CIHC Advanced Nurse Practitioner	Ongoing –completion March 2025 Commenced 20.1.2025. Completion March 2025.
1d)	Strengthen leadership and management systems to ensure robust governance oversight of medicines management systems and audit processes	Medicines Management	A BCUHB Medication Management dashboard is now 'live' – this is quarterly reporting via self-audit and providing assurance around medication management and security standards. This will be completed January 2025 by our ANP and Ward Management team	Advanced Nurse Practitioner	Commenced January 2025 and will be ongoing quarterly

			jointly. This system will report into the Patient Safety and Quality (PSQ) forum.		
1e)	Review the outdated Medicines Policy to provide clear and current guidance to staff.	Medicines Management	The Chief Pharmacist's Office is actively conducting a comprehensive review and update of the Health Board's Medicines Policy, with dedicated resources prioritising this requirement. While no significant updates are anticipated regarding the quality standards for medicine storage and security beyond those already in progress, a formal update to this section is planned for approval and release by 31 March 2025. Following the publication of the updated Medicines Policy, the Chief Pharmacist will issue formal communication to all services responsible for maintaining compliance with medicines storage and security standards, directing them to provide assurance of adherence to the updated requirements.	BCUHB Chief Pharmacist	31.03.25

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): Gareth Evans
Job role: IHC Director
Date: 22.01.2025

Appendix C - Improvement plan

Service: Kestrel Ward, Abergele Hospital

Date of inspection: 13-15 January 2025

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	The ward's garden areas required minor weeding and general maintenance.	The health board must ensure the ward garden areas are routinely maintained to support the physical and mental wellbeing of the young people.	Health promotion	A regular contract for the scheduling of garden maintenance work will be organised through estates and work monitored through the NWAS Estates Working Group.	Director of Environment and Estates	6th May 2025
2.	We did not see evidence that the young people were provided with a structured programme of individualised therapeutic activities to support their	The health board must implement a structured programme of individualised therapeutic activities for young people on the ward, to support their health, wellbeing and rehabilitation.	Health promotion	Psychologist, Occupational Therapist and Ward Activity Co-Ordinator to jointly consider and develop an individualised, and a general ward	Clinical Psychologist, NWAS	30th June 2025

	health, wellbeing and rehabilitation.			programme of structured therapeutic activity for each young person. This will include day and evening activities.		
3.	The windows in the main communal area of the ward were not fitted with privacy glass, which posed a risk of the young people being seen from outside.	The health board must implement suitable measures to ensure young people cannot be seen from the external areas of the ward, to protect their privacy and dignity.	Dignified and respectful care	To apply opaque film on low windows to obscure view from outside to inside.	Director of Environment and Estates	6th May 2025
4.	The therapy faith room lacked appropriate multifaith decoration, information and equipment.	The health board should ensure the therapy faith room is suitably decorated to provide appropriate multifaith facilities and equipment for young people.	Rights and equality	To consider multifaith requirements with the BCUHB spiritual care and chaplaincy. To ensure the therapy faith room is suitably decorated to provide appropriate multifaith facilities and equipment for young people.	Ward Manager	6th May 2025

5.	Staff were unable to provide documentary evidence that regular service maintenance checks of the oxygen cylinders were being conducted.	The health board must ensure regular service maintenance checks of oxygen cylinders are conducted and documented, to support the safety of staff and young people.	Risk management	Asset register with EBME of all equipment that requires maintenance to be developed; to include record of service maintenance schedule and results. Lead to be identified within the service. This will be monitored via the Quality and Safety Sub-Group.	Central IHC Operations Lead	6th May 2025
6.	Not all staff carried personal safety alarms and there was no personal safety alarm policy in place to provide clear guidance to staff.	The health board must implement a personal safety alarm policy to provide clear guidance to staff regarding the requirement to carry alarms, to support the safety of staff and young people.	Risk management	All staff to be immediately reminded of their responsibility to carry the provided personal safety alarms at all times – via email, poster within staff areas and within staff meeting/support (twice weekly). Personal Safety Alarm Standard Operating	Clinical Service Manager	30th March 2025 20th May 2025

