Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

Deeside Medical Centre, Betsi Cadwaladr University Health Board

Inspection date: 04 February 2025

Publication date: 07 May 2025

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Digital ISBN 978-1-83715-657-3

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 Deeside Medical Centre, Betsi Cadwaladr Health Board on 04 February 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. Only one patient completed a questionnaire and we received no responses from staff.

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 inspection highlighted the practice's efforts in various areas, including health promotion, dignified and respectful care, timely care, and rights and equality. Patients are encouraged to manage their health through pamphlets, leaflets. Advice sheets or web-links are also provided during consultations, where appropriate.

Health promotion information was mostly English, and the active offer of Welsh language is not promoted. A translation service is available for patients whose first language is not English, but the practice does not have a hearing loop for patients who are hard of hearing and wear hearing aids.

Conversations at the reception desk may be overheard, but a consulting room is available for confidential discussions. Privacy and dignity are promoted through closed doors and privacy curtains in consulting rooms, but privacy locks should be fitted to consulting/treatment room doors and internal link doors.

There is current policy in place for the use of chaperones, but staff have not completed formal chaperone training. The offer of a chaperone is recorded in patient’s records, but there are no notices displayed advising patients of their right to request a chaperone.

Staff assess patients' individual needs and ensure timely access to care with the most appropriate person. The telephone answering service did not initially advise patients on what to do in case of serious issues, such as chest pain, but this was updated following our inspection.

The practice does not have a patient information leaflet which would assist those patients without internet access. This should be developed and implemented promptly. In addition, limited parking is available, but access to the main entrance is good, with a ramp for people with mobility needs. All facilities are located on the ground floor.

Delivery of Safe and Effective Care

Overall summary:
The premises were found to be adequately maintained, with a current general risk assessment covering fire, environment, and health and safety. However, exposed hot water pipes surrounding the door frame to the patient toilet posed a risk of accidental scalding, which was addressed under HIW's immediate assurance process.

Fire safety equipment was available and was recently serviced, but concerns were raised about the upper floor's evacuation safety, due to the large number of paper records stored near escape routes.

Patient safety alerts and significant event notifications are shared with staff through in person and electronically. There was an absence of an emergency call system in the patient toilet which needs addressing. In addition, we found insufficient oxygen cylinder levels although immediate actions taken to address these issues.

Infection control measures were in place, including an infection control policy and designated nurse lead, but recommendations were made for an external audit and the implementation of a cleaning schedule. Personal protective equipment and hand sanitizers were readily available, and staff had completed mandatory IPC training.

Waste management systems were appropriate, but difficult to clean wood panelling in the waiting area, and inconsistent handwashing facilities were identified within consultation/ treatment rooms, which need improvement.

Medicines management policies were in place, but several issues were noted, including the location of the medication refrigerator and gaps in temperature records. Safeguarding policies were present but lacked specific contact details for the local safeguarding team, and there was little documented evidence of staff safeguarding training.

Medical devices and equipment were regularly safety tested, but emergency kit checks were not conducted weekly as required.

Immediate assurances:

- Ensure that the temperature of the medication storage refrigerator is checked and recorded daily
- Ensure that the exposed hot water pipes are covered to prevent the risk of burn

- Ensure that measures are in place to regularly check expiry dates of single use consumables and remove and dispose of items which have passed their expiry dates.

Quality of Management and Leadership

Overall summary:

The practice's governance and leadership are well-structured, with appropriate management oversight and a supportive environment for staff. The management team and GP partners are approachable, and there is a robust management structure in place.

Team meetings and clinical discussions were taking place on an informal basis with no record maintained. The practice is advised to formalise the recording of team meetings and clinical discussions.

Staff receive regular appraisals. Recruitment processes include reference checks and DBS checks, although documentation supporting these processes is lacking. It is recommended that the practice retains copies of application forms and recruitment checks in staff files. Staff have completed most mandatory training, and a staff training matrix is suggested to monitor training compliance and renewal dates.

Patient feedback is actively sought through annual questionnaires, and this feedback is used to improve services. Information governance and digital technology arrangements are adequate, ensuring patient confidentiality and compliance with GDPR 2018.

Quality improvement activities were in place, with staff engaging in innovative ways of delivering care, including involvement in cluster-wide projects. The practice collaborates within the cluster, attending cluster meetings and providing services on a cluster-wide basis. Located in the heart of the community, the practice has opportunities to strengthen its links with other nearby services.

