Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Tonyfelin Medical Centre practice, Aneurin Bevan 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 announced inspection of Tonyfelin Medical Centre, Aneurin Bevan University Health Board on 11 February 2025.

Our team for the inspection comprised of a HIW healthcare inspector 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 24 questionnaires were completed by patients or their carers and seven 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:
The findings in our patient questionnaire were mostly positive across all areas, with accessing the GP and booking appointments gaining the most negative responses. All but one of the respondents rated the service as ‘very good’ or ‘good’. We witnessed staff speaking to patients in a polite and respectful manner.

Appointments were made mostly by telephone, but some appointments could also be made online and in-person. Appointments comprised of urgent on the day appointments, or routine bookable appointments. We were told that the practice offered bookable appointments two weeks in advance. Appointments could be face to face or over the telephone, however, we were told that all patients under 16-years-old would be seen face to face. While most patients could get timely appointments, some expressed dissatisfaction with appointment access.

The practice had a 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 as well as a healthy lifestyle board in the waiting area.

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

There are no Welsh speaking staff within the practice, however as part of the “active offer” for Welsh patients, all practice information and signs should be bilingual.

This is what we recommend the service can improve:

- Ensure that information is available to patients regarding the option of a chaperone in all clinical treatment rooms, and that the offering, acceptance and rejection of a chaperone should be recorded in the patients record
- Ensure that the active offer of Welsh is promoted to patients.

This is what the service did well:

- Good evidence of health promotion literature being available for patients
- Appropriate processes in place for the recording and action of information from secondary care

- Evidence of an equality and diversity policy in place, and staff had completed equality and diversity training.

Delivery of Safe and Effective Care

Overall summary:
The practice was clean and tidy and free of clutter. There were also processes in place to help protect the health, safety and wellbeing of all who used the practice services.

However, the IPC arrangements in place needed strengthening to ensure the practice always upholds the required standards of IPC to maintain the safety of staff and patients. This was addressed through our immediate assurance process.

The patient records we reviewed were clear, written to a good standard and completed with appropriate information. Record entries were contemporaneous and were easy to understand by other clinicians. Although the use of read codes were mostly used well and were appropriate for a patient's clinical condition, we found some inconsistencies in the way that different clinicians recorded patients' problems/ presentation. For example, when different read codes are used for the same presenting problem, continuity and follow up can become an issue, when seeing the same patient again. We also found that 'safety netting' needed to be strengthened to ensure patients are provided with clear instructions and guidance on what to do if their condition, worsens, changes or if they had any further concerns, ensuring timely follow up and re-assessment.

The practice has implemented a palliative care board which identified patients who may be approaching end of life, allowing GP's and healthcare staff to provide proactive and personalised palliative and end of life care planning. They also have a death register board.

We considered the safeguarding arrangements in place at the practice which included a policy for both adults and children. The practice had a named safeguarding lead for adults and children. Staff had access to practice safeguarding policies and procedures, which were ratified, up to date and included contact details of designated leads within the practice.

On review of patient records, we saw examples where people were appropriately flagged subject to any safeguarding concerns and followed a suitable safeguarding pathway. However, it was not easy for all relevant staff to identify children subject to the child protection register.

There were appropriate resuscitation equipment and emergency drugs in place to manage a patient emergency, such as cardiac arrest. We saw evidence that the

checking of the drugs and emergency equipment was being recorded appropriately and this was completed daily. The primary care equipment standards outlined by the Resuscitation Council UK guidance currently states that these checks should be done weekly. However, we found that the emergency drugs were not stored in tamper-evident containers. All resuscitation drugs must be stored in tamper-evident container and be easily accessible in the event of a patient emergency, in line with the Resuscitation Council UK.

Immediate assurances:
We identified several areas which needed to be address through our immediate assurance process, where we wrote to the practice within two working days of our inspection requesting an immediate improvement plan. The issues included:

- the accessible toilet within the practice did not have an emergency pull cord fitted
- The building was in need of repair, we found areas of potential dry rot on skirtings, plaster flaking away on walls, and sink splashbacks were absent in some consultation/ treatment rooms, therefore, potentially harbouring microorganisms.
- None of the consultation rooms had privacy curtains, and we were told that a portable rail would be used when necessary, however the curtain was not disposable, and the rail showed signs of rust.
- These issues were not identified in the practice IPC audit we reviewed. Therefore, attention is needed with the overall IPC audit process, including the environment, to minimise the risk of infection transmission/ cross contamination.

