Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report
(Announced)
Clare Road Medical Centre, Cardiff and Vale University Health Board

Inspection date: 21 January 2025
Publication date: 23 April 2025

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

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

In writing:

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

Or via

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

Digital ISBN 978-1-83715-615-3

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 announced inspection of Clare Road Medical Centre, Cardiff and Vale University Health Board on 21 January 2025.

Our team for the inspection comprised of one HIW healthcare inspectors and three clinical peer reviewers.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 11 questionnaires were completed by patients or their carers and 5 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:
Patients felt they were treated with dignity and respect, and within our questionnaire, rated the service as ‘good’ or ‘very good’. We witnessed staff speaking to patients in a polite and respectful manner.

We found the practice emphasised health promotion and wellbeing to patients. A wide range of information was displayed, which including screening services, smoking cessation, vaccinations and carers information.

There was good access into the premises allowing patients with impaired mobility and wheelchair users to easily access the facilities. The practice also used translation services to support their diverse community with specific language needs although the practice was urged to promote bilingual information for Welsh speakers.

Preparations by the practice to manage the annual winter vaccination programme were suitable and included arrangements for vulnerable patients and those without digital access. The cluster worked hard to increase childhood Immunisations, and we were told that the practice worked closely with the local mosques to encourage the uptake of children immunisations for flu.

We were told the practice engaged with several agencies to improve access to various healthcare professionals via their cluster group. These included access to physiotherapy, mental health services and pharmacists, and enables patients to access help and support from other agencies in a timely manner. There were also a number of cluster led projects taking place, including the Grow Cardiff project. However, these additional services were not listed on the practice website.

Appointments were mostly made via telephone, but online booking and in-person appointments could also be made. Appointments comprised of urgent on the day appointments or routine bookable appointments. The practice telephone system has a queue system which tells patients where they are. The GP call log activity for December 2024, suggested a lot of patients are having to wait to get through, The possible delay may be down to a shortage of call handlers within the practice.

This is what we recommend the service can improve:

- practice should include a list of their additional services on the website, so patients are aware what services are available to them

- The practice should ensure that the active offer of Welsh is promoted to patients.
- Access to appointments via telephone needs to be strengthened as the GP call log activity data is poor

This is what the service did well:

- Worked closely with the local mosques to encourage the uptake of children immunisations for flu
- A number of Cluster led projects taking place for example Grow Cardiff

Delivery of Safe and Effective Care

Overall summary:
Overall, we found that the infection prevention and control (IPC) arrangements in place were not acceptable, with some arrangements needing strengthening to ensure the practice always upholds the required standards of IPC to maintain the safety of staff and patients. This was addressed under our immediate assurance process.

The process in place for managing patient safety alerts and significant incidents was robust. The practice manager was responsible for receiving patient safety alerts, and we saw how these were received and disseminated to staff and communicated in meetings. Patient safety alerts were added to a patient safety log which showed the actions and the staff that had seen it.

Processes were in place to ensure the safe prescribing of medication, and the process for patients to request repeat medication was clear. However, we found that the practice did not have an audit trail of when and who collects prescriptions, nor was there a process to ensure all controlled drugs prescriptions are signed for on collection.

Safeguarding policies needed formalisation, and not all staff had completed required training.

Daily temperature checks were taking place for medicines that require refrigeration. We found one fridge was full, which could impede the flow of air to maintain an appropriate temperature, therefore advice must be sought to ensure the correct storage of stock.

We found the continuity of care was good, with close oversight and supervision of patients and patients records by all the GPs. The records seen evidenced good quality patient consultations.

Immediate assurances:

- expired nebuliser masks were found within the emergency bags in the clinical treatment rooms- these had not been removed from use.
- appropriate checks were not undertaken on the emergency drugs and equipment. The records we reviewed showed not all checks were being recorded within the clinical treatment rooms.
- robust procedures were not in place to ensure infection prevention and control (IPC) was being maintained at the practice.
- We did not see evidence that all staff had completed IPC training relevant to their role
- IPC audits had not been undertaken.

This is what we recommend the service can improve:

- a log to ensure there is an audit trail for the collection of prescriptions, as well as a process to ensure all controlled drugs scripts are signed for should be developed
- Safeguarding policies and processes including mandatory training compliance
- Guidance must be sought from the fridge manufacturer to ensure the storage of stock is appropriate and ensures proper cool air flow.

This is what the service did well:

- There was a robust system in place for patient safety alerts
- Good process for the safe prescribing of medication, and the process for patients to request repeat medication was clear
- Good quality records of patient consultations

Quality of Management and Leadership

Overall summary:
There were processes in place to support effective governance, leadership and accountability, to ensure a sustainable delivery of safe and effective care. Staff were clear about their roles, responsibilities and reporting lines and the importance of working within their scope of practice.

The practice had most relevant policies and procedures in place and there were processes in place to share any information updates with staff. There were, however, limited document control systems in place, and some policies had not been implemented to align with the specific needs of the practice.

Despite there being an appropriate skill mix across the teams to deliver the services required, the practice reported there were no substantive nurses in post

at the time of our visit. However, we were told that regular locum nurses are available to deliver the practices' services and clinics.