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

Person-centred

Health promotion
Patients were encouraged to take responsibility for managing their own health, through the provision of health promotion advice available in the form of pamphlets and leaflets within the waiting area. Clinical staff also printed off advice sheets and shared relevant web-links during consultations where applicable.

Patients with internet access can also find some information about the services available on the practice's website.

Information relating to practice opening times was available on the practice website.

Dignified and respectful care
We saw staff greeting patients in a professional manner, both face to face and over the telephone.

An up-to-date written policy was in place in relation to the use of chaperones. However, staff had not completed formal chaperone training.

The practice must ensure that staff complete chaperone training if undertaking this role.

The offer of a chaperone was recorded on patients' notes. However, there were no notices displayed in the waiting room advising patients of their right to request a chaperone.

The practice should ensure that notices are visitable within waiting areas and consultation rooms, advising patients of their right to request a chaperone.

The reception desk was in the waiting room and there was potential for conversations to be overheard. However, we were told that a consulting room would be made available should patients need to discuss anything confidential.

There were satisfactory arrangements in place to promote patients' privacy and dignity. Doors to consulting rooms were closed when patients were being reviewed, and consulting rooms also had privacy curtains that could be used when

patients were undressing or being examined. However, to ensure privacy is always maintained, we recommended that privacy locks be fitted to consulting/treatment room doors, and to internal link doors connecting two rooms.

The practice should fit privacy locks to consulting/treatment room doors and to internal link doors connecting two rooms.

Timely

Timely care

Staff described the arrangements for assessing patients by healthcare professionals, to identify their individual care and treatment needs.

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

Patients who contact the service by telephone are provided with options to select which service they require. However, the recorded message on the answering service did not advise patients of what to do if they were experiencing serious issues, such as chest pain, difficulty breathing or heavy bleeding. This was escalated to the practice manager during the inspection, and we received confirmation immediately after the inspection, that the message on the answering service had been updated to include this information.

We saw evidence of the practice manager monitoring patient satisfaction using a questionnaire.

Equitable

Communication and language

The practice does not currently have a patient information leaflet which would assist those without internet access. We recommended that this is addressed promptly with a leaflet developed and implemented as soon as possible. This should contain key information such as contact details and opening times, services provided, appointment options, prescriptions, an overview of the practice team.

The practice should develop and implement a patient information leaflet to assist those who are digitally excluded.

Whilst an array of health promotion and other useful information was available within the waiting room, most was displayed in English only.

We were told that very few Welsh speaking patients attended the practice, and no staff who spoke Welsh. This meant that the active offer of Welsh was not promoted within the practice.

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

Staff told us they could access a translation service to help communicate with patients whose first language is not English.

The practice did not have a hearing loop to support communication with patients who are hard of hearing and wear hearing aids.

The practice must install a hearing loop to support patients who are hard of hearing and wear hearing aids.

Rights and equality
There was limited parking available at the practice although there was a public car park nearby. Access to the main entrance was good, with a ramp in place to assist people with mobility needs. All facilities, including the reception desk, waiting room, patients' toilet and consulting rooms were located on the ground floor.

There was an up-to-date written policy on obtaining valid patient consent.

Our examination of a sample of patient records confirmed that clinicians were recording when patients gave verbal consent to examination or treatment.

Delivery of Safe and Effective Care

Safe

Risk management
Arrangements were in place to help maintain the safety and wellbeing of staff and people visiting the practice.

The premises were adequately maintained both internally and externally, and we saw a current general risk assessment in place, covering fire, environment, and health and safety, and regularly reviewed.

Whilst most areas were free from obvious hazards, we found exposed hot water pipes surrounding the door frame to the patient toilet. This placed patients, visitors and staff at risk of accidental scalding from the hot pipes. These issues were dealt with under HIW's immediate assurance process and further detail is highlighted in Appendix B of this report.

Fire safety equipment was available at various locations around the practice, and we saw these had been serviced within the last 12 months. However, we were concerned that the upper floor of the building posed significant risks to evacuate safely in the event of a fire. This was compounded by the large number of paper records stored between the practice manager's office and any escape route.

The practice must ensure there is always easy access to fire exits and should consult with the Fire Service to confirm whether the fire safety measures in place on the first floor are adequate and safe.

We were told that patient safety alerts and significant event notifications are shared with staff through face to face discussions or through electronic messaging.

There was no emergency call system in the patient toilet, to seek help if required.

The practice should install an emergency call bell within the patient toilet.