The practice submitted an immediate improvement plan to us which we reviewed and accepted. Details of the immediate improvements are highlighted in Appendix B.

This is what we recommend the service can improve:

- ‘Safety netting’ needed to be strengthened to ensure patients are provided with clear instructions and guidance on what to do if their condition, worsens, changes or if they had any further concerns, ensuring timely follow up and re-assessment
- Ensure that staff are able to identify children subject to the child protection register within patient records
- Ensure the Hepatitis B policy specifies that clinical staff undertaking exposure prone procedures should have the vaccination and it should reference the relevant national guidance
- The practice must ensure that all significant events are recorded

This is what the service did well:

- Patient records we reviewed were clear, written to a good standard and completed with appropriate information
- Appropriate processes in place for the recording and action of information from secondary care
- A palliative care board which identified patients who may be approaching end of life, allowing GP's and healthcare staff to provide proactive and personalised palliative and end of life care planning
- Patient referrals were managed to a good standard, including those which are urgent.

Quality of Management and Leadership

Overall summary:
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.

Most staff we spoke with felt supported and able to approach leaders with any concerns and felt these would be addressed appropriately. Leaders confirmed that an open-door policy was in place to enable staff to share concerns and ideas for the practice.

We reviewed a comprehensive suite of policies and procedures, although one key policy was not in place (Medicine Management Policy). There was also a limited document control process in place, and some policies had not been implemented to align with the specific needs of the practice.

The practice sought patient feedback via their website. However, there was no information displayed in the waiting area detailing how people could feedback on their experiences. We also found no evidence to demonstrate that patient feedback is routinely used by the practice to learn and inform service improvement.

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

This is what we recommend the service can improve:

- There were limited document control systems in place, and some policies had not been implemented to align with the specific needs of the practice

- Ensure that information is displayed in the waiting area detailing how people could feedback on their experiences, and to ensure that patient feedback is routinely used by the practice to learn and inform service improvement.

This is what the service did well:

- 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.

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 at Tonyfelin Medical Centre, prior to the inspection undertaken in February 2025. In total, we received 24 responses. Responses were mostly positive across all areas, with accessing the GP and booking appointments gaining the most negative responses. All but one of the respondents rated the service as 'very good' or 'good'.

Some of the comments included the following:

> *"Very good service."*

> *"All GPs are really welcoming and make me feel comfortable and heard during appointments. The only negative I would say is the booking system, I feel as though it's quite hard to get an appointment without it being weeks in advance. Although apart from that, it is a clean environment, reception staff are helpful and as mentioned already all GPs and staff are really helpful and welcoming."*

> *"Every time I visit GP which is not very often, I have excellent service. From reception staff to GPs very friendly and professional and GP listens to your problem and if possible give options of your treatment."*

> *"The only major Issue is the lack of privacy when discussing personal details to reception in earshot of everyone in the waiting room. You can leave there knowing a complete strangers name, date of birth, address and phone number."*

> *"I think GP has deteriorated from the brilliant system it used to be, it is no reflection on the doctor or staff, I'm incredibly impressed with the care and service they provide a still with a smile very unfortunately if something isn't done in my view it will implode so please help get it sorted."*

Person-centred

Health promotion
During our inspection we saw that the practice had 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 as well as a healthy lifestyle board in the waiting area. **We suggested that the practice could consider applying something similar to other boards in the waiting area.**

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 (for complex cases) and mental health services which enables patients to access help and support from other agencies in a timely manner.

Preparations by the practice to manage the annual winter vaccination programme were suitable and included arrangements for vulnerable patients and those without digital access.

All respondents to our patient questionnaire felt that health promotion information was on display at the practice, and all but one respondent felt they were offered healthy lifestyle advice. All patients agreed that their GP explained things well to them and answered their questions. In addition, all but one respondent felt they were 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 some level of privacy, with doors kept closed during consultations. However, none of the consultation rooms had privacy curtains, and we were told that a portable rail would be used when necessary, however, the curtain was not disposable and the rail showed signs of rust. **This was addressed under our immediate assurance process at Appendix B.**

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. The reception desk was partitioned by glass, which offered some level of privacy from the waiting area.

The practice offered chaperones in all appropriate circumstances, and there was a chaperone policy in place. The policy states that the practice should document when a chaperone is offered and who is present and if a chaperone was offered and declined however, we did not see evidence of this being recorded. A

chaperone information notice was displayed in the waiting area, however, not all clinical treatment rooms had notices indicating that this service was available.