Some staff were compliant with aspects of mandatory training; however, our review of staff records highlighted several examples of non-compliance.

Staff felt comfortable to speak up regarding any concerns they may have, and a whistleblowing policy was in place to support this. In addition, staff felt comfortable to share any suggestions they might have and could provide these to their manager for consideration.

We found evidence of partnership working with the practice's collaboration within a GP cluster with lots of good projects taking place. One of which is the grow Cardiff programme. Medical staff attended cluster meetings and provided services on a cluster wide basis.

This is what we recommend the service can improve:

- The practice must ensure all staff are compliant with all mandatory training relevant to their role
- Policies and procedures need to be updated so the information is specific to the practice and strengthen governance arrangements to include robust document control and review process, to ensure all policies and procedures are in date, reviewed regularly, are available to staff and relevant to the practice
- Successful recruitment of nursing staff to compliment the practices services and deliver these consistently.

This is what the service did well:

- Staff are supported to raise a concern should the need arise
- evidence of partnership working with the practice's collaboration within a GP cluster with lots of good projects taking place.

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

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued a questionnaire to obtain patient views on the care and services provided at Clare Road Medical Centre prior to the inspection that took place in January 2025. In total, we received 11 responses. Responses were overall positive, all respondents who answered rated the service as 'very good' or 'good.'

Person-centred

Health promotion
During our inspection we saw that the practice had a wide range of written health promotion information available for patients. The information was displayed in the patient waiting areas and promoted through the practice website. We saw health promotion information on a variety of topics including screening services, smoking cessation, vaccinations and carers information.

We were told the practice engaged with several agencies to improve access to various healthcare professionals via their cluster group. These included access to physiotherapy, mental health services and pharmacists, and enables patients to access help and support from other agencies in a timely manner. We were told about the practice's ongoing work with the cluster community connectors, and its support for the project; 'Grow Cardiff', which was due to recommence that winter. The project supports social prescribing to therapeutic community gardens for health and well-being.

There are also Healthy lives community events where blood testing for diabetes Hba1c takes place. The cluster also has two specialist diabetics nurses who work with patients that have a high Hba1c.

Preparations by the practice to manage the annual winter vaccination programme were suitable and included arrangements for vulnerable patients and those without digital access. The cluster worked hard to increase childhood Immunisations, and we were told that the practice worked closely with the local mosques to encourage the uptake of children immunisations for flu. **This was viewed as notable good practice.**

All respondents to our patient questionnaire felt that health promotion information was on display at the practice and they were offered healthy lifestyle advice. All patients agreed that their GP explained things well to them and answered their questions. In addition, they felt listened to and they were involved as much as they wanted to be in decisions about their healthcare.

Dignified and respectful care
We found patients were treated with dignity and respect throughout their GP journey. Clinical rooms provided patients with an appropriate level of privacy, with doors kept closed during consultations. Privacy curtains were also available.

All respondents to the patient questionnaire felt they were treated with dignity and respect, and that measures were taken to protect their privacy.

Reception staff were observed welcoming patients in a professional and friendly manner. To protect confidentiality, some telephone calls were taken in the administration office, away from the reception desk. The reception desk was partitioned by glass, which offered some level of privacy from the waiting area. For those responding to our patient questionnaire, they felt could talk to reception staff without being overheard.

The practice offered chaperones in all appropriate circumstances, and there was a chaperone policy in place. A chaperone information notice was displayed in the waiting areas, however, not all clinical treatment rooms had notices indicating that this service was available.

The practice must ensure that information is available to patients regarding the option of a chaperone in all clinical treatment rooms

Timely

Timely care
There were processes in place to ensure patients could access care and with the most appropriate person in a timely manner.

Appointments were made mostly by telephone, but online booking and in-person appointments could also be made. Appointments comprised of urgent on the day appointments or routine bookable appointments.

We were told that children would be seen face to face on the same day. All the respondents to our patient survey said they were able to get a same-day appointment when they needed to see a GP urgently, and they could get routine appointments when they needed them.

The practice telephone queuing system which tells patients where they are in the queue to speak with receptionists. The GP call log activity for December 2024, suggested many patients were having to wait to get through to reception. In December 2024 2863 calls were received. The number of calls answered within 2 minutes was only 114 calls, with 904 calls abandoned.

The practice should consider how it can improve the numbers of calls answered within two minutes.

We were not provided with an access policy during the inspection, however, staff advised us that a policy should be implemented on how people can access the practice, which would explain the opening times, appointment system and service provided. There is, however, a patient information leaflet available that provides this information to patients.

The practice must ensure that an Access Policy is implemented that is specific to the practice

There were processes in place to support patients in mental health crisis. Where appropriate, patients are referred to the mental health crisis team/ child and adolescent mental health team for urgent crisis support. Alternative support and signposting were also available for patients needing mental health support.

Equitable

Communication and language
We found staff communicating in a clear manner and in a language appropriate to patient needs. They provided information in a way that enabled patients to make informed decisions about their care. The surgery had a hearing loop to support those hard of hearing.

Patients are usually informed about the services offered at the practice through reception staff and the Website. Where patients are known not to have digital access, letters would be sent to individuals, and communication through telephone calls.

