Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report
(Announced)
Gardden Road Surgery, Betsi Cadwaladr University Health Board

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In writing:

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

Or via

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

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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 Gardden Road Surgery, Betsi Cadwaladr University Health Board on 25 March 2025.

Our team for the inspection comprised of one 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. A total of 37 questionnaires were completed. 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:
Patient comments on the quality of the service were generally positive.

We saw staff greeting patients in a professional manner, both face to face and over the telephone and there were processes in place to ensure patients could access care in a timely manner, and with the most appropriate person.

This is what we recommend the service can improve:

- Promote the active offer of Welsh language
- Produce a patient information leaflet.

This is what the service did well:

- Patient centred service
- Accessibility of service
- Double appointments if translation required
- Maintenance of privacy and dignity.

Delivery of Safe and Effective Care

Overall summary:
The premises were generally well maintained both internally and externally. However, some corridor areas required re-decorating.

The areas of the practice we viewed were visibly clean and staff had access to personal protective equipment, such as gloves and disposable plastic aprons to reduce cross infection.

Patient records were well organised and contained details of the clinician and sufficient details of the clinical findings and the care/treatment given to each patient.

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.

Immediate assurances:

- Ensure that Patient Group Directions (PGD) are correctly authorised and in date.

This is what we recommend the service can improve:

- Some aspects of infection prevention and control
- Some aspects of medication management
- Set up a process for regularly auditing Read Coding and summarising of notes to ensure accuracy and consistency.

This is what the service did well:

- Well organised and legible patient care notes
- Linkage of medication to patient care notes
- Avoidance of hospital admissions through collaborative working with other professionals.

Quality of Management and Leadership

Overall summary:
The oversight by the practice manager of the services provided was appropriate and staff told us the practice manager and GP partners were approachable and supportive.

Processes were in place to ensure that the focus on continuous improvement is maintained.

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 and had access to appropriate training.

This is what we recommend the service can improve:

- Review the practice manager role and responsibilities to ensure that they have sufficient time and resources to fully perform their duties
- Review GP partners roles and input in the management of the service in support of the practice manager
- Formalise processes for general and more specific clinical audit and peer review
- Ensure that all staff have an annual performance, development and appraisal meeting with their line manager.

This is what the service did well:

- Comprehensive policies and procedures
- Manager oversight and dedication to improving 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

Patient feedback

Responses to the patient survey were mostly positive across all areas. Most respondents rated the service as very good or good. Two respondents rated the service as poor.

Many patients who completed the survey told us that they were able to get a same-day appointment when they need to see a GP urgently and where applicable, most said they could get routine appointments when they need them.

Less than half of patients who completed the survey said they were offered the option to choose the type of appointment they preferred.

All but one respondent felt they were treated with dignity and respect and said measures were taken to protect their privacy.

All but one of those who completed the survey felt the GP explained things well and answered their questions and all but two felt involved in decisions about their healthcare.

Most patients felt they were able to access right healthcare at the right time.

Patient comments included:

> *"The doctors are mostly very good but getting access to them is very difficult."*
>
> *Email system for booking my blood tests works very well. When you finally get to see a doctor, all is good. Receptionists are very efficient."*

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 areas. 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, and staff had completed formal chaperone training.

The offer of a chaperone was recorded on patients' notes and notices displayed in the waiting room advising patients of their right to request a chaperone.

The reception desk was in the main 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.

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.

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 only one staff member 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 also told us they could access a translation service to help communicate with patients whose first language is not English.

Rights and equality

There was limited parking available at the practice and 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

The premises were generally well maintained both internally and externally. However, some corridor areas required re-decorating.

The practice must ensure that the affected corridor areas are re-decorated.

The practice manager told us that the surgery is no longer fit for purpose and they are unable to offer additional clinics due to the lack of clinical rooms and limited car parking spaces. Consequently, they considering withdrawing two supplementary services in order to facilitate more face to face appointments. In addition, they are finding it difficult to attract more GPs, but due to the current constraints.

There is very little free space for general storage and the storage of medical records. There is no space for staff to have their breaks and no dedicated room for meetings or staff training to take place.

There was a current general risk assessment in place, covering fire, environment, and health and safety, and was regularly reviewed.

Arrangements were in place to help maintain the safety and wellbeing of staff and people visiting the practice. However, one of the heaters in the corridor leading from the main waiting area to the consulting rooms was very hot and could present a risk of burn injury to patients and staff.