The practice must ensure that:

- **The offering, acceptance and rejection of a chaperone should be recorded in the patients record, as well as who was present or the reasons why the patient has declined**
- **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 some appointments could also be made online and in-person. Appointments comprised of urgent on the day appointments, or routine bookable appointments. We were told that the practice offered bookable appointments 2 weeks in advance. Appointments could be face to face or over the telephone, however, we were told that all patients under 16-years-old would automatically be triaged to have face to face appointments, **which we viewed as good practice.**

Many of 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 said they could get routine appointments when they needed them. Over half of the respondents also said they were offered the option to choose the type of appointment they preferred.

Some patients commented on access to appointments, which included:

> ***"On the very rare occasion that you can actually get through to the surgery on the phone you just get told no you cannot see a doctor. Even when NHS website and the correct channels advice you need to see a doctor you get told no. I have been down in person and been the very first one in to get an appointment and just told no I cannot see a doctor. There is a duty of care that this surgery is not providing."***

> ***"Sometimes telephone appointment suits me better when I'm working."***

"Is difficult to book an appointment."

"Can't always get a routine appointment to suit when my daughter can bring me, but the receptionist always tries her best to accommodate me."

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 service for urgent crisis support. Alternative support and signposting were also available for patients needing mental health support.

We were told the current waiting list into a Community Mental Health Team was 6 months plus. **During our inspection we suggested that self-help care groups could be advertised in the waiting room and/or on the website.**

Equitable

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

Patients were usually informed about the services offered at the practice through the website and by sharing information and updates via a text messaging service. Where patients were known not to have a mobile phone, 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 staff 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 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.

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. However, during our inspection we found that the accessible toilet within the practice did not have an emergency pull cord fitted. This cord is an important safety feature to ensure patients can raise the alarm to summon help when they may require assistance. **This was addressed under our immediate assurance process at Appendix B.**

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

We saw evidence of an equality and diversity policy in place, and staff had completed equality and diversity training. Most respondents who answered the question confirmed they had not faced discrimination when accessing or using this health service, however, four respondents told us they feel they cannot access the right healthcare at the right time.

The practice was proactive in upholding the rights of transgender patients. We were told transgender patients were treated with sensitivity and it was confirmed that their preferred names and pronouns would always be used.

Delivery of Safe and Effective Care

Safe

Risk management
The practice was clean and tidy, free of clutter however, we found some areas that were in need of repair. An infection, prevention and control (IPC) audit had been undertaken but did not specifically identify certain IPC issues, for example damaged walls, lack of splashbacks and textured ceilings. **This was addressed under our immediate assurance process at Appendix B.**

There were processes in place to protect the health, safety and wellbeing of all who used the practice services.

We reviewed the practice business continuity plan which covered the business partnership risk, pandemic risk and appropriately detailed contingencies for long-term sickness absence.

The practice demonstrated cluster collaboration to ensure patient care could continue in the event of an extreme situation.

The was a process in place for managing patient safety alerts and significant incidents. However, we found that staff would not record significant events if it was deemed administrative and were told only clinically significant events would be recorded. The practice manager was responsible for receiving patient safety alerts who disseminated to staff. All patient safety alerts were also stored on the practices electronic shared drive for easy access for staff.

The practice must ensure that all significant events are recorded

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. For example, we found that the building was in need of repair, with areas of potential dry rot on skirtings, plaster flaking away on walls, and sink splashbacks were absent in some consultation/ treatment rooms, therefore, potentially harbouring microorganisms. These issues were not identified in the practice IPC audit we reviewed. Therefore, attention is needed with the overall IPC audit process, including the environment, to minimise the risk of infection transmission/ cross contamination. **This was addressed under our immediate assurance process within Appendix B.**

As mentioned previously, none of the consultation rooms had privacy curtains, and we were told that a portable rail would be used when necessary, however, the curtain was not disposable, and the rail showed signs of rust. These issues were not identified in the practice IPC audit we reviewed. Therefore, as noted above, attention is needed with the overall IPC audit process.

There was an IPC policy in place which was specific to the practice. We saw there was a specific local policy for the management of blood borne viruses however, we did not see a cold chain management policy or a sharps management policy that were specific to the practice. The practice has a named IPC lead, which was checked and confirmed by staff members. However, the last IPC audit undertaken was not undertaken by the IPC lead.

The practice should have practice specific policies in place for:

- **Cold chain management; and**
- **Sharps management.**

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

We were told that the practice employs external contractors to provide the cleaning. On the day of the inspection there were no weekly cleaning schedules available. However, we found that the public areas, treatment rooms/consulting rooms and reception were all clean and tidy.