We saw two oxygen cylinders stored on the premises. However, it was concerning to find one was less than half full and the other less than a quarter full. This posed a risk with the supply of oxygen, particularly if used at high flow during an emergency. This was escalated to the practice manager during the inspection, and we received confirmation immediately after the inspection, that replacement oxygen cylinders had been delivered.

There was no signage indicating the location of the oxygen, which increases the risk of combustion in the event of a fire.

The practice must display clear signage to identify where oxygen is stored.

Infection, prevention and control (IPC) and decontamination
There was an infection control policy in place, and the practice had a designated nurse as the lead for IPC. They were also responsible for conducting relevant audits and facilitating staff IPC training. We recommended that an external, independent infection prevention and control audit be arranged to support current arrangements.

The practice should arrange for an independent infection prevention and control audit be conducted to support current arrangements.

The areas of the practice we viewed were visibly clean. A cleaner is employed by the practice. However, there was no cleaning schedule in place, nor was there a log to evidence that cleaning had taken place.

The practice should implement a cleaning schedule and maintain a log to evidence that cleaning has taken place.

Staff had access to personal protective equipment, such as gloves and disposable plastic aprons to reduce cross infection.

Hand sanitizers were readily available around the practice, and hand washing and drying facilities were provided in clinical areas and toilets.

The practice training information showed infection prevention and control was part of the mandatory training programme. We saw that all clinical and non-clinical staff had completed IPC training, at a level appropriate to their role.

Appropriate arrangements were in place to deal with sharps injuries. However, the Hepatitis B immunisation status for relevant staff had not been established, therefore highlighting the risk that patients and clinical staff were not protected from blood borne viruses.

The practice must establish the Hepatitis B immunity status of relevant staff, and risk assessments are completed and mitigations in place until this is identified, and/ or if immunity status is known to be low.

There was a system in place to manage waste appropriately and safely. Contract documentation was in place for the disposal of hazardous (clinical) and non-

hazardous (household) waste. We saw that all waste had been segregated into the designated bags / containers in accordance with the correct method of disposal.

Wall surfaces in consulting/treatment rooms and waiting areas were partially covered in wood panelling of tongue and groove construction. This means it is more difficult to maintain robust cleaning and preventing the colonising of microorganisms.

The practice should consider how the wood panels can be appropriately cleaned and/or renovated to minimise the risk of cross infection.

Hand washing facilities in the consulting/treatment rooms were not consistent with current standards. For example, the absence of elbow operated taps, tiled splashbacks, and no overflow drains. This was also identified as an area for improvement in the 2024 practice development plan.

The practice must promptly address the handwashing facilities within consulting/ treatment rooms, to minimise the risk of cross infection.

Medicines management
There were policies and procedures in place for the storage and administration of medication. However, we identified several areas for improvement.

Medication requiring refrigeration was stored located next to a wash basin and mop storage area. This increased the risk of cross infection. This was also identified as an area for improvement in the 2024 practice development plan. In addition, the room containing the medication refrigerator was not locked, and there was no locking mechanism on the refrigerator itself, posing the risk of unauthorised access.

The practice must:

- **Relocate the medicines refrigerator promptly, to minimise the risk of cross infection**
- **Ensure a lock is installed on the door to the room containing the medication refrigerator and/ or to the refrigerator door.**

We found gaps in the checking of medication refrigerator temperature records, and the ambient temperature of the room housing it not monitored. **These issues were dealt with under HIW's immediate assurance process and are referred to in more detail within Appendix B of this report.**

Some medication was also found stored on the fridge floor, and other items were stored inadequately on the shelving, which may impede the effective circulation of cold air.

The practice must ensure that medication is appropriately stored within the refrigerator.

Safeguarding children and safeguarding vulnerable adults
There were policies and procedures in place to promote and protect the welfare and safety of children and adults who are vulnerable or at risk. However, the policies did not contain the specific contact details for the local safeguarding team.

The practice must ensure that all contact details for the local safeguarding team are included within the safeguarding policy/procedures.

We were told that staff had undertaken safeguarding training at a level appropriate to their roles. However, there was little documented evidence of this.

The practice manager must ensure staff complete safeguarding training relevant to their role, in line with the Wales Safeguarding Procedures, and a record of compliance must be kept.

Read Codes were used to identify children subject to safeguarding concerns. However, appropriate Read Codes were not routinely used to identify the family members of these children.

The practice must ensure that family members of children subject to safeguarding concerns are highlighted using appropriate Read Codes.

Medical devices, equipment and diagnostic systems
We found that portable electrical appliances were safety tested on a regular basis. It was confirmed that disposable single use clinical equipment is used where appropriate.