The practice serves a diverse community and staff confirmed that language and translation support were used as needed, to support both staff and patients to communicate effectively.

We were told that there were no Welsh speaking patients and no staff who spoke Welsh at the practice. However, as part of the "active offer" for Welsh patients, all practice information and signs should be bilingual. We saw that some posters were available in Welsh, however, the practice information was available in English only.

The practice should ensure that the active offer of Welsh is promoted to patients.

There were appropriate processes in place for the recording and action of information from secondary care. Letters and documents are directed to the correct health care practitioner to action as required and are then sent to be scanned onto patient records. From the records we observed, we saw healthcare staff had provided information to patients in a way that met their individual needs. Although the practice ensured messages were communicated internally, we were told that this was sometimes done via handwritten notes. The practice should consider how task messages are formally recorded, as currently there is no auditable trace of these messages.

The practice should ensure task messages are formally recorded to ensure there is an audit trail of decision making

Rights and equality
The practice offered good access for patients. We noted that patient areas including treatment rooms, and an accessible toilet were all located on the ground floor.

All patients responding to our questionnaire thought the building was easily accessible.

An equality and diversity policy were in place, and staff had completed equality and diversity training. All patients responding to our questionnaire said they had not faced discrimination when accessing or using this health service.

The rights of transgender patients were also upheld, staff confirmed that preferred pronouns and names were used from the outset of transition.

Delivery of Safe and Effective Care

Safe

Risk management
The practice was clean, tidy and free of clutter.

We reviewed the business continuity plan (BCP), which adequately covered the business partnership risk, pandemic risk and appropriately detailed contingencies for long-term sickness absence. The BCP was available to all staff via the practices electronic shared drive to ensure staff had clarity on their responsibilities and contact details in the event of an urgent or emergency impacting the business. The practice also demonstrated cluster collaboration to ensure patient care could continue in the event of an extreme situation.

The process in place for managing patient safety alerts and significant incidents was robust. Patient safety alerts are received and disseminated to staff electronically and communicated in meetings. Patient safety alerts were added to a patient safety log which showed the actions and the staff that had seen it.

We discussed the action taken when patient home visits are requested and found staff triaged and risk assessed all home visits before attending.

Infection, prevention and control (IPC) and decontamination
Overall, the IPC arrangements in place were not acceptable, with some arrangements needing strengthening to ensure the practice always upholds the required standards of IPC to maintain the safety of staff and patients. This was addressed under our immediate assurance process within Appendix B.

The IPC policy was not specific to the practice, but a generic overarching document. We saw there were specific local policies for management of blood borne viruses, cold chain management and sharps management, however, we recommended a local IPC policy is implemented and should include a named IPC lead.

The practice must implement an IPC policy specific to the practice and ensure a named IPC lead is included.

A blood borne virus policy was in place however, the wording infers that clinical practitioners can choose not to be vaccinated for Hepatitis B, rather than stating that practitioners should be vaccinated against Hepatitis B if they are undertaking exposure prone procedures. This policy needs to be reviewed to provide the

correct guidance. However, a record was in place to evidence that clinical staff had received their Hepatitis B vaccinations and immunity response.

The practice must update the blood borne virus policy, ensuring it is reflective of current guidance in relation to Hepatitis B.

A needlestick injury policy was in place however, we found that needlestick injury advice posters were not on display in the clinical treatment rooms, to support staff in the event of such injury.

The practice must ensure that needlestick injury posters are displayed in the clinical treatment rooms

Suitable procedures were in place for the management and disposal of all waste, and a policy was in place to support this. We noted that the waste was secure, with no public access. However, on the day of our inspection we found that sharps bins were not being labelled. This was also identified during audits on four occasions over a nine-month period.

The practice must ensure that sharps bins are appropriately labelled at all times.

The practice had a suitable COSHH policy in place, but we found there were no data sheets for the items within the practice.

The practice must ensure that data sheets are completed for COSHH items in the practice

Suitable arrangements were in place to segregate people with transmissible infections to reduce the risk of cross infection. All patients responding to the questionnaire agreed there were signs at the entrance explaining what to do if they had a contagious infection, with one respondent stating they were not sure.

We recommended that a thorough IPC audit is implemented to monitor the environment against recognised standards. This would help ensure that areas for improvement are identified promptly. For example, minimising the use of paper notices attached to walls, and lamination of notices as appropriate; identifying unsuitable sink splash backs and handwash facilities; and the stippled non-smooth wall surfaces that are not easily wipeable. We also noted that the toilets within the practice did not have any female hygiene bins. The lack of IPC audits was addressed under our immediate assurance process at Appendix B.

We noted carpet was used throughout the upstairs of the practice. Although this area was not used clinically, we recommended that regular carpet cleaning is

undertaken by the cleaning contractor and added to the cleaning schedules. We also found one privacy curtain that was visibly dirty, and we recommended that this was changed.

The practice must:

- **update the cleaning schedule to include regular carpet cleaning to minimize the risk of cross infection**
- **ensure privacy curtains are regularly checked for soiling and are replaced within a 6-month timeframe or sooner as appropriate.**

There was no record maintained to identify any staff who had completed IPC training, or when refresher training was needed. This was addressed under our immediate assurance process.