The practice must ensure weekly cleaning schedules are implemented.

The training matrix included IPC training as a mandatory for staff. All staff had completed IPC training relevant to their roles.

On review of human resource files and documentation, we found an appropriate system in place to check that all staff have immunity and/or are protected against the transmission of hepatitis B. However, the practice's hepatitis B policy is not suitable as it does not specify that clinical staff undertaking exposure prone procedures should have the vaccination. The policy does not reference the relevant national guidance (Green Book).

The practice must ensure the Hepatitis B policy specifies that clinical staff undertaking exposure prone procedures should have the vaccination and it should reference the relevant national guidance (Green Book).

There was a process in place for the management and disposal of all waste, and a policy was in place to support this. The waste was observed to be secure, without public access. However, during our inspection, the external waste bin was found to be very full, with no additional space available. We also found that there were full sharp bins being stored in an unlocked area adjacent to the patient waiting area, that were waiting for collection. The practice informed us that they were unable to lock this door as it is classed as a fire exit.

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

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

Medicines management
Processes were in place to ensure the safe prescribing of medication. The process for patients to request repeat medication was clear. Staff told us that most patients order prescriptions through the practice or online. Prescriptions were processed by suitably trained clerks with the GP's authorising any actions or reauthorisations.

Prescriptions collected by the pharmacy are managed by maintaining a log to ensure a clear audit trail. Prescriptions can also be collected at the reception desk, where a check of name, address and date of birth is conducted.

A prescribing policy was in place and prescribing clerks had access to training to ensure their skills and knowledge remains up to date. However, the staff training records we reviewed showed that they had not undertaken any medicine management training, nor did the practice have a medicine management policy in place.

The practice must ensure:

- **Staff undertake medicine management training, and a record should be kept to evidence this; and**
- **A medicine management policy is in place.**

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 were told that the secretary conducted referral audits, for example looking at urgent and expected cancer. However, the information from these audits is not currently being used to influence or inform change.

The practice should look at how information collated from audits could be used to aid improvement

There was a cold chain process in place for medications or vaccines that required refrigeration. There were dedicated clinical refrigerators for certain items, such as vaccines. Twice daily checks were completed and the documentation we reviewed confirmed this. Conversations with staff confirmed that they were aware of the upper and lower temperature and what to do in the event of a breach to the cold chain. We were told there was a rotation system for vaccines, the new medications are put at the back of the fridges and older stock at the front. They also spread-out stock between three fridges. However, during our inspection 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 recommend the practice contact the fridge manufacturer to obtain guidance on the correct storage of stock to maintain adequate circulation of cool air.

The practice must contact the fridge manufacturer to obtain guidance to ensure the storage of stock is appropriate and ensure appropriate cool airflow

On the day of the inspection, we saw evidence that the practice kept medication in the controlled drugs cupboard. It was advised that this was not necessary or appropriate as it was not in tamper evident storage and should be stored with all the emergency drugs.

We saw that oxygen cylinders were in date, with appropriate stock levels and arrangements were in place for reporting any incidents. We referred staff to a recent safety alert regarding staff training requirements for the use of oxygen and ensuring cylinders are correctly opened. Whilst we were told that the practice nurse had provided staff with training, they had not completed the appropriate online 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.

All necessary emergency equipment was in place. An automated external defibrillator (AED) was in place and was fully charged. A sign was in reception stating where the emergency equipment was located, however, we suggested a further sign be placed on the door of the treatment room where the equipment is actually stored. **This was completed on the day of the inspection.**

There were appropriate resuscitation equipment and emergency drugs in place to manage a patient emergency, such as cardiac arrest. We saw evidence that the checking of the drugs and emergency equipment was being recorded appropriately and this was completed daily. The primary care equipment standards outlined by the Resuscitation Council UK guidance currently states that these checks should be done weekly. However, we found that the emergency drugs were not stored in tamper-evident containers. All resuscitation drugs must be stored in tamper-evident containers and be easily accessible in the event of a patient emergency, in line with the Resuscitation Council UK.

The practice must ensure that the emergency drugs are easily accessible to staff and are stored in a secure location, in tamper-evident containers.

All staff had undertaken appropriate basic life support training.

Safeguarding of children and adults
We considered the safeguarding arrangements in place at the practice which included a policy for both adults and children. The practice had a named safeguarding lead for adults and children. Staff had access to practice safeguarding policies and procedures, which were ratified, up to date and included contact details of designated leads within the practice.