				Procedure (SoP) for NWAS to be developed that is aligned to the current MHLD Policy. SoP to be approved via the Tier 4 Programme Meeting – Holding oversight.	Clinical Service Manager	 30th June 2025
7.	Several environmental risks were awaiting remedial action by the estates team, including anti-ligature risks.	The health board must ensure the ward's ongoing programme of anti-ligature works is robustly addressed to ensure the safety of the young people.	Risk management	The register of estates work to be reviewed and tracker updated with any outstanding work to be actioned accordingly. This will be monitored through the NWAS Estates Working Group and escalated as required via the monthly Quality and Safety Sub-Group Meeting.	Director of Environment and Estates Clinical Services Manager	30th April 2025 1st June 2025
8.	We were not assured there was an effective process in place to	The health board must implement a programme of governance oversight which	Risk management	A review of the NWAS governance structure has been completed	Senior Leadership Team	9th April 2025

	ensure estates issues were identified, addressed and signed off for the awareness of all staff.	ensures that the hospital's estates maintenance issues are promptly and effectively recorded, addressed and signed off.		and processes mapped to be agreed at the Tier 4 Programme meeting and shared widely within the team so all staff aware of how to raise estates issues. Ward Manager/Deputy Ward Manager and Housekeeper to undertake a weekly walk around the unit to identify estates issues at the earliest opportunity. All estates issues will be recorded on an Estates Tracker, raised with estates. All logged issues will be monitored and signed off in the NWAS Estates Working Group.	Ward Manager NWAS Operations Manager	7th April 2025 7th April 2025

				Any issues for escalation from this meeting will be shared and discussed within the NWAS Quality and Safety Sub-Group Meeting.	Clinical Services Manager	30th June 2025
9.	There was some confusion amongst staff regarding the identity of the current IPC lead.	The health board should ensure a nominated IPC lead is appointed to the ward, to provide clear guidance and support for staff.	Infection, prevention and control and decontamination	Identification of an IPC lead. Role definition to be developed outlining responsibilities i.e. IPC Audits. All staff to be aware of nominated IPC lead via email, poster in staff areas and via the daily morning meeting for a period of 1 week. IPC lead to attend and update at the Quality & Safety Sub-group to ensure effective governance.	Clinical Services Manager	7th April 2025 14th April 2025 2nd June 2025

10.	The ward's echocardiogram (ECG) equipment was due for calibration in July 2023. Staff were unable to evidence whether the ECG equipment was in date.	The health board must implement reliable systems to ensure the ward's medical devices and equipment are routinely checked, maintained and calibrated to support staff and young people' safety.	Management of medical devices and equipment	Both ECG machines have been serviced & email evidence provided to HIW. Asset register with EBME to be developed to support ongoing monitoring of items for regular checks. This will be monitored via the NWAS Quality and Safety Sub-Group.	Head of Nursing Central IHC Operations Lead Clinical Service Manager	Completed February 2025 26th May 2025 7th July 2025
11.	Paper medication records were poorly organised, and some documents were torn or damaged, which posed a potential risk of them being mislaid or misfiled.	The health board must improve the organisation of MAR charts to ensure they are appropriately filed and securely stored, to support patient safety and ease of access for staff.	Medicines management	Written standards to be developed and shared with the ward team. Weekly audit of MAR charts to be included within the weekly audit process and monitored via the Monthly Clinical Effectiveness meeting	Advanced Nurse Practitioners	14th April 2025 7th July 2025