The practice must ensure that the heater in the corridor leading from the main waiting area to the consulting rooms is covered or the temperature regulated to reduce the risk of harm to patients and staff.

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 on a weekly basis.

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

Infection, prevention and control (IPC) and decontamination

There was an infection control policy in place which was reviewed in February 2025. However, the policy was not signed by the staff member undertaking the review.

The practice must ensure that policies are signed by the staff member undertaking the review.

The areas of the practice we viewed were visibly clean and 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. However, hand washing facilities in the consulting/treatment rooms were not consistent with current standards as they had tiled splashbacks. This made the splashbacks difficult to clean and increased the risk of cross infection.

The practice must promptly replace the splashbacks within consulting/ treatment rooms, to minimise the risk of cross infection.

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.

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.

Medicines management

There were policies and procedures in place for the storage and administration of medication and documented evidence of excellent linkage of medication and repeat prescribing to diagnosis. However, we identified several areas for improvement.

We looked at the Patient Group Directions in use at the practice and found that some were not correctly authorised and not in date. This placed patients at risk of harm. **This was dealt with under HIW's immediate assurance process and is referred to in more detail within Appendix B of this report.**

We found that medication for use in an emergency was not stored in a tamper evident container.

The practice must ensure that medication for use in an emergency is stored in a tamper evident container.

The medication storage refrigerator temperature was monitored on a regular basis by electronic means and records maintained. However, there was no means of monitoring the refrigerator temperature in the event of a power failure. In addition, the temperature of the room containing non refrigerated medication was not monitored.

The practice must ensure that the temperature of the refrigerator can be monitored in the event of a power failure.

The practice must ensure that the temperature of the room containing non refrigerated medication is monitored on a regular basis.

Safeguarding of children and 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.

We were told that staff had undertaken safeguarding training at a level appropriate to their roles.

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.

Management of medical devices and equipment

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. However, we found that an annual check and calibration on some items of medical equipment was overdue from February 2025.

The practice must ensure that overdue checks and calibration of medical equipment is undertaken without further delay.

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 with evidence of holistic, person centred approach to the provision of care.

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 ten 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. However, there was little evidence of audit activity around Read Coding and notes summarising.

The practice must set up a process for regularly auditing Read Coding and summarising of notes to ensure accuracy and consistency.

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 oversight by the practice manager of the services provided was appropriate and staff told us the practice manager and GP partners were approachable and supportive. However, the practice manager role and responsibilities required review to ensure that they have sufficient time and resources to fully perform their duties. In addition, the GP partners should review their roles and input in the management of the service in support of the practice manager.

The practice must review the practice manager role and responsibilities to ensure that they have sufficient time and resources to fully perform their duties, and the GP partners should review their roles and input in the management of the service in support of the practice manager.

Processes were in place to ensure that the focus on continuous improvement is maintained. However, there was little evidence of general and more specific clinical audit and peer review.

The practice must formalise processes for general and more specific clinical audit and peer review.

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 discussed staff recruitment 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.

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

The practice should maintain a staff training matrix to easily identify training compliance and any renewal dates.

Staff received informal, day to day support and supervision. Annual performance, development and appraisal meetings were sporadic. However, the practice manager plans to formalise the process for all staff.

The practice must ensure that all staff have an annual performance, development and appraisal meeting with their line manager.

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 on how to raise a concern or make a complaint was posted in the main waiting area.

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
No immediate concerns were identified on this inspection.			

Appendix B – Immediate improvement plan

Service: Gardden Road Surgery

Date of inspection: 25 March 2025

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

	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 ensuring that medication is being administered in line with authorised and in date Patient Group Directions. Some Patient Group Directions in use at the practice were not correctly authorised and not in date. This	The practice must ensure that Patient Group Directions are correctly authorised and that they are in date.	Delivery of Safe and Effective Care	We have reviewed all the PGD's and can confirm that they are all up to date and correctly authorised by the GP.	Rachel Barnes	Completed

	placed patients at risk of harm.					