On review of patient records, we saw examples where people were appropriately flagged subject to any safeguarding concerns and followed a suitable safeguarding pathway. However, it was not easy for all relevant staff to identify children subject to the child protection register.

The practice must ensure a process is implemented to ensure relevant staff are aware of children subject to the child protection register, and for those removed from the register and that this is appropriately coded in child records.

During the inspection we saw evidence that all staff had completed safeguarding training at the required level.

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**.** However, these were often informal meetings, with no minutes or actions taken.

Staff meeting minutes should be recorded and actions documented, and shared with all staff

We were told that any safety notices, 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.

The practice has a palliative care board which identified patients who may be approaching end of life, allowing GP's and healthcare staff to provide proactive and personalised palliative and end of life care planning. They also have a death register board. **We saw this as good practice.**

Patient records
We reviewed eight 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.

Read codes were mostly used well and were appropriate for a patient's clinical condition, although some inconsistencies were seen in the way that different clinicians recorded patients' problems/ presentation. For example, when different read codes are used for the same presenting problem, continuity and follow up can become an issue, when seeing the same patient again. We also found that 'safety netting' needed to be strengthened to ensure patients are provided with clear instructions and guidance on what to do if their condition, worsens, changes or if they had any further concerns, ensuring timely follow up and re-assessment.

The practice must audit patient records and Read coding use, to ensure a consistent approach in recording information.

The practice must ensure that patients are provided with clear instructions and guidance on what to do if their condition, worsens, changes or if they have any further concerns, ensuring timely follow up and re-assessment

As highlighted earlier, the practice has a chaperone policy which states that the practice should document when a chaperone is offered, who is present and if a chaperone was offered and declined. During the review of the patients records we did not see evidence of this being recorded.

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, mental health services, drug and alcohol support and sexual health services via the cluster group.

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

Quality of Management and Leadership

Staff feedback

We engaged with staff throughout our inspection and sought feedback through a staff questionnaire. All respondents agreed that they had received the appropriate training to undertake their role and that they had had their appraisal, development review or annual review.

All respondents 'strongly agreed' or 'agreed' that they were able to meet the conflicting demands on their time at work, had adequate materials, supplies and equipment to do their work and there were enough staff to allow them to do their job properly. Two respondents felt they were not able to make suggestions to improve GP services.

All respondents 'strongly agreed' or 'agreed' that the care of the patient is the practice's top priority.

All respondents felt:

- Content with the efforts of the practice to keep staff and patients safe
- They would recommend the practice as a good place to work
- They would be happy with the standard of care provided by the practice for myself or friends and family.

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 that the GP partners had been at the practice for many years, and they all knew each other and their patients very well. It was apparent that the GP's were very supportive of each other and their staff.

As mentioned previously, we were told staff meetings were routine however, these were not formally recorded nor was a record of actions recorded to enable action owners to understand what was required of them. We were told clinical meetings, such as their 6 weekly multidisciplinary team meetings were formally recorded.

We reviewed a comprehensive suite of policies and procedures, with only one not being in place (Medicine Management 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, during our inspection we identified some training gaps which have been highlighted already in this report.**

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 they only had one substantive nurse in post who was available to deliver the practices' services and clinics. The practice uses two locum nurses who are also available to deliver the practices' services and clinics. We were told during our inspection the practice is in the process of recruiting another nurse however, a workforce plan needs to be considered for continuity of care and familiarisation with the environment, policies and procedures.

The practice should develop a workforce plan and consider recruitment of substantive practice nurses as the reliance on locum nurses is a risk.

Culture

People engagement, feedback and learning
The practice sought patient feedback via their website. However, there was no information displayed in the waiting area detailing how people could feedback on their experiences. We also found no evidence to demonstrate that patient feedback is routinely used by the practice to learn and inform service improvement.

The practice must ensure that:

- **Information is displayed in the waiting area detailing how people can feedback on their experiences; and**
- **Patient experience feedback is used to help inform service improvement and enhance the patient experience.**

An effective complaints process and tracking system was in place to monitor, review and resolve complaints and feedback. This was aligned to the NHS Wales Putting Things Right process.

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, however, two respondents to the staff questionnaire disagreed they could make suggestions to improve services at the practice.

We spoke to staff about the arrangements in place regarding compliance with the Duty of Candour. A Duty of Candour policy was in place and the records we reviewed showed all staff had completed training on this topic. The members of staff who completed a questionnaire agreed that they knew and understood their role in line with Duty of Candour.