The patients responding to the questionnaire felt there were hand sanitizers available, and those that answered the question said that healthcare staff washed their hands before and after being treated. We saw evidence that handwashing audits had taken place.

The patients who indicated they had received an invasive procedure at the practice, said that staff used PPE during the procedure. The patients said the equipment used was individually packaged or sanitised and that antibacterial wipes were used to clean the skin prior to a procedure.

Medicines management

Processes were in place to ensure the safe prescribing of medication. The process for patients to request repeat medication was clear.

We saw that prescription pads were securely stored in a locked cupboard. We were told there was a process in place to securely dispose of prescription pads when a GP leaves the practice.

We found that the practice did not have an audit trail of when and who collects prescriptions, nor was there a process to ensure all controlled drugs prescriptions are signed for on collection.

The practice must implement a record to maintain an audit trail for the collection of prescriptions, and that all controlled drugs prescriptions are signed for when collected.

Staff were trained in managing repeat prescribing, and the GP's authorise these or ongoing any actions. The GP's also complete annual medication reviews, with the cluster pharmacy conducting asthma and direct oral anticoagulant reviews. The

practice has a comprehensive prescribing policy in place, which included repeat prescribing.

The staff training records we reviewed showed that they had not undertaken any medicine management training.

The practice must ensure staff undertake medicine management training and a record should be kept to evidence this.

A medication cold chain policy was in place for medicines and vaccines that require refrigeration, and clinical refrigerators were used to store them as appropriate. Daily fridge temperature checks were completed and recorded. We also found that a cold chain disruption flow chart was on the front of the fridges.

We found one refrigerator was full, with stock being kept on the fridge base. This could impede the flow of air and the maintenance of appropriate temperatures. We recommended the practice contact the fridge manufacturer to obtain guidance on the correct storage of stock to maintain adequate circulation of cool air. We also found that the lock on the refrigerator was difficult to open.

The practice must:

- **contact the fridge manufacturer to obtain guidance to ensure the storage of stock is appropriate and ensure appropriate cool airflow**
- **ensure the lock on the refrigerator is fully operational**

Emergency drugs were appropriately stored on the emergency trolley, and staff could locate them during an emergency. However, emergency equipment was not kept with the drugs on the same trolley. It is important to store emergency drugs and equipment together so staff can quickly access them in an emergency.

Emergency drugs were also found in each clinical treatment room. The locum practice nurse was unaware of this and had not been checking them according to the Resuscitation Council UK's Quality Standards: Primary Care Equipment and Drug List. This issue was addressed through our immediate assurance process, as noted in Appendix B. Additionally, expired nebuliser masks were discovered in the emergency bags within the treatment rooms, posing a potential risk to patient safety. This was also addressed through our immediate assurance process, as detailed in Appendix B.

The locum nurse was unaware that portable oxygen cylinders were being stored in the treatment rooms, with one cylinder found empty and another half full, indicating they were not being checked as per the Resuscitation Council UK's Standards.

The practice must ensure the portable oxygen cylinders are regularly checked according to the standards.

Whilst notices were attached to the doors of where oxygen cylinders were stored, however, there was no fire safety plan that easily identified where the oxygen was stored.

The practice should ensure the storage location of oxygen cylinders is clearly identified on the fire safety plan.

We also found that staff had not completed appropriate training for Portable Oxygen Cylinder

The practice must ensure a process is in place to check all staff working at the practice they are suitably trained to operate oxygen cylinders. A record should be kept to evidence this. This should include locum staff.

All staff had undertaken appropriate basic life support training.

There was no ambient temperature monitoring for the emergency drugs and other medications stored in the practice. It is important to check and record ambient room temperatures where these medications are stored to ensure their safety and efficacy.

No controlled drugs are kept at the practice.

Safeguarding of children and adults
We considered the safeguarding arrangement in place at the practice which included a policy for both adults and children. The practice had a named safeguarding lead which was recorded in the policy. However, the policy had not been reviewed since 2016, and we found it to be limited in its content, for example it did not include the current training requirement for staff. The policy must be reviewed to ensure itis robust and aligns to the Wales Safeguarding procedures.

The practice must ensure Safeguarding policies and procedures are robust and align to the Wales Safeguarding Procedures

On review of patient records, we saw examples where people were appropriately flagged with any safeguarding concerns and followed a suitable safeguarding pathway. This included care experienced children.

During the inspection we did not see evidence that all staff had completed safeguarding training at the required level.

The practice must ensure all staff undertake the required level of safeguarding training (both children and adult) appropriate to their role, and a record should be kept to evidence this

Management of medical devices and equipment

The practice had processes in place to safely maintain equipment. We found all equipment was in a good condition, well maintained with appropriate electrical checks had been carried out. There were contracts in place for maintenance and calibration of equipment as appropriate, and for any emergency repairs and replacement.

Effective

Effective care

Processes were in place to support safe and effective care, and this included the process for receiving treatment or care across the GP cluster and wider primary care services. We found examples of acute and chronic illness management, and clear narrative with evidence of patient centred decision making.

There was an appropriate system in place for reporting incidents, and any shared learning was completed within team meetings.

We were told that any changes or new guidance is shared with staff via email and discussed with staff as appropriate, and the information is stored on the shared drive for all staff to access.