12.	The current Mental Health Act (MHA) legal status was not recorded in one MAR chart we viewed.	The health board must ensure that the MHA legal status of the young people is clearly recorded within their MAR charts, to provide clear guidance to staff.	Medicines management	Written standards to be developed and shared with the ward team. Current cohort of young people's MAR charts to be reviewed and amended accordingly. Audit of MAR charts to be included within the weekly audit process and monitored via the Monthly Clinical Effectiveness meeting.	Advanced Nurse Practitioners Advanced Nurse Practitioners Clinical Service Manager	14th April 2025 7th April 2025 7th July 2025
13.	Photos of the young people were attached to only two of the eight medication records we reviewed.	The health board should consider attaching patient photographs to their MAR charts, to reduce the risk of medication errors and support the safe administration of their medicines.	Medicines management	Written standards to be developed and shared with the ward team. NWAS to consistently adopt the recommendation of photographs attached to MAR charts.	Advanced Nurse Practitioners Advanced Nurse Practitioners	14th April 2025 21st April 2025

				Current cohort of young people's MAR charts to be reviewed and amended accordingly. Audit of MAR charts to be included within the weekly audit process and monitored via the Monthly Clinical Effectiveness meeting.	Advanced Nurse Practitioners Clinical Service Manager	14th April 2025 7th July 2025
14.	Overall staff compliance with Restrictive Physical Intervention (RPI) training was low. One incident of physical restraint had involved an agency staff member who had not completed the health board's RPI training.	The health board must: • Ensure all staff on Kestrel Ward are compliant with their RPI training to ensure the safety of staff and young people is maintained • Implement measures to ensure there are sufficiently trained staff members to manage incidences of restraint until all	Effective care	All staff who can be, and should be trained to have attended the 5 day RPI training. Any staff not able to be trained for health reasons to have an OH exemption on record. Rostering, safe staffing reviews RPI/skill mix to be discussed daily in the	Clinical Service Manager Clinical Service Manager Clinical Service Manager	27th June 2025 26th May 2025 14th April 2025

		staff have received their training • Review the existing temporary staff booking process for bank and agency staff to ensure staff are suitably skilled to care for the young people • Ensure our findings in relation to restraint training compliance are not systemic across other areas of the organisation.		NWAS staff meeting and actions recorded. Link with Temporary Staffing colleagues for assurances that bank and agency staff are suitably skilled to provide care to young people. SBAR to the Nurse Executive Workforce Meeting detailing the BCUHB requirements for Non-BCUHB staff (Agency) working within environments where RPI may be required. Share findings with colleagues in MHLD and provide compliance for assurance.	 Head of Nursing Director of Nursing Head of Nursing	 12th May 2025 12th May 2025 12th May 2025

15.	Robust improvements were required in the general standard of record keeping on the ward.	The health board must review the ward's record keeping arrangements to ensure young people's records are well-organised, accessible and easy to navigate, to support staff in their roles and ensure the timely care of young people.	Patient records	Standard of Clinical Notes document to be written and shared widely. All health records within the unit for current admitted young people to be reviewed and organised to enable easy access and navigation. Weekly notes audit to include a review of the standard of the health record and monitored through monthly Clinical Effectiveness Meeting.	Advanced Nurse Practitioners Ward Clerk Ward Manager	5th May 2025 7th April 2025 26th May 2025
16.	Staff told us their working practices would be improved with the introduction of a fully electronic health record system.	The health board should review the current paper health record system with a view to implementing a fully electronic health record system on the ward.	Patient records	Health Board has secured agreement for a Strategic Outline Case for an Acute and Community Electronic Healthcare Record	Chief Digital and Information Officer	30th September 2025

				System. This is to be presented for wider consultation with Welsh Government and other key stakeholders for approval. This capability and change will join up workflows and present a single view of the whole patient record across Acute and Community hospitals in the first instance, with integrations with primary care and mental health. It is expected to be a 3-4 year programme to realise its benefits if it is readily approved in the next 6 months.		
17.	We found two errors within a report for a young person's Mental	The health board must ensure MHA statutory	Mental Health Act monitoring	A reminder to all staff on the importance of accurate recording	Clinical Service Manager	7th April 2025