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

The practice engaged in learning from internal and external reviews, including incidents and complaints. We were told learning was shared across the practice via regular staff meetings to make improvements, however, as highlighted earlier, there were no formal minutes or actions recorded.

Whole-systems approach

Partnership working and development
We found evidence of partnership working with the practice's collaboration within a GP cluster. Medical staff attended cluster meetings and provided services on a cluster wide basis.

We were told that the practice was looking at getting social hub connectors/ prescriber so they could connect their patients to community resources. They can currently prescribe patients gardening which is cluster funded.

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
An automated external defibrillator (AED) was in place and was fully charged. A sign was in reception stating where the emergency equipment was located, however we suggested a further sign be placed on the door of the treatment room where the equipment is stored.	Staff not being aware what room the emergency equipment is stored in, which could delay treatment to a patient in an emergency	Raised with nurse during the inspection	Sign printed and placed on the door of treatment room where the emergency equipment is being stored

Appendix B - Immediate improvement plan

Service: Tonyfelin Medical Centre

Date of inspection: 11 February 2025

Findings

During our inspection we found that the accessible toilet within the practice did not have an emergency pull cord fitted. This cord is an important safety feature to ensure patients can raise the alarm to summon help when they may require assistance.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	An emergency pull cord should be fitted in the accessible toilet within the practice	Health & Care Quality Standards (2023) – Safe	An electrician has been appointed with view to fit an emergency pull cord. Installation will be carried out as soon as possible to ensure safety and compliance.	Debra Tucker – Practice Manager	Completed 19/02/2025

Findings

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

The building was in need of repair, we found areas of potential dry rot on skirtings, plaster flaking away on walls, and sink splashbacks were absent in some consultation/ treatment rooms, therefore, potentially harbouring microorganisms.
None of the consultation rooms had privacy curtains, and we were told that a portable rail would be used when necessary, however the curtain was not disposable, and the rail showed signs of rust.

These issues were not identified in the practice IPC audit we reviewed. Therefore, attention is needed with the overall IPC audit process, including the environment, to minimise the risk of infection transmission/ cross contamination.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale

2.	The practice must review its IPC audit processes and: • Include the clinical environment, equipment, fixtures and fittings • Repeat an IPC audit promptly, including the clinical environment • Implement and maintain a regular IPC audit programme that includes the clinical environment and is specific to the practice • Consider the option of commissioning an external IPC review of the practice, to include the environment.	Health & Care Quality Standards (2023) – Safe	• An IPC audit has been completed, and findings have been identified below: 1.1.1. Cleaning instructions needed for baby changing facility 1.1.2. Cleaning wipes needed for baby changing facility 1.1.3. Signs needed for general waste bins 1.1.4. Remove Velux blinds in staff room 1.1.5. Remove and renew vertical blinds in room clinical rooms when necessary 1.1.6. Lever taps needed in rooms (2, 3, 4, 5, 6, 7, 8, 9, 10,11, 12, 13, examination rooms & phlebotomy rooms 1.1.7. Splashbacks needed in above rooms 1.1.8. Replace fabric chairs in rooms (2, 3, 5, 8, 12,13) for wipeable chairs	Debra Tucker – Practice Manager	3 months

			1.1.9. Some damage to walls outside room 8, outside room 14, treatment suite, areas in corridors 1.1.10. Repair treatment room floor and replace toilet flooring in patients, staff and disabled toilets on a rolling replacement basis 1.1.11. Emergency pullcord in disabled toilet 1.1.12. Privacy blinds / curtains are in some of the clinical rooms however the rooms that have not got them the GP's will utilise the examination rooms. The examination rooms will be fitted with privacy replacement blinds • A plan has been put in place to address these findings, with appropriate corrective actions and improvements to be implemented. Required changes will be carried out on a rolling replacement basis to ensure minimal disruption while maintaining compliance infection control standards.	Debra Tucker Debra Tucker – Practice Manager Debra Tucker- Practice Manager	This has been completed. 3 months 6 months

			• A robust procedure has been implemented with a new IPC policy. • IPC audit will be reviewed 6 monthly.		