There were procedures in place showing how to respond to patient medical emergencies, and a system was in place to check the emergency drugs and equipment. However, the emergency kit checks were undertaken monthly and not weekly, as stipulated within the Resuscitation Council (UK) quality standards for primary care. Consequently, we found items passed their expiry date stored on the emergency trolley. **These issues were dealt with under HIW's immediate assurance process and are referred to in more detail within Appendix B of this report.**

Effective

Effective care

From our discussions with staff, and examination of patient records, we found that patients were receiving safe and clinically effective care.

A range of written policies and procedures were available to support the operation of the practice, and we were told that these were being reviewed and updated on a regular basis.

We reviewed a sample of patient records and found they were well organised. The records contained details of the clinician and sufficient details of the clinical findings and the care/treatment given to each patient.

Patient records

There was a robust information governance framework in place, and staff were aware of their responsibilities in respect of accurate record keeping and maintaining confidentiality.

Through examination of training records, we confirmed that staff had received training on information governance.

We reviewed the records of eight patients and saw an effective records management system in place, maintaining their security to prevent unauthorised access. Records entries were contemporaneous, clear, legible and of good quality, and evidenced patient consent being obtained, where appropriate.

Efficient

Efficient

Processes were in place to promote safe and effective care. We found good examples of acute and chronic illness management, and a clear narrative with evidence of patient centred decision making.

Staff described appropriate systems for reporting and learning from significant events and from audit activity, such as improving practice following antibiotic audits.

Clinical staff confirmed that a comprehensive process was in place to receive and share new evidence-based practice and updated or new NICE guidance.

Quality of Management and Leadership

Leadership

Governance and leadership
The management oversight of the services provided was appropriate, and staff told us the practice manager and GP partners were approachable and supportive.

There was a robust management structure in place, and clear lines of reporting were described. The Practice Manager and their deputy work daily and actively monitor the quality of the service provided.

We found well defined processes in place to ensure that the focus on continuous improvement is maintained. This was, in part, achieved through a rolling programme of audit and established governance structure, which enabled staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care. However, due to the size of the practice and the small number of staff employed, these meetings and discussions tend to take place on an informal basis with no record maintained.

The practice must formalise the recording of team meetings and clinical discussions and share with staff as appropriate.

Staff were respectful and courteous, and we found a patient-centred team who were very committed to providing the best services they could.

Staff had access to policies and procedures to guide them in their day-to-day work.

Workforce

Skilled and enabled workforce
We found that staff received regular appraisal of their work performance.

We were told that staff recruitment was undertaken through an external organisation. We discussed the process with the practice manager who confirmed that appropriate recruitment processes were followed, which included checking of references and undertaking Disclosure and Barring Service (DBS) checks on staff appropriate to the work they undertake. However, there was little evidence on staff files to support this.

The practice must retain copies of application forms and recruitment checks on individual staff files, along with a record of their DBS certificate number.

Information we saw within staff files demonstrated that staff had completed mandatory training, and other training relevant to their roles. We recommended that a staff training matrix is implemented to easily identify training compliance and any renewal dates.

Culture

People engagement, feedback and learning
We discussed the mechanism for actively seeking patient feedback, which is done by issuing questionnaires to patients annually. Patient feedback is discussed with staff to improve or further develop the service.

Information

Information governance and digital technology
Adequate arrangements were in place for maintaining patient confidentiality, and adherence to Information Governance and the General Data Protection Regulations (GDPR) 2018.

Learning, improvement and research

Quality improvement activities
We found that staff engaged with quality improvement by developing and implementing innovative ways of delivering care. This included the involvement in cluster wide projects.

Whole-systems approach

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

The practice is located in the heart of the community with a wide variety of other services located nearby. Therefore, additional opportunities are present for the practice to strengthen its links with the community.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
The recorded message on the answering service did not advise patients of what to do if they were experiencing chest pain, difficulty breathing etc.	This means that patients may not receive the urgent care that they required which could cause them harm.	This issue was escalated to the practice manager during the inspection.	We received confirmation from the practice manager immediately after the inspection confirming that the message on the answering service had been updated to include this information.
Two oxygen cylinders were stored on the premises. However, one was found to be less than half full and the other less than quarter fully.	The supply of oxygen could run out if used in an emergency.	This issue was escalated to the practice manager during the inspection.	We received written confirmation from the practice manager, immediately after the inspection, that replacement oxygen cylinders had been delivered.