	Health Review Tribunal.	documentation is accurately completed.		within MHA documentation. To include within the weekly audit and monitored in the monthly Clinical Effectiveness Meeting.	 Ward Manager	 26th May 2025
18.	We saw no evidence that mental capacity assessments were routinely undertaken to ensure young people could make decisions for themselves about their treatment.	The health board must ensure mental capacity assessments are undertaken on the young people and suitably recorded within their records.	Mental Health Act monitoring	Provide internal focussed training to clinical staff to support regular assessment and documentation of mental capacity within health records. Ensure MHA and MCA training compliance is and remains above 85%. To include within the weekly audit and monitored in the monthly Clinical Effectiveness Meeting.	Advanced Nurse Practitioners Clinical Service Manager Clinical Service Manager	7th July 2025 7th July 2025 26th May 2025

19.	The ward did not store photographs of the young people alongside their MHA records.	The health board should consider adding photographs to the Section 17 leave forms, to help identify young people in the event of them not returning from leave.	Mental Health Act monitoring	Written record keeping standards to be developed and shared with the ward team.	Advanced Nurse Practitioners	5th May 2025
				NWAS to consistently adopt the recommendation of photographs attached to MAR charts with immediate effect	Ward Manager	5th May 2025
				Current cohort of young people's MAR charts to be reviewed and amended accordingly.	Ward Manager	7th April 2025
				Weekly audit of MAR charts to be included within the weekly audit process and monitored via the Monthly Clinical Effectiveness meeting/	Clinical Service Manager	26th May 2025

20.	Navigation of the care plans was difficult due to the disorganisation of the paper folders and multiple recording formats.	The health board must improve care planning processes to ensure information is captured and recorded in a clear and consistent way within young people's records, to support their safety and ensure efficiency and accessibility for staff.	Monitoring the Mental Health (Wales) Measure 2010: care planning and provision	Processes to be reviewed to ensure information is captured and recorded in a clear and consistent way and a written Care Planning standard to be included within the record keeping standards for NWAS.	Advanced Nurse Practitioners	5th May 2025
				All current health records to be reviewed and organised to enable easy access and navigation.	Ward Clerk	7th April 2025
				Weekly notes audit to include a review of the standard of the health record and monitored in the monthly Clinical Effectiveness Meeting.	Clinical Service Manager	26th May 2025

21.	The ward CTPs did not reflect the Mental Health Wales Measure 2010 domains and were not correlated to the NWAS CTPs. Staff told us there were sometimes delays in the ward receiving the NWAS CTP upon a young person's admission.	The health board must: • Review the current arrangements for completing and sharing care plans between community and ward teams to ensure prompt sharing, effective communication and alignment of young people's records across community and inpatient services • Ensure all Care and Treatment Plans reflect the domains of the Mental Health Wales Measure 2010.	Monitoring the Mental Health (Wales) Measure 2010: care planning and provision	Processes to be reviewed to ensure information is captured and recorded in a clear and consistent way and reflects the domains of the mental Health Measure 2010. A written Care Planning standard to be included within the record keeping standards for NWAS. CTP's to be consistently reviewed and shared within the weekly patient Progress and Planning Meeting as a standing agenda. If Community colleagues not in attendance the CTP to be shared	Advanced Nurse Practitioners Advanced Nurse Practitioners Consultant Nurse Consultant Nurse	5th May 2025 5th May 2025 5th May 2025 5th May 2025

				electronically post meeting.		
22.	The ward-based CTPs were not always person-centred and did not always reflect the voice and involvement of the young people. Some CTPs did not consider their social, cultural and spiritual needs, nor identify a full range of patient interventions.	The health board must ensure the CTPs reflect the voice and involvement of the young people, their social, cultural and spiritual needs, and identify a full range of interventions.	Monitoring the Mental Health (Wales) Measure 2010: care planning and provision	Care Planning processes to be reviewed to ensure plans are collaboratively developed with young people and reflects their social, cultural and spiritual views alongside the range of interventions that will support these. CTP documents/records to clearly and consistently reference the young person's voice. To be included in the weekly quality audit and reported to the NWAS Clinical	Advanced Nurse Practitioners Advanced Nurse Practitioners Clinical Service Manager	5th May 2025 5th May 2025 26th May 2025