Patient referrals were managed to a good standard, including those which are urgent. Patient records contained investigation/ test results and had narrative as to why investigations were requested.

Patient records

We reviewed ten electronic patient records, which were stored securely and were password protected from unauthorised access. Overall, the records were clear, written to a good standard and complete with appropriate information. They were contemporaneous and information was easy to understand for other clinicians reviewing the records. However, we found omissions in recording consent for intimate exams and the offer of a chaperone was not documented.

The practice should ensure:

- **Consent is documented in the patient records; and**
- **The offer of a chaperone is documented in the patient records**

We found there was a good and consistent use of clinical read codes, which makes analysis and audit easier. The patient records where chronic disease was recorded contained a full summary of conditions, including all past and continuing problems, as well as the prescribed medication.

We found the continuity of care was overall good, with close oversight and supervision of patients and patients records by all the GPs. The records seen evidenced good quality patient consultations.

Efficient

Efficient
We found that services were arranged in an efficient manner and are person centred, to ensure people feel empowered in their healthcare journey.

The practice can refer to physiotherapy and mental health services, including counselling via the cluster group.

There are good processes in place, active collaboration with the cluster and lots of good projects taking place.

Quality of Management and Leadership

We engaged with staff throughout our inspection and sought feedback through a staff questionnaire.

Leadership

Governance and leadership
There were processes in place to support effective governance, leadership and accountability. Staff were clear about their roles, responsibilities and reporting lines, and the importance of working within their scope of practice.

Leaders confirmed that there was an open-door policy for staff to share concerns and ideas for the practice.

We were told staff meetings were routine and these were formally recorded. The meeting minutes we reviewed did not however, include a record of actions, where applicable, to enable action owners to understand what was required of them.

The practice should consider including an action log on meeting minutes to effectively allocate and monitor actions appropriately.

We reviewed a comprehensive suite of policies and procedures, with only two not being in place (Access Policy and Duty of Candour Policy). There were, however, limited document control systems in place, and some policies had not been implemented to align with the specific needs of the practice.

The practice must strengthen governance arrangements to include robust document control and review process, to ensure all policies and procedures are in date, reviewed regularly, are available to staff and relevant to the practice.

Workforce

Skilled and enabled workforce
We were provided with evidence that most staff had completed mandatory training and were told that plans were in place for staff to renew their training where applicable. However, there was no process in place to easily monitor staff compliance with mandatory training. Implementing a training matrix for all staff roles would clearly identify training compliance and those due to complete update training. As a result, it was not possible to confirm staff training compliance for

Infection, Prevention and Control. This was addressed under our immediate assurance process at Appendix B.

The practice must ensure staff are supported to attend mandatory training and should implement a system to record all staffs mandatory training compliance.

We found evidence that annual appraisals for most staff had been completed, and any additional training needs were identified to support professional development.

There were appropriate recruitment policies and procedures in place, and the practice manager described the required pre-employment checks for any new members of staff before they joined the practice. This included checking of references and undertaking Disclosure and Barring Service (DBS) checks appropriate to their role.

The practice reported there were no substantive nurses in post. The practice uses regular locum nurses who are available to deliver the practices' services and clinics. However, a workforce plan needs to be considered for continuity of care and familiarisation with the environment, policies and procedures. In particular, one regular locum nurse is soon due to retire.

The practice should develop a workforce plan and consider recruitment of substantive practice nurses. Reliance on locum nurses is a risk, and the current locum in place was imminently due to retire.

Culture

People engagement, feedback and learning
The practice sought patient feedback. Information was displayed detailing how people could feedback on their experiences and a suggestions box was available in the patient waiting area. However, there was no evidence to demonstrate that patient feedback is routinely used by the practice to learn and inform service improvement.

The practice must ensure that any patient experience feedback is used to help inform service improvement and enhance the patient experience.

A complaints policy was in place; however, it is not currently aligned to the NHS Wales Putting Things Right process. The Patient Complaints leaflet also did not have details of Llais, the Ombudsman and advocacy service, neither was it available on the practice website. The practice manager was responsible for managing all complaints and this was clear within the complaints policy and

procedure documents. Complaints/concerns are monitored to identify any themes and trends, and any actions for improvement are communicated to staff.

The practice should update:

- **The Complaints Policy, so it aligns with the NHS Patient Wales Putting Things Right process**
- **The Complaints leaflet to incorporate details of Llais, the Ombudsman and advocacy service, as well as being available on the practice website.**

Staff felt comfortable to speak up regarding any concerns they may have, and a whistleblowing policy was in place to support this. In addition, staff felt comfortable to share any suggestions they might have and could provide these to their manager for consideration.

We spoke to senior staff about the arrangements in place regarding compliance with the Duty of Candour. From the training records we reviewed, we saw evidence that staff had completed training on this topic, however a Duty of Candour policy was not in place. The members of staff who completed a questionnaire agreed that they knew and understood their role in line with Duty of Candour.

The practice must implement a Duty of Candour policy.

Information

Information governance and digital technology

The practice understood its responsibility when processing information and demonstrated that data is managed in a safe and secure way. A current information governance policy was in place to support this, and we saw evidence that all staff had completed training on this topic.