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: Debra Tucker

Name (print): Debra Tucker

Job role: Practice Manager

Date: 18.02.2025

Appendix C - Improvement plan

Service: Tonyfelin Medical Centre

Date of inspection: 11 February 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 practice offered chaperones in all appropriate circumstances, and there was a chaperone policy in place. The policy states that the practice should document when a chaperone is offered and who is present and if a chaperone was offered and declined however, we did not see evidence of this being recorded.	**The practice must ensure that:** • **The offering, acceptance and rejection of a chaperone should be recorded in the patients record, as well as who was present or the reasons why the patient has declined** • **Information is available to patients regarding the option**	Health & Care Quality Standards - Information	All clinicians have been reminded to document chaperone information in patient records	DT DT	Complete Complete

	A chaperone information notice was displayed in the waiting area, however, not all clinical treatment rooms had notices indicating that this service was available.	**of a chaperone in all clinical treatment rooms.**		Laminated chaperone notices have now been placed outside all clinical and Waiting Room Areas		
2.	We were told that there were no Welsh speaking staff 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	**The practice should ensure that the active offer of Welsh is promoted to patients.**	Health & Care Quality Standards – Information	Dr Erica Lloyd is a Welsh speaker The practice information is now available in Welsh	DT	Complete

	available in English only.					
3.	The was a process in place for managing patient safety alerts and significant incidents. However, we found that staff would not record significant events if it was deemed administrative and were told only clinically significant events would be recorded.	**The practice must ensure that all significant events are recorded**	Health & Care Quality Standards – Information; Safe	All significant events will now be documented and discussed with staff. SEA's will be distributed to staff, saved and stored on Global drive for all staff to access.	DT	Complete
4.	We saw there was a specific local policy for the management of blood borne viruses however, we did not see a cold chain management policy or a sharps management	**The practice should have practice specific policies in place for:** • **Cold chain management; and** • **Sharps management.**	Health & Care Quality Standards – Information; Safe	Cold Chain policy and Sharps Management policy updated. Saved and stored on Global drive for all staff to access.	DT	Complete

	policy that were specific to the practice.					
5.	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; Safe	Needlestick Injury advice posters have now been placed in all clinical rooms	DT	Complete
6.	We were told that the practice employs external contractors to provide the cleaning. On the day of the inspection there were no weekly cleaning schedules available. However, we found that the public areas, treatment rooms/consulting	**The practice must ensure weekly cleaning schedules are implemented.**	Health & Care Quality Standards – Information; Safe	Weekly cleaning schedules available.	DT	Complete

	rooms and reception were all clean and tidy.					
7.	The practice's hepatitis B policy is not suitable as it does not specify that clinical staff undertaking exposure prone procedures should have the vaccination. The policy does not reference the relevant national guidance (Green Book).	**The practice must ensure the Hepatitis B policy specifies that clinical staff undertaking exposure prone procedures should have the vaccination and it should reference the relevant national guidance (Green Book).**	Health & Care Quality Standards – Information	Staff Immunisation Policy updated. Saved and stored on Global drive for all staff to access.	DT	Complete
8.	We found that there were full sharp bins being stored in an unlocked area adjacent to the patient waiting area, that were waiting for collection. The practice informed us that they were unable	**The practice must ensure that sharps bins are appropriately stored at all times.**	Health & Care Quality Standards – Safe	Full sharp bins that are waiting for collection will now be stored in a locked cupboard.	DT	Complete

	to lock this door as it is classed as a fire exit.					
9.	A prescribing policy was in place and prescribing clerks had access to training to ensure their skills and knowledge remains up to date. However, the staff training records we reviewed showed that they had not undertaken any medicine management training, nor did the practice have a medicine management policy in place.	**The practice must ensure:** • **Staff undertake medicine management training, and a record should be kept to evidence this; and** • **A medicine management policy is in place.**	Health & Care Quality Standards – Information; Workforce; safe	All relevant staff have been added to the UHB waiting list for prescqipp prescription training. Once training is complete, a training record will be kept for evidence	DT	3 months depending on when UHB have training availability
10.	We were told that the secretary conducted referral audits, for example looking at urgent and expected cancer. However, the information from these audits is not	**The practice should look at how information collated from audits could be used to aid improvement**	Health & Care Quality Standards – Information	Referral audit data is collected for monitoring purposes; however, responsibility for influencing service change and managing referrals rests with	DT/LN	Complete

	currently being used to influence or inform change.			NHS clinicians upon receipt of referral information.		
11.	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 recommend the practice contact the fridge manufacturer to obtain guidance on the correct storage of stock to maintain adequate circulation of cool air.	**The practice must contact the fridge manufacturer to obtain guidance to ensure the storage of stock is appropriate and ensure appropriate cool airflow**	Health & Care Quality Standards – Information; Safe	Stock is now distributed between other 3 fridges.	DT/EG	Complete
12.	Whilst we were told that the practice nurse had provided staff with training, they had not completed the appropriate online	**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.**	Health & Care Quality Standards – Information; Safe; Workforce	Training will be arranged for relevant practice staff that operate oxygen cylinders.	DT	2 months