Appendix B – Immediate improvement plan

Service: Deeside Medical Centre

Date of inspection: 04/02/25

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.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	HIW was not assured that there are robust arrangements in place for the checking of consumables within the practice. We looked at the emergency trolley located within the Health Care Assistant consulting/treatment room and found consumable items, such as syringes, needles, oxygen mask, oxygen tubing and ampoules of water for	• Ensure that measures are in place to regularly check expiry dates of single use consumables • Remove and dispose of items which have passed their expiry dates.	Delivery of Safe and Effective Care	Expiry dates on medication are checked monthly and always checked before being used. Due to a few consumables in our emergency box being out of date. The practice has now implemented a checklist sheet that the practice nurse or HCA will complete monthly.	Philip Evans	1 week

	injection that were past their expiry dates. This placed the patients at risk of harm.					
2.	HIW was not assured that there were robust arrangements in place for the checking and recording of the medication storage refrigerator temperature. We reviewed the medication refrigerator temperature records and found occasions when the temperature readings had not been recorded. This meant we could not be assured that the fridge temperatures remain in range to maintain the viability of some medication and vaccines. This may impact on patient safety.	HIW requires details on how the practice will ensure that the temperature of the medication storage refrigerator is checked and recorded daily.	Delivery of Safe and Effective Care	The temperature of our fridge is checked twice a day and recorded by our staff. We have a data logger in the fridge that is reviewed every 3 months. Due to staff absence, it appears a few readings had been missed. All staff have been informed, suitable cover is arranged for checking the fridge temperature when staff are absent.	Philip Evans	1 week

3.	HIW was not assured that there were robust arrangements in place for managing the risk of harm to patients, visitors and staff. During a tour of the practice, we found exposed hot water pipes surrounding the door frame to the patient toilet located within the waiting area. This placed patients, visitors and staff at risk of harm if skin contact is made with the hot pipes.	The practice must ensure that the exposed hot water pipes are covered safely to prevent the risk of burn.	Delivery of Safe and Effective Care	Local builder has been contacted and will carry out the work in the next two weeks.	Philip Evans	1-2 weeks

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): **PHILIP EVANS**

Job role: **Practice Manager**

Date: **07/02/2025**

Appendix C - Improvement plan

Service: Deeside Medical Centre

Date of inspection: 04/02/25

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.	Staff had not completed formal chaperone training.	The practice must ensure that staff complete chaperone training if undertaking this role.	Person Centred Care	In house formal training to be taken at the next protected time	Philip Evans (PM)	3 months
2.	There were no notices in the waiting room advising patients of their right to request a chaperone.	The practice should ensure that notices are visitable within waiting areas and consultation rooms, advising patients of their right to request a chaperone.		Chaperone posters in the waiting area	Philip Evans (PM)	Complete
3.	No privacy locks were fitted to doors leading into consulting/treatment rooms and also to internal link doors connecting	The practice should fit privacy locks to consulting/treatment room doors and to internal link doors connecting two rooms.		The practice manager will enquire into getting privacy locks fitted	Philip Evans (PM)	1 month

	consulting/treatment rooms.					
4.	The practice does not have a patient information leaflet which would assist those patients without internet access.	The practice should develop and implement a patient information leaflet to assist those who are digitally excluded.		We already have a patient information leaflet in place?	Philip Evans (PM)	Complete
5.	The active offer of Welsh was not promoted within the practice.	The practice must ensure that the active offer of Welsh language is promoted to patients.		We have ordered bilingual posters from Health Information Resources - Public Health Wales	Philip Evans (PM)	Complete
6.	The practice did not have a hearing loop to help staff communicate with patients who are hard of hearing and wear hearing aids.	The practice must install a hearing loop to support patients who are hard of hearing and wear hearing aids.		The practice manager will enquire into purchasing a hearing loop	Philip Evans (PM)	1month
7.	The upper floor of the building would have proved to be very difficult to evacuate safely in the event of a fire. This was compounded by the	The practice must ensure there is always easy access to fire exits and should consult with the Fire Service to confirm whether the fire safety measures in place on		The practice manager will enquire into the practicality and cost for stairs to be attached the second floor	Philip Evans (PM)	3 months