The practice's process for handling patient data was available for review on the website.

Learning, improvement and research

Quality improvement activities

There was evidence of some clinical and internal audit in place to monitor quality. We were told learning was shared across the practice to make improvements.

Whole-systems approach

Partnership working and development

We found evidence of partnership working with the practice's collaboration within a GP cluster with lots of good projects taking place. Medical staff attended cluster meetings and provided services on a cluster wide basis.

We were told about the practice's ongoing work with the cluster community connectors, and its support for the project; 'Grow Cardiff', which was due to recommence that winter. The project supports social prescribing to therapeutic community gardens for health and well-being.

The practice is also involved in the Deep End Wales project, which includes participation from 100 practices across Wales, which have the highest proportion of patients living in the most deprived areas. 'Deep End' describes the additional needs for populations living in the most deprived areas with the concomitant increase in workload and complexity for GP practices that support these communities.

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
No immediate concerns were resolved during this inspection			

Appendix B – Immediate improvement plan

Service: Clare Road Medical Centre

Date of inspection: 21 January 2025

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Findings

During the inspection HIW found expired nebuliser masks within the emergency bags in the clinical treatment rooms- these had not been removed from use. If emergency equipment is out-of-date, it may pose a risk to patient safety.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	The practice must: • Ensure all expired items are removed from emergency equipment and disposed of in an appropriate manner • Develop, implement and maintain a robust system for the management of single use items	Health and Care Quality Standards – Safe (Devices)	All Expired Items have been removed from the Emergency Equipment in the Clinical Rooms & have been disposed of appropriately. All Emergency Equipment will be checked on a Weekly Basis, A Log sheet will be kept recording Expiry Dates & date of Check & any expired equipment to be removed & replaced immediately	Practice Manager & Senior Receptionist	Immediate & going forward Checks will be carried out Weekly

Findings

HIW is not assured that appropriate checks are undertaken on the emergency drugs and equipment. The records we reviewed showed not all checks were being recorded within the clinical treatment rooms. Checks should be carried out weekly, in line with the Resuscitation Council UK; Quality Standards: Primary care equipment and drug list.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
2.	The practice must ensure all emergency drugs and equipment are checked and recorded on a weekly basis.	Health & Care Quality Standards (2023) – Safe; Timely; Information	Emergency Drugs & Equipment Are being checked weekly for the Resuscitation Trolley by Practice Nurse. Emergency Drugs & Equipment in the Clinical Rooms will now be checked weekly. A Log will be held to record Date checked & Expiry Dates	Practice Manager Practice Nurse Senior Receptionist	1st February 2025

Findings

HIW is not assured that robust procedures are in place to ensure infection prevention and control (IPC) is being maintained at the practice.

We did not see evidence that all staff had completed IPC training relevant to their role, neither had IPC audits been undertaken.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
3.	The practice must: • Ensure all staff complete the level of IPC training appropriate to their role. Records of training should be maintained to evidence staff compliance • Arrange for an IPC audit to be completed as soon as possible • Develop, implement and maintain a regular IPC audit programme	Health & Care Quality Standards (2023)	All Appropriate staff will be asked to carry out IPC Training appropriate to their role. Records of Training will be held & Maintained in the Training Record Folder in the Practice Manager Office. IPC Audit request has been requested 22/1/25 to the Local Health Board Awaiting a response After the IPC Audit we will Develop implement & maintain regular IPC Audit Programme.	Practice Manager Practice Manager Practice Manager Practice Manager	1st March 2025 1st March 2025 Awaiting a response from LHB

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): Ann-Marie O'Hanlon

Job role: Practice Manager

Date: 28/01/2025

Appendix C - Improvement plan

Service: Clare Road Medical Centre

Date of inspection: 21 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.	A chaperone information notice was displayed in the waiting areas, however, not all clinical treatment rooms had notices indicating that this service was available.	**The practice must ensure that information is available to patients regarding the option of a chaperone in all clinical treatment rooms**	Health & Care Quality Standards - Information	**Laminated Chaperone Notices has been placed in all clinical & Waiting Room Areas**	Practice Manager	Completed
2.	The GP call log activity for December 2024, suggested many patients were having to wait to get through to reception. In December 2024, 2863 calls were received. The number of calls answered within 2	**The practice should consider how it can improve the numbers of calls answered within two minutes.**	Health & Care Quality Standards - Timely	Currently looking for Extra Administration Staff. We have a New Starter on 17/3/2025 for 20hrs & looking for another 1 admin staff member.	Practice Manager	3 Months

	minutes was only 114 calls, with 904 calls abandoned.					
3.	We were not provided with an access policy during the inspection	**The practice must ensure that an Access Policy is implemented that is specific to the practice**	Health & Care Quality Standards – Information	We have an Access Policy dated 2024/25 Which is practice specific	Practice Manager	Completed
4.	As part of the "active offer" for Welsh patients, all practice information and signs should be bilingual. We saw that some posters were available in Welsh, however, the practice information was available in English only.	**The practice should ensure that the active offer of Welsh is promoted to patients.**	Health & Care Quality Standards – Information	All Practice Information Signs are currently being printed Bilingual into Welsh	Practice Manager	April 2025
5.	Although the practice ensured messages were communicated internally, we were told that this was sometimes done via handwritten notes.	**The practice should ensure task messages are formally recorded to ensure there is an audit trail of decision making**	Health & Care Quality Standards – Information	Email we have implemented a Read receipt procedure on all internal Emails & we also use our Daily Task Book which gives	Practice Manager	April 2025