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): Rachel Barnes

Job role: Clinical Lead ANP

Date: 31/03/2025

Appendix C - Improvement plan

Service: Gardden Road Surgery

Date of inspection: 25 March 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 does not currently have a patient information leaflet which would assist those without internet access.	The practice should develop and implement a patient information leaflet to assist those who are digitally excluded.	Person Centred Care	The practice does have a patient information leaflet available. Please see attached.	PM	Completed
2.	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.		Bilingual signs have been updated. All job advertisements will promote the recruitment of a Welsh speaker. Encourage staff to access free Welsh Language online sessions	PM	Ongoing

3.	Some corridor areas required re-decorating.	The practice must ensure that the affected corridor areas are re-decorated.	Safe Care	This will addressed as and when funds are available	PM	Ongoing
4.	One of the heaters in the corridor leading from the main waiting area to the consulting rooms was very hot and could present a danger to patients and staff.	The practice must ensure that the heater in the corridor leading from the main waiting area to the consulting rooms is covered or the temperature regulated to reduce the risk of harm to patients and staff.		Awaiting professional advise	PM	Ongoing
5.	The infection control policy, which was reviewed in February 2025, was not signed by the staff member undertaking the review.	The practice must ensure that policies are signed by the staff member undertaking the review.		This will be reviewed again and will be signed by clinical lead ANP once completed.	Clinical Lead ANP	3months
6.	Hand washing facilities in the consulting/treatment rooms were not consistent with current standards as they had tiled splashbacks. This	The practice must promptly replace the splashbacks within consulting/ treatment rooms, to minimise the risk of cross infection.		We are currently reviewing this area of concern and this will be addressed finances permitting	Clinical Lead ANP/PM/GP	3months

	made the splashbacks difficult to clean and increased the risk of cross infection.					
7.	Medication for use in an emergency was not stored in a tamper evident container.	The practice must ensure that medication for use in an emergency is stored in a tamper evident container.		This has been actioned	Clinical Lead ANP	Completed
8.	There was no means of monitoring the refrigerator temperature in the event of a power failure.	The practice must ensure that the temperature of the refrigerator can be monitored in the event of a power failure.		We have a data logger in every fridge from which the data is downloaded monthly. We monitor the temperatures twice a daily in paper format. The data loggers would inform us precisely when the temperature was not within the range. Unsure what further monitoring process needs to be implemented?	Clinical Lead ANP	Completed
9.	The temperature of the room housing non refrigerated	The practice must ensure that the temperature of the room housing non		Mobile digital thermometer ordered	Clinical Lead ANP	Completed

	medication was not monitored.	refrigerated medication is monitored on a regular basis.		and temperatures monitored daily.		
10.	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.		We have carried out an audit and will appropriately code all children identified from the search.	Clinical Lead ANP	3months
11.	An annual check and calibration on some items of medical equipment was overdue from February 2025.	The practice must ensure that overdue checks and calibration of medical equipment is undertaken without further delay.		Completed 16th April 2025	PM	Completed
12.	There was little evidence of audit activity around Read Coding and notes summarising.	The practice must set up a process for regularly auditing Read Coding and summarising of notes to ensure accuracy and consistency.		We will review between 10-20 care records on a monthly basis to ensure that appropriate read have been used and will audit medical notes summarisation	GP/Clinical Lead ANP	Ongoing
13.	The role and responsibilities of the practice manager	The practice must review role and responsibilities of the practice manager to	Leadership	Ongoing discussions. We will imminently be advertising for	PM/GP	Ongoing

	requires review to ensure that they have sufficient time and resources to fully perform their duties. In addition, the GP partners should review their roles and input in the management of the service in support of the practice manager.	ensure that they have sufficient time and resources to fully perform their duties, and the GP partners should review their roles and input in the management of the service in support of the practice manager.		reception manager to relieve some of the pressure from the current PM. GP's to engage regularly with PM to provide support.		
14.	There was little evidence of general and more specific clinical audit and peer review taking place.	The practice must formalise processes for general and more specific clinical audit and peer review.		Clinical Lead ANP is currently reviewing audits and clinical supervision sessions and to provide support to clinical staff as and when required	Clinical Lead ANP/GP	Ongoing
15.	There was no staff training matrix in place to easily identify training compliance and any renewal dates.	The practice should maintain a staff training matrix to easily identify training compliance and any renewal dates.	Workforce	Currently working on completion of matrix	PM	Ongoing

16.	Annual performance, development and appraisal meetings were sporadic.	The practice must ensure that all staff have an annual performance, development and appraisal meeting with their line manager.		Arranging annual reviews for all staff at the same time	Clinical Lead ANP/PM	Annual

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): Dr Sushila Manilal

Job role: Practice Manager

Date: 21/05/2025