				Effectiveness Sub-Group Ensure Equality and Diversity training compliance above 85% to promote awareness of social, cultural and spiritual aspects of care	Clinical Service Manager	26th May 2025
23.	The family/carers who completed our questionnaire commented that communication with staff could be improved.	The health board should reflect on this aspect of family/carer feedback and consider whether improvements in relation to communication with family/carers could be made.	Monitoring the Mental Health (Wales) Measure 2010: care planning and provision	Continue to review PREMS and identify themes and respond to any themes identified Actively encourage and engage in feedback activity. Weekly 'drop in' session to be established Feedback to be discussed and shared within the NWAS Quality and Safety Sub-Group	Ward Manager Family Support Officer Clinical Service Manager	1st August 2025 5th May 2025 1st August 2025

24.	Weekly care plan audits were not being completed within set timescales and there was no evidence to indicate which staff member completed the audits.	The health board must ensure that ward-based CTPs are reviewed in a timely manner and clearly identify the staff members involved.	Monitoring the Mental Health (Wales) Measure 2010: care planning and provision	Standard and proforma for Care Plan audit to be reviewed To monitor compliance and address any deficits with individual staff. Report compliance for assurance to the NWAS Clinical Effectiveness Sub-Group	Clinical Services Manager Clinical Services Manager Clinical Services Manager	5th May 2025 26th May 2025 26th May 2025
25.	Improvements were required in overall staff compliance with Restrictive Physical Intervention and Safe administration of Medications training.	The health board must ensure all staff are supported to complete mandatory training in a timely manner, particularly Restrictive Physical Intervention and safe administration of medications.	Skilled and enabled workforce	All staff who can be, and should be trained to have attended the 5 day RPI training. Unit to have 100% compliance for Medication Management training. Ongoing monitoring of training compliance will be maintained via	Clinical Services Manager Clinical Services Manager Clinical Services Manager	27th June 2025 27th June 2025 1st August 2025

				the monthly NWAS T4 Programme Meeting.		
26.	Staff told us they had not received any DoC training to support them in their roles.	The health board must implement DoC training for staff to support them in their roles.	People engagement, feedback and learning	Requirement to attend DoC training notice sent to all staff via email and by poster within staff areas Unit to have 100% compliance for Duty of Candour training Ongoing monitoring of training compliance will be maintained via the monthly NWAS T4 Programme Meeting	Head of Nursing Clinical Services Manager Clinical Services Manager	30th March 2025 25th July 2025 1st August 2025
27.	The bi-weekly supportive staff meetings were not minuted to record the matters discussed and any actions taken as a result.	The health board must ensure staff meetings are minuted to evidence and action matters discussed, to identify themes and drive quality improvement.	People engagement, feedback and learning	Action log for this has been developed and will be reviewed within the weekly management meeting and the Monthly Team Meeting as required	Clinical Service Manager	30th March 2025
28	Several health board policies or procedures	The health board must ensure key policies and procedures are reviewed	Information governance and digital technology	NWAS to prioritise policy updates specific to the service via the	Clinical Service Manager	26th September 2025

were past their review dates.	and updated in a timely manner to ensure staff are supported in their roles.		Clinical Effectiveness Sub-Group. On-going monitoring of NWAS Policies via the Clinical Effectiveness Sub-Group Meeting (monthly).	Clinical Service Manager	26th September 2025

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): Naomi Holder
Job role: Director of Nursing, Central IHC
Date: 06 March 2025