	The practice should consider how task messages are formally recorded, as currently there is no auditable trace of these messages.			us an Audit trail on our vision system.		
6.	The IPC policy was not specific to the practice, but a generic overarching document.	**The practice must implement an IPC policy specific to the practice and ensure a named IPC lead is included**	Health & Care Quality Standards – Information	We have Implemented & completed a Practice IPC Policy & named IPC lead is included	Practice Manager	Completed
7.	A blood borne virus policy was in place however, the wording infers that clinical practitioners can choose not to be vaccinated for Hepatitis B, rather than stating that practitioners should be vaccinated against Hepatitis B if they are undertaking exposure prone procedures.	**The practice must update the blood borne virus policy, ensuring it is reflective of current guidance in relation to Hepatitis B.**	Health & Care Quality Standards – Information	Our Blood Borne Virus policy has been updated & is awaiting final approval	Practice Manager	April 2025

	This policy needs to be reviewed to provide the correct guidance.					
8.	A needlestick injury policy was in place however, we found that needlestick injury advice posters were not on display in the clinical treatment rooms, to support staff in the event of such injury.	**The practice must ensure that needlestick injury posters are displayed in the clinical treatment rooms**	Health & Care Quality Standards – Information	Needlestick Injury Advice Posters has now been placed in all Clinical Rooms	Practice Manager	Completed
9.	On the day of our inspection we found that sharps bins were not being labelled.	**The practice must ensure that sharps bins are appropriately labelled at all times.**	Health & Care Quality Standards – Information	We have now made sure that Sharp Bins are now being checked on a weekly basis & also monthly as part of our IPC Monthly Audit	Practice Manager & Senior Receptionist	Completed
10.	The practice had a suitable COSHH policy in place, but we found there were no data sheets for the items within the practice.	**The practice must ensure that data sheets are completed for COSHH items in the practice**	Health & Care Quality Standards – Information	We now have data sheets for Oxygen & Bleach & these are held in all areas where Oxygen & Bleach are held.	Practice Manager	Completed

11.	We noted carpet was used throughout the upstairs of the practice. Although this area was not used clinically, we recommended that regular carpet cleaning is undertaken by the cleaning contractor and added to the cleaning schedules. We also found one privacy curtain that was visibly dirty, and we recommended that this was changed.	**The practice must:** • **update the cleaning schedule to include regular carpet cleaning to minimize the risk of cross infection** • **ensure privacy curtains are regularly checked for soiling and are replaced within a 6-month timeframe or sooner as appropriate.**	Health & Care Quality Standards – Safe	We have incorporated a sheet to record the Carpet Cleaning. Privacy Curtain was changed immediately after visit & we have put in place a Curtain check recording sheet for weekly checks	Practice Manager	Completed Completed
12.	We found that the practice did not have an audit trail of when and who collects prescriptions, nor was there a process to ensure all controlled drugs prescriptions	**The practice must implement a record to maintain an audit trail for the collection of prescriptions, and that all controlled drugs prescriptions are signed for when collected.**	Health & Care Quality Standards – Information	Controlled Drug Book are on Order & Signing Receipt process will be put in place	Practice Manager	April 2025

	are signed for on collection					
13.	The staff training records we reviewed showed that they had not undertaken any medicine management training.	**The practice must ensure staff undertake medicine management training and a record should be kept to evidence this.**	Health & Care Quality Standards – Information; workforce	All relevant staff have been asked to complete Medicine management Training once completed a training record will be kept for evidence	Practice Manager	April 2025
14.	We found one refrigerator was full, with stock being kept on the fridge base. This could impede the flow of air and the maintenance of appropriate temperatures. We recommended the practice contact the fridge manufacturer to obtain guidance on the correct storage of stock to maintain adequate circulation of cool air. We also found that the lock on	**The practice must:** • **contact the fridge manufacturer to obtain guidance to ensure the storage of stock is appropriate and ensure appropriate cool airflow** • **ensure the lock on the refrigerator is fully operational**	Health & Care Quality Standards – Information; Safe	WE have a large LEC Fridge Upstairs in our Meeting Room. This will be used to accommodate an appropriate Airflow between 2 fridges, Temperature & Calibration is up to date on both fridges, so they are fully operational. Locks on both fridges are working.	Practice Manager	Completed

	the refrigerator was difficult to open.					
15.	The locum nurse was unaware that portable oxygen cylinders were being stored in the treatment rooms, with one cylinder found empty and another half full, indicating they were not being checked as per the Resuscitation Council UK's Standards.	**The practice must ensure the portable oxygen cylinders are regularly checked according to the standards.**	Health & Care Quality Standards – Safe	Log Sheet put in place for all Oxygen Cylinders to be checked weekly	Practice Manager	Completed
16.	Whilst notices were attached to the doors of where oxygen cylinders were stored, however, there was no fire safety plan that easily identified where the oxygen was stored.	**The practice should ensure the storage location of oxygen cylinders is clearly identified on the fire safety plan.**	Health & Care Quality Standards – Information; Safe	A Laminated Oxygen Cylinder Map has been put in place at both Surgery Entrance Doors for Fire Safety	Practice Manager	Completed