	training for Portable Oxygen Cylinder.			Record of training will be held as evidence		
13.	We found that the emergency drugs were not stored in tamper-evident containers. All resuscitation drugs must be stored in tamper-evident containers and be easily accessible in the event of a patient emergency, in line with the Resuscitation Council UK.	**The practice must ensure that the emergency drugs are easily accessible to staff and are stored in a secure location, in tamper-evident containers.**	Health & Care Quality Standards – Information; Safe; Workforce	Training will be arranged for relevant practice staff that operate oxygen cylinders. Record of training will be held as evidence	DT	2 months
14.	On review of patient records, we saw examples where people were appropriately flagged subject to any safeguarding concerns and followed a suitable safeguarding pathway. However, it was not easy for all relevant staff to	**The practice must ensure a process is implemented to ensure relevant staff are aware of children subject to the child protection register, and for those removed from the register and that this is appropriately coded in child records.**	Health & Care Quality Standards – Information; Safe	Ensure clinical notes for children at risk and looked after children are read coded properly.	DT	Complete

	identify children subject to the child protection register.					
15.	There was an appropriate system in place for reporting incidents, and any shared learning was completed within team meetings. However, these were often informal meetings, with no minutes or actions taken.	**Staff meeting minutes should be recorded and actions documented, and shared with all staff**	Health & Care Quality Standards – Information	Minutes of meetings, including action logs, to be distributed to staff, saved and stored on Global drive for all staff to access.	DT	Complete
16.	Read codes were mostly used well and were appropriate for a patient's clinical condition, although some inconsistencies were seen in the way that different clinicians recorded patients' problems/ presentation. For example, when	**The practice must audit patient records and Read coding use, to ensure a consistent approach in recording information.** **The practice must ensure that patients are provided with clear instructions and guidance on what to do if their condition, worsens, changes or if they have**	Health & Care Quality Standards – Information; Safe	GP's have met and reflected on comments. To ensure consistency in the way clinicians read code patient's problems and presentation a read code guide for common presentations, conditions and complaints will be developed. A quarterly audit of	BP	3M

	different read codes are used for the same presenting problem, continuity and follow up can become an issue, when seeing the same patient again. We also found that 'safety netting' needed to be strengthened to ensure patients are provided with clear instructions and guidance on what to do if their condition, worsens, changes or if they had any further concerns, ensuring timely follow up and re-assessment.	**any further concerns, ensuring timely follow up and re-assessment**		consultation read codes will be undertaken to identify inconsistencies and provide feedback. GP's to strengthen their documentation for safety netting for patients	DT	1M

17.	We reviewed a comprehensive suite of policies and procedures, with only one not being in place (Medicine Management 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	We use a software programme that generates reports that capture the date and time staff members read and acknowledges the policy. If polices are updated, the system resets acknowledgements and tracks the updated version maintaining records of who read each version. Automatic emails are sent to staff when new or updated polices require reading. Currently policies are saved and stored on Global drive for all staff to access, however we are in the process of moving	DT	3M

				them all across to the new software that all staff have access to.		
18.	The practice reported they only had one substantive nurse in post who was available to deliver the practices' services and clinics. The practice uses two locum nurses who are also available to deliver the practices' services and clinics. We were told during our inspection the practice is in the process of recruiting another nurse however, a workforce plan needs to be considered for continuity of care and familiarisation with the environment,	**The practice should develop a workforce plan and consider recruitment of substantive practice nurses as the reliance on locum nurses is a risk.**	Health & Care Quality Standards – Workforce	We have recruited a Practice Nurse and a Health Care Assistant.	DT	Complete

	policies and procedures.					
19.	The practice sought patient feedback via their website. However, there was no information displayed in the waiting area detailing how people could feedback on their experiences. We also found no evidence to demonstrate that patient feedback is routinely used by the practice to learn and inform service improvement.	**The practice must ensure that:** • **Information is displayed in the waiting area detailing how people can feedback on their experiences; and** • **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 and any suggestions are discussed and if suitable carried out. The most recent improvements made by the practice, following patient feedback are currently displayed in the waiting room	DT	Complete

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): Debra Tucker

Job role: Practice Manager

Date: 01/05/2025