	large number of paper records stored between the practice manager's office and any escape route.	the first floor are adequate and safe.				
8.	There was no emergency call system in the patient toilet.	The practice should install an emergency call bell within the patient toilet.	Safe Care	Practice manager will enquire to have emergency call system in the patient toilet	Philip Evans (PM)	1 month
9.	There was no signage indicating the location of the oxygen, which increases the risk of combustion in the event of a fire.	The practice must display clear signage to identify where oxygen is stored.		Location added to the door where oxygen is located	Philip Evans (PM)	Complete
10.	No independent infection prevention and control audit had been undertaken.	The practice should arrange for an independent infection prevention and control audit be conducted to support current arrangements.		Practice manager will enquire with SRCL who dispose of our hazardous waste	Philip Evans (PM)	1 month
11.	There was no cleaning schedule in place, nor was there a log to evidence that cleaning had taken place.	The practice should implement a cleaning schedule and maintain a log to evidence that cleaning has taken place.		Cleaning log introduced	Philip Evans (PM)	Complete
12.	The Hepatitis B immunisation status	The practice must establish the Hepatitis B immunity		The practice manager has emailed all staff	Philip Evans (PM)	1 month

	for staff had not been established.	status of relevant staff, and risk assessments are completed and mitigations in place until this is identified, and/ or if immunity status is known to be low.	further information on their Hep B status		
13.	Wall surfaces in consulting/treatment rooms and waiting areas were partially covered in wood panelling of tongue and groove construction. This means it is more difficult to maintain robust cleaning and preventing the colonising of microorganisms.	The practice should consider how the wood panels can be appropriately cleaned and/or renovated to minimise the risk of cross infection.	Cleaner has reported that cleaning the wood has been no problem.	Philip Evans (PM)	Complete
14.	Hand washing facilities in the consulting/treatment rooms were not consistent with current standards e.g elbow operated taps,	The practice must promptly address the handwashing facilities within consulting/ treatment rooms, to minimise the risk of cross infection.	Practice manager will contact a plumber to adapt sinks with elbow operated taps	Philip Evans (PM)	3 months

	tiled splashbacks, no overflow drains. This has already been identified as an area for improvement in the 2024 practice development plan.					
15.	Medication requiring refrigeration was stored within a floor standing refrigerator which was located next to the to a wash basin and mop storage area. This increased the risk of cross infection and consideration should be given to relocating the refrigerator to a more suitable location. This has already been identified as an area for improvement in the 2024 practice development plan.	The practice must relocate the medicines refrigerator promptly, to minimise the risk of cross infection.		Assessment undertaken, nowhere more suitable for the fridge to be stored	Philip Evans (PM)	Complete

16.	The room containing the medication storage refrigerator was not locked and there was no locking mechanism on the refrigerator itself.	The practice must ensure that a lock is installed on the door to the room containing the medication refrigerator and/ or to the refrigerator door.		Practice manager to purchase a lock	Philip Evans (PM)	1 month
17.	Some medication was stored on the fridge floor and other items were stored in a somewhat haphazard fashion on the shelving, which may impede the effective circulation of cold air.	The practice must ensure that medication is appropriately stored within the refrigerator.		Nurses confirm they will continue to monitor and make sure the fridge is orderly	Philip Evans (PM)	Complete
18.	The safeguarding policy/procedures did not contain the contact details for the local safeguarding team.	The practice must ensure that the contact details for the local safeguarding team are included within the safeguarding policy/procedures.		Practice manager has assed contact details for the local safeguarding team to the policy and procedure	Philip Evans (PM)	Complete
19.	There was little documented evidence of staff safeguarding training.	The practice manager must ensure staff complete safeguarding training relevant to their role, in line with the Wales		Staff complete safeguarding training via e learning and are provided with certificates	Philip Evans (PM)	Complete

		Safeguarding Procedures, and a record of compliance must be kept.				
20.	Appropriate Read Codes were not routinely used to identify the family members of children subject to safeguarding concerns.	The practice must ensure that family members of children subject to safeguarding concerns are highlighted using appropriate Read Codes.		Staff aware to appropriately code letters received from safeguarding	Philip Evans (PM)	Complete
21.	Team meetings and clinical discussions were taking place on an informal basis with no record maintained.	The practice must formalise the recording of team meetings and clinical discussions and share with staff as appropriate.		Team meetings are already formally recorded, the practice have decided to increase staff formal meetings	Philip Evans (PM)	Complete
22.	There was very little evidence of pre-employment checks on staff files.	The practice must retain copies of application forms and recruitment checks on individual staff files, along with a record of their DBS certificate number.	Workforce	Application forms are to be kept in staff files along with DBS certificate number	Philip Evans (PM)	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): Philip Evans

Job role: Practice Manager

Date: 19/03/2025