17.	We found that staff had not completed appropriate training for Portable Oxygen Cylinder	**The practice must ensure a process is in place to check all staff working at the practice they are suitably trained to operate oxygen cylinders. A record should be kept to evidence this. This should include locum staff.**	Health & Care Quality Standards – Information; Workforce	Training will be arranged for all practice staff that operate Oxygen cylinders. Record of training will be held as evidence	Practice Manager	April 2025
18.	The practice had a named safeguarding lead which was recorded in the policy. However, the policy had not been reviewed since 2016, and we found it to be limited in its content, for example it did not include the current training requirement for staff. The policy must be reviewed to ensure itis robust and	**The practice must ensure Safeguarding policies and procedures are robust and align to the Wales Safeguarding Procedures**	Health & Care Quality Standards – Information	Policy review completed awaiting final approval	Practice Manager & Partners	April 2025

	aligns to the Wales Safeguarding procedures.					
19.	During the inspection we did not see evidence that all staff had completed safeguarding training at the required level.	**The practice must ensure all staff undertake the required level of safeguarding training (both children and adult) appropriate to their role, and a record should be kept to evidence this**	Health & Care Quality Standards – Information; Workforce	All staff have been given a list of all their Mandatory training to be completed which includes Safeguarding training	Practice Manager	Given 3 months to complete
20.	We found omissions in recording consent for intimate exams and the offer of a chaperone was not documented in the patient records	**The practice should ensure:** • **Consent is documented in the patient records; and** • **The offer of a chaperone is documented in the patient records**	Health & Care Quality Standards – Information	All Clinical staff will record consent into patient's computer records.	All Clinical Staff	Completed
21.	We were told staff meetings were routine and these were formally recorded. The meeting minutes we reviewed did not	**The practice should consider including an action log on meeting minutes to effectively allocate and monitor actions appropriately.**	Health & Care Quality Standards – Information	Action log for all Practice Meeting will be put in place for all ongoing Practice Meetings	Practice Manager	April 2025

	however, include a record of actions, where applicable, to enable action owners to understand what was required of them.					
22.	We reviewed a comprehensive suite of policies and procedures, with only two not being in place (Access Policy and Duty of Candour Policy). There were, however, limited document control systems in place, and some policies had not been implemented to align with the specific needs of the practice.	**The practice must strengthen governance arrangements to include robust document control and review process, to ensure all policies and procedures are in date, reviewed regularly, are available to staff and relevant to the practice**	Health & Care Quality Standards – Information	All completed awaiting final approval	Practice Manager & Partners	April 2025
23.	We were provided with evidence that most staff had completed mandatory training and were told that plans were in	**The practice must ensure staff are supported to attend mandatory training and should implement a system to record all staffs**	Health & Care Quality Standards – Information; Workforce	All staff have been given a list of their Mandatory Training & an Excel Log Sheet is updated & held on Practice Managers	Practice Manager	Completed

	place for staff to renew their training where applicable. However, there was no process in place to easily monitor staff compliance with mandatory training.	**mandatory training compliance.**		Desktop & In paper Record File in P/M Room. All staff are given protected time to carry out training		
24.	The practice reported there were no substantive nurses in post. The practice uses regular locum nurses who are available to deliver the practices' services and clinics.	**The practice should develop a workforce plan and consider recruitment of substantive practice nurses. Reliance on locum nurses is a risk, and the current locum in place was imminently due to retire.**	Health & Care Quality Standards – Information; Safe	We are currently working on a substantive recruitment process for a Practice Nurse	Practice Manager & Business Manager	May 2025
25.	There was no evidence to demonstrate that patient feedback is routinely used by the practice to learn and inform service improvement.	**The practice must ensure that any patient experience feedback is used to help inform service improvement and enhance the patient experience.**	Health & Care Quality Standards – Information; Learning, Improvement and Research	We currently have a Suggestion Box in Reception & all suggestions are discussed & Improvements is carried out. We will keep an Evidence Log going forward	Practice Manager	April 2025

26.	A complaints policy was in place; however, it is not currently aligned to the NHS Wales Putting Things Right process. The Patient Complaints leaflet also did not have details of Llais, the Ombudsman and advocacy service, neither was it available on the practice website.	**The practice should update:** • **The Complaints Policy, so it aligns with the NHS Patient Wales Putting Things Right process** • **The Complaints leaflet to incorporate details of Llais, the Ombudsman and advocacy service, as well as being available on the practice website.**	Health & Care Quality Standards – Information	Our Patient Information Leaflet has now been updated to include details of Llais, Ombudsman & Advocacy Service & has been put on our Practice Website	Practice Manager & Senior Administrator	completed
27.	A Duty of Candour policy was not in place.	**The practice must implement a Duty of Candour policy.**	Health & Care Quality Standards – Information	All completed awaiting final approval	Practice Manager & Partners	April 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): Ann-Marie O'Hanlon

Job role: Practice Manager

Date: 14/